The Joint Commission

Critical Access Hospital Crosswalk – Current State Compared to Future State

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§412.25	§412.25 Excluded hospital units: Common Requirements		
§412.25(a)	(a) Basis for exclusion. In order to be excluded from the prospective payment systems as specified in §412.1(a)(1) and be paid under the inpatient psychiatric facility prospective payment system as specified in §412.1(a)(2) or the inpatient rehabilitation facility prospective payment system as specified in §412.1(a)(3), a psychiatric or rehabilitation unit must meet the following requirements.		
§412.25(a)(1)	(1) Be part of an institution that—		
§412.25(a)(1)(i)	(i) Has in effect an agreement under part 489 of this chapter to participate as a hospital;		
§412.25(a)(1)(ii)	(ii) Is not excluded in its entirety from the prospective payment systems; and		
§412.25(a)(1)(iii)	(iii) Unless it is a unit in a critical access hospital, the hospital of which an IRF is a unit must have at least 10 staffed and maintained hospital beds that are not excluded from the inpatient prospective payment system, or at least 1 staffed and maintained		

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	hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater. Otherwise, the IRF will be classified as an IRF hospital, rather than an IRF unit. In the case of an inpatient psychiatric facility unit, the hospital must have enough beds that are not excluded from the inpatient prospective payment system to permit the provision of adequate cost information, as required by §413.24(c) of this chapter.		
§412.25(a)(2)	(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.	**PC.01.01.01, EP 2** The critical access 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 Note: For rehabilitation distinct part units in critical access hospitals: A rehabilitation physician reviews and approves the patient's preadmission screening prior to the patient's admission to the unit.	**PC.11.01.01, EP 1** The critical access hospital develops and implements a written process for accepting a patient that addresses admission criteria and procedures for accepting referrals. Note: Admission criteria is applied uniformly to all patients (both Medicare and non-Medicare patients).
§412.25(a)(3)	(3) Have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.	**RC.01.01.01, EP 12** For rehabilitation and psychiatric distinct part units in critical access hospitals: Admission and discharge records for rehabilitation and psychiatric distinct part units are separately identified from those of the critical access hospital in which the units are located.	**RC.11.01.01, EP 8** For rehabilitation and psychiatric distinct part units in critical access hospitals: Admission and discharge records for rehabilitation and psychiatric distinct part units are separately identified from those of the critical access hospital in which the units are located.
§412.25(a)(4)	(4) Have policies specifying that necessary clinical information is transferred to the unit when a	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide	**PC.14.02.01, EP 1** The critical access hospital develops and implements a process to receive or share patient information when

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	patient of the hospital is transferred to the unit.	and support patient care, treatment, and services. **PC.02.02.01, EP 1** The critical access hospital follows a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. **PC.02.02.01, EP 2** The critical access 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 critical access 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.	the patient is referred to internal providers of care, treatment, and services. Note: For rehabilitation distinct part units in critical access hospitals: The process includes how it will transmit necessary clinical patient information to the distinct part unit when a critical access hospital patient is transferred to the unit.
§412.25(a)(5)	(5) Meet applicable State licensure laws.	**LD.04.01.01, EP 1** The critical access 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 critical access 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	**LD.13.01.01, EP 2** The critical access hospital is licensed in accordance with law and regulation to provide the care, treatment, or services for which the critical access hospital is seeking accreditation from The Joint Commission. Note: For rehabilitation or psychiatric distinct part units in critical access hospitals: The critical access hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality.

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		CFR 493.55 and 493.3) and applicable state law. 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.	
§412.25(a)(6)	(6) Have utilization review standards applicable for the type of care offered in the unit.	**LD.04.01.01, EP 9** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has utilization review standards appropriate to rehabilitation or psychiatric services, or verification that the quality improvement organization (QIO) is conducting review activities.	**LD.13.01.03, EP 11** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has utilization review standards appropriate to the services offered in the unit(s).
§412.25(a)(7)	(7) Have beds physically separate from (that is, not commingled with) the hospital's other beds.	**LD.04.01.01, EP 11** For rehabilitation and psychiatric distinct part units in critical access hospitals: The rehabilitation or psychiatric distinct part unit(s) beds are physically separate from the critical access hospital's other beds.	**LD.13.01.01, EP 4** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.
§412.25(a)(8)	(8) Be serviced by the same fiscal intermediary as the hospital.		

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§412.25(a)(9)	(9) Be treated as a separate cost center for cost finding and apportionment purposes.		
§412.25(a)(10)	(10) Use an accounting system that properly allocates costs.		
§412.25(a)(11)	(11) Maintain adequate statistical data to support the basis of allocation.		
§412.25(a)(12)	(12) Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital.		
§412.25(a)(13)	(13) As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.	**LD.01.03.01, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body provides for organization management and planning. **LD.03.03.01, EP 2** Planning is hospitalwide, systematic, and involves designated individuals and information sources. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.11, EP 2** The arrangement and allocation of space supports safe, efficient, and effective care, treatment, and services.	**NPG.12.01.01, EP 1** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other

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		LD.04.01.11, EP 5 The leaders provide for equipment, information systems, supplies, and other resources.	exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.
§412.25(b)	(b) Changes in the size of excluded units. Except in the special cases noted at the end of this paragraph, changes in the number of beds or square footage considered to be part of an excluded unit under this section are allowed one time during a cost reporting period if the hospital notifies its Medicare contractor and the CMS RO in writing of the planned change at least 30 days before the date of the change. The hospital must maintain the information needed to accurately determine costs that are attributable to the excluded unit. A change in bed size or a change in square footage may occur at any time during a cost reporting period and must remain in effect for the rest of that cost reporting period. Changes in bed size or square footage may be made at any time if these changes are made necessary by relocation of a unit to permit construction or renovation necessary for compliance with changes in		

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	Federal, State, or local law affecting the physical facility or because of catastrophic events such as fires, floods, earthquakes, or tornadoes.		
§412.25(c)	(c) Changes in the status of hospital units. For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.		
§412.25(c)(1)	(1) The status of a hospital unit may be changed from not excluded to excluded only at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.		
§412.25(c)(2)	(2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains		

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	the information needed to accurately determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.		
§412.25(d)	(d) Number of excluded units. Each hospital may have only one unit of each type (psychiatric or rehabilitation) excluded from the prospective payment systems.		
§412.25(e)	(e) Satellite facilities.		
§412.25(e)(1)	(1) For purposes of paragraphs (e)(2) through (e)(5) of this section, a satellite facility is a part of a hospital unit that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.		
§412.25(e)(2)	(2) Except as provided in paragraphs (e)(3) and (e)(6) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the acute care		

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	hospital inpatient prospective payment systems for any period:		
§412.25(e)(2)(i)	(i) In the case of a unit excluded from the prospective payment systems for the most recent cost reporting period beginning before October 1, 1997, the unit's number of State-licensed and Medicare-certified beds, including those at the satellite facility, does not exceed the unit's number of State-licensed and Medicare-certified beds on the last day of the unit's last cost reporting period beginning before October 1, 1997.		
§412.25(e)(2)(ii)	(ii) The satellite facility independently complies with—		
§412.25(e)(2)(ii)(A)	(A) For a rehabilitation unit, the requirements under §412.29; or		
§412.25(e)(2)(ii)(B)	(B) For a psychiatric unit, the requirements under §412.27(a).		
§412.25(e)(2)(iii)	(iii) The satellite facility meets all of the following requirements:		
§412.25(e)(2)(iii)(A)	(A) Effective for cost reporting periods beginning on or after October 1, 2002, it is not under the control of the governing body or chief executive officer of the hospital in which it is located, and it furnishes inpatient care through the use of medical personnel who are not under the control of the medical staff or chief medical		

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	officer of the hospital in which it is located.		
§412.25(e)(2)(iii)(B)	(B) It maintains admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available.		
§412.25(e)(2)(iii)(C)	(C) It has beds that are physically separate from (that is, not commingled with) the beds of the hospital in which it is located.		
§412.25(e)(2)(iii)(D)	(D) It is serviced by the same fiscal intermediary as the hospital unit of which it is a part.		
§412.25(e)(2)(iii)(E)	(E) It is treated as a separate cost center of the hospital unit of which it is a part.		
§412.25(e)(2)(iii)(F)	(F) For cost reporting and apportionment purposes, it uses an accounting system that properly allocates costs and maintains adequate statistical data to support the basis of allocation.		
§412.25(e)(2)(iii)(G)	(G) It reports its costs on the cost report of the hospital of which it is a part, covering the same fiscal period and using the same method of apportionment as the hospital of which it is a part.		
§412.25(e)(2)(iv)	(iv) Effective for cost reporting periods beginning on or after October 1, 2019, the requirements		

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	of paragraph (e)(2)(iii)(A) of this section do not apply to a satellite facility of a unit that is part of a hospital excluded from the prospective payment systems specified in §412.1(a)(1) that does not furnish services in a building also used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1), or in one or more entire buildings located on the same campus as buildings used by another hospital that is not excluded from the prospective payment systems specified in §412.1(a)(1).		
§412.25(e)(3)	(3) Except as specified in paragraphs (e)(4) and (e)(5) of this section, the provisions of paragraph (e)(2) of this section do not apply to any unit structured as a satellite facility on September 30, 1999, and excluded from the prospective payment systems on that date, to the extent the unit continues operating under the same terms and conditions, including the number of beds and square footage considered to be part of the unit at the satellite facility on September 30, 1999.		

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§412.25(e)(4)	(4) In applying the provisions of paragraph (e)(3) of this section, any unit structured as a satellite facility on September 30, 1999, may increase or decrease the square footage of the satellite facility or may decrease the number of beds in the satellite facility considered to be part of the satellite facility at any time, if these changes are made by the relocation of a facility—		
§412.25(e)(4)(i)	(i) To permit construction or renovation necessary for compliance with changes in Federal, State, or local law affecting the physical facility; or		
§412.25(e)(4)(ii)	(ii) Because of catastrophic events such as fires, floods, earthquakes, or tornadoes.		
§412.25(e)(5)	(5) For cost reporting periods beginning on or after October 1, 2006, in applying the provisions of paragraph (e)(3) of this section—		
§412.25(e)(5)(i)	(i) Any unit structured as a satellite facility on September 30, 1999, may increase the square footage of the unit only at the beginning of a cost reporting period or decrease the square footage or number of beds considered to be part of the satellite facility subject to the provisions of paragraph (b)(2) of		

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	this section, without affecting the provisions of paragraph (e)(3) of this section; and		
§412.25(e)(5)(ii)	(ii) If the unit structured as a satellite facility decreases its number of beds below the number of beds considered to be part of the satellite facility on September 30, 1999, subject to the provisions of paragraph (b)(2) of this section, it may subsequently increase the number of beds at the beginning or a cost reporting period as long as the resulting total number of beds considered to be part of the satellite facility does not exceed the number of beds at the satellite facility on September 30, 1999.		
§412.25(e)(6)	(6) The provisions of paragraph (e)(2)(i) of this section do not apply to any inpatient rehabilitation facility that is subject to the inpatient rehabilitation facility prospective payment system under subpart P of this part, effective for cost reporting periods beginning on or after October 1, 2003.		
§412.25(f)	(f) Changes in classification of hospital units. For purposes of exclusions from the prospective payment system under this section, the classification of a		

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	hospital unit is effective for the unit's entire cost reporting period. Any change in the classification of a hospital unit is made only at the start of a cost reporting period.		
§412.25(g)	(g) CAH units not meeting applicable requirements. If a psychiatric or rehabilitation unit of a CAH does not meet the requirements of §485.647 with respect to a cost reporting period, no payment may be made to the CAH for services furnished in that unit for that period. Payment to the CAH for services in the unit may resume only after the start of the first cost reporting period beginning after the unit has demonstrated to CMS that the unit meets the requirements of §485.647.		
§412.27	§412.27 Excluded psychiatric units: Additional requirements. In order to be excluded from the prospective payment system as specified in §412.1(a)(1), and paid under the prospective payment system as specified in §412.1(a)(2), a psychiatric unit must meet the following requirements:		
§412.27(a)	(a) Admit only patients whose admission to the unit is required	**PC.01.01.01, EP 33** For psychiatric distinct part units in critical access	**PC.11.01.01, EP 3** For psychiatric distinct part units in critical access

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	for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the Fourth Edition, Text Revision of the American Psychiatric Association's Diagnostic and Statistical Manual, or in Chapter Five ("Mental Disorders'') of the International Classification of Diseases, Ninth Revision, Clinical Modification.	hospitals: Patients with a psychiatric principal diagnosis (listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) or in Chapter 5 of the International Classification of Diseases, 9th Revision (ICD-9-CM)) are admitted only when the intensity of the active treatment can be provided only in an inpatient hospital setting.	hospitals: Patients with a psychiatric principal diagnosis (listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) or in Chapter 5 of the International Classification of Diseases, 9th Revision (ICD-9-CM)) are admitted only when the intensity of the active treatment can be provided only in an inpatient hospital setting.
§412.27(b)	(b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and therapeutic activities.	**LD.04.03.01, EP 14** For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities.	**LD.13.03.01, EP 18** For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. Note 2: The psychological services are provided in accordance with accepted standards of practice, service objectives, and established policies and procedures.
§412.27(c)	(c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and		**RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the

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	that meet the following requirements:		psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(c)(1)	(1) Development of assessment/diagnostic data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.	**PC.01.02.13, EP 1** For psychiatric distinct part units in critical access hospitals: Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes a history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and their treatment. **PC.01.02.13, EP 2**	**RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status

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		For psychiatric distinct part units in critical access hospitals: 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 - Reason for admission as stated by the patient and/or others significantly involved in the patient's care. **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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports	- Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge

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		- Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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	
§412.27(c)(1)(i)	(i) The identification data must include the inpatient's legal status.	**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	**RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is

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

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		- 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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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	time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge

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		- Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	
§412.27(c)(1)(iii)	(iii) The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.	**PC.01.02.13, EP 2** For psychiatric distinct part units in critical access hospitals: 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 - Reason for admission as stated by the patient and/or others significantly involved in the patient's care.	**RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare,

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			and a brief summary of the patient's condition on discharge
§412.27(c)(1)(iv)	(iv) The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.	**PC.01.02.13, EP 3** For psychiatric distinct part units in critical access hospitals: 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 **PC.01.02.13, EP 4** For psychiatric distinct part units in critical access hospitals: 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	**RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Self care **PC.01.02.13, EP 5** For psychiatric distinct part units in critical access hospitals: 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	
§412.27(c)(1)(v)	(v) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.	**PC.01.02.13, EP 6** For psychiatric distinct part units in critical access hospitals: Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following: - A psychiatric evaluation - Psychological assessments, including intellectual, projective, neuropsychological, and personality testing - Complete neurological examination, when indicated	**PC.11.02.03, EP 1** For psychiatric distinct part units in critical access hospitals: Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes a history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and their treatment. **RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(c)(2)	(2) Psychiatric evaluation. Each inpatient must receive a psychiatric evaluation that must—		
§412.27(c)(2)(i)	(i) Be completed within 60 hours of admission;	**PC.01.02.13, EP 7** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission.	**PC.11.02.03, EP 2** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(ii)	(ii) Include a medical history;	**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 rehabilitation and psychiatric distinct part units in critical access hospitals: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text. **PC.01.02.03, EP 5** For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: Medical histories and physical examinations are performed as required in this element of performance, except 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	**PC.11.02.03, EP 2** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.	
§412.27(c)(2)(iii)	(iii) Contain a record of mental status;	**PC.01.02.13, EP 2** For psychiatric distinct part units in critical access hospitals: 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 - Reason for admission as stated by the patient and/or others significantly involved in the patient's care.	**PC.11.02.03, EP 2** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(iv)	(iv) Note the onset of illness and the circumstances leading to admission;	**PC.01.02.13, EP 1** For psychiatric distinct part units in critical access hospitals: Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes a history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and their treatment. **PC.01.02.13, EP 2** For psychiatric distinct part units in critical access hospitals: 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	**PC.11.02.03, EP 2** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Reason for admission as stated by the patient and/or others significantly involved in the patient's care.	
§412.27(c)(2)(v)	(v) Describe attitudes and behavior;	**PC.01.02.13, EP 2** For psychiatric distinct part units in critical access hospitals: 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 - Reason for admission as stated by the patient and/or others significantly involved in the patient's care. **PC.01.02.13, EP 4** For psychiatric distinct part units in critical access hospitals: 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	**PC.11.02.03, EP 2** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(vi)	(vi) Estimate intellectual functioning, memory functioning, and orientation; and	**PC.01.02.13, EP 2** For psychiatric distinct part units in critical access hospitals: Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following: - Current mental, emotional, and behavioral functioning	**PC.11.02.03, EP 2** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Maladaptive or other behaviors that create a risk to the patient or others - Mental status examination - Reason for admission as stated by the patient and/or others significantly involved in the patient's care.	- Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(2)(vii)	(vii) Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.	**PC.01.02.13, EP 3** For psychiatric distinct part units in critical access hospitals: 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	**PC.11.02.03, EP 2** For psychiatric distinct part units in critical access hospitals: Each patient receives a psychiatric evaluation completed within 60 hours of admission. The psychiatric evaluation includes the following: - Medical history - Record of mental status - Description of the onset of illness and the circumstances leading to admission - Description of attitudes and behavior - Estimation of intellectual functioning, memory functioning, and orientation - Inventory of the patient's assets in descriptive, not interpretative, fashion
§412.27(c)(3)	(3) Treatment plan.		
§412.27(c)(3)(i)	(i) Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.	**PC.11.03.01, EP 3** For psychiatric distinct part units in critical access hospitals: Each patient has an individual comprehensive treatment plan that is based on an inventory of the patient's strengths and disabilities. The written plan includes the following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and	**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 distinct part units in critical access hospitals: The patient's goals include both short- and long-term goals. **PC.01.03.01, EP 43** For psychiatric distinct part units in critical access hospitals: The plan of care includes the responsibilities of each member of the treatment team.	- Substantiated diagnosis - Short-term and long-term goals - Specific treatment modalities utilized - Responsibilities of each member of the treatment team - Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
§412.27(c)(3)(ii)	(ii) The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.	**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 critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services	**RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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.	physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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	
§412.27(c)(4)	(4) Recording progress. Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 22** Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs. **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	**RC.12.01.01, EP 4** For psychiatric distinct part units in critical access hospitals: Progress notes are recorded at least weekly for the first two months of a patient's stay and at least monthly thereafter by the following individuals involved in the active treatment of the patient: - Physician(s), psychologist(s), or other licensed practitioner(s) responsible for the care of the inpatient - Nurse - Social worker - Others involved in active treatment modalities The progress notes include revisions to the treatment plan and assessments of the patient's progress in accordance with the original or revised treatment plan.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation **RC.02.01.01, EP 7** For psychiatric distinct part units in critical access hospitals: Progress notes are recorded by the following individuals involved in the active treatment of the patient: - The physician(s), psychologist(s), or other licensed practitioner(s) responsible for the care of the inpatient - A nurse - A social worker - Others involved in active treatment modalities The above individuals record progress notes at least weekly for the first two months of a patient's stay and at least monthly thereafter.	
§412.27(c)(5)	(5) Discharge planning and discharge summary. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.	**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 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 - For critical access hospitals with swing beds: Where the	**RC.11.01.01, EP 6** For psychiatric distinct part units in critical access hospitals: The medical record reflects the degree and intensity of treatment and contains the following information: - History of findings and treatment provided for the psychiatric condition for which the patient is hospitalized - Identification data, including the patient's legal status - Provisional or admitting diagnosis for the patient at the time of admission that includes the diagnoses of intercurrent diseases as well as the psychiatric

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		resident plans to reside 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 critical access 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.	diagnoses - Reasons for admission, as stated by the patient and/or others significantly involved - Social service records, including reports of interviews with patients, family members, and others; an assessment of home plans, family attitudes, and community resource contacts; and a social history - When indicated, record of a complete neurological examination, recorded at the time of the admission physical examination - Documentation of treatment received, including all active therapeutic efforts - Discharge summary of the patient's hospitalization that includes a recapitulation of the patient's hospitalization in the unit, recommendations from appropriate services concerning follow-up or aftercare, and a brief summary of the patient's condition on discharge
§412.27(d)	(d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning, as follows:	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities.	**NPG.12.03.01, EP 4** For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- Maintain progress notes on each patient - Provide essential psychiatric services
§412.27(d)(1)	(1) Personnel. The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to—	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities.	
§412.27(d)(1)(i)	(i) Evaluate inpatients;	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities.	**NPG.12.03.01, EP 4** For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services
§412.27(d)(1)(ii)	(ii) Formulate written, individualized, comprehensive treatment plans;	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.	**NPG.12.03.01, EP 4** For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 distinct part units in critical access hospitals: The patient's goals include both short- and long-term goals. **PC.01.03.01, EP 22** Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care.	osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services
§412.27(d)(1)(iii)	(iii) Provide active treatment measures; and	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 5** The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric distinct part units in critical access	**NPG.12.03.01, EP 4** For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospitals: The patient's goals include both short- and long-term goals. **PC.01.03.01, EP 22** Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care.	- Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services
§412.27(d)(1)(iv)	(iv) Engage in discharge planning.	**PC.04.01.03, EP 1** The critical access hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.04.01.03, EP 2** The critical access hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. **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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of	**NPG.12.03.01, EP 4** For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		"physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move 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 critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **PC.04.01.05, EP 1** When the critical access 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.	
§412.27(d)(2)	(2) Director of inpatient psychiatric services: Medical staff. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for	**LD.04.01.05, EP 1** Leaders of the program, service, site, or department oversee operations. **LD.04.01.05, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: Programs, services, sites, or	**MS.17.01.03, EP 6** For psychiatric distinct part units in critical access hospitals: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.	departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **MS.03.01.03, EP 1** Physicians and other licensed practitioners with appropriate privileges manage and coordinate the patient's care, treatment, and services. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).	requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
§412.27(d)(2)(i)	(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.	**MS.06.01.03, EP 7** For psychiatric distinct part units in critical access hospitals: 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.	**MS.17.01.03, EP 6** For psychiatric distinct part units in critical access hospitals: Inpatient psychiatric services are under the direction and supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program and who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
§412.27(d)(2)(ii)	(ii) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	**LD.04.01.05, EP 3** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: This includes the full-time employee who directs	**MS.16.01.01, EP 8** For psychiatric distinct part units in critical access hospitals: The clinical director, service chief, or equivalent for inpatient psychiatric services monitors and evaluates the medical staff's treatment and services for quality and appropriateness.

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		and manages dietary services. **MS.05.01.01, EP 13** The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A Quality Improvement Organization (QIO) or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan	**MS.17.01.03, EP 9** The quality and appropriateness of the diagnosis and treatment provided by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A quality improvement organization or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan Note: In the case of distant-site physicians and practitioners providing telemedicine services to the critical access hospital's patients under an agreement between the critical access hospital and a distant hospital or between the critical access hospital and a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment provided is evaluated by one of the entities listed in this element of performance.
§412.27(d)(3)	(3) Nursing services. The unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each inpatient's active treatment program and to maintain progress notes on each inpatient.	**HR.01.01.01, EP 30** For psychiatric distinct part units in critical access hospitals: The director of psychiatric nursing is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.	**NPG.12.02.01, EP 6** For psychiatric distinct part units in critical access hospitals: The director of psychiatric nursing is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided.

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		LD.03.06.01, EP 2 Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities.	**NPG.12.03.01, EP 4** For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services
§412.27(d)(3)(i)	(i) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and	**HR.01.01.01, EP 30** For psychiatric distinct part units in critical access hospitals: The director of psychiatric nursing is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.	**NPG.12.02.01, EP 6** For psychiatric distinct part units in critical access hospitals: The director of psychiatric nursing is a registered nurse who has a master's degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care provided.

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	evaluate the nursing care furnished.		
§412.27(d)(3)(ii)	(ii) The staffing pattern must ensure the availability of a registered nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each inpatient's active treatment program.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **NR.02.03.01, EP 4** For rehabilitation and psychiatric distinct part units in critical access hospitals: The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week.	**NPG.12.03.01, EP 2** For psychiatric distinct part units in critical access hospitals: The critical access hospital makes certain a registered professional nurse is available 24 hours a day. **NPG.12.03.01, EP 4** For psychiatric distinct part units in critical access hospitals: There is an adequate number of qualified professional, technical, and consultative staff (including but not limited to doctors of medicine and/or osteopathy, registered nurses, licensed practical nurses, and mental health workers) to do the following: - Evaluate patients - Formulate written individualized, comprehensive treatment plans - Provide active treatment measures - Engage in discharge planning - Provide the nursing care necessary under each patient's active treatment program - Maintain progress notes on each patient - Provide essential psychiatric services
§412.27(d)(4)	(4) Psychological services. The unit must provide or have available psychological services to meet the needs of the inpatients. The services must be furnished in accordance with acceptable standards of practice, service objectives, and established policies and procedures.	**LD.03.03.01, EP 2** Planning is hospitalwide, systematic, and involves designated individuals and information sources. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.	**LD.13.03.01, EP 18** For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal

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		LD.04.03.01, EP 1 The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. **LD.04.03.01, EP 14** For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities.	levels of physical and psychosocial functioning. Note 2: The psychological services are provided in accordance with accepted standards of practice, service objectives, and established policies and procedures.
§412.27(d)(5)	(5) Social services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **HR.01.06.01, EP 1** The critical access hospital defines the competencies it	**NPG.12.03.01, EP 6** For psychiatric distinct part units in critical access hospitals: The critical access hospital has a director of social services who monitors and evaluates the quality and appropriateness of social services provided. Social services staff responsibilities include but are not limited to the following: - Participating in discharge planning - Arranging for follow-up care - Developing mechanisms for the exchange of appropriate information with sources outside the critical access hospital Note: Social services are provided in accordance with accepted standards of practice and established policies and procedures.

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		requires of its staff who provide patient care, treatment, or services. **LD.04.01.05, EP 1** Leaders of the program, service, site, or department oversee operations. **LD.04.01.05, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: This includes the full-time employee who directs and manages dietary services. **LD.04.01.05, EP 10** For psychiatric distinct part units in critical access hospitals: The critical access 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. **LD.04.03.01, EP 14**	

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		For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities. **PC.04.01.03, EP 1** The critical access hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.04.01.03, EP 2** The critical access hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. **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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if	

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		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 critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.	
§412.27(d)(6)	(6) Therapeutic activities. The unit must provide a therapeutic activities program.	**LD.04.03.01, EP 14** For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities.	**LD.13.03.01, EP 18** For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. Note 2: The psychological services are provided in accordance with accepted standards of practice, service objectives, and established policies and procedures.
§412.27(d)(6)(i)	(i) The program must be appropriate to the needs and interests of inpatients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.	**LD.03.03.01, EP 1** Planning activities focus on the following: - Improving patient safety and health care quality - Supporting a culture of safety and quality - Adapting to changes in the environment **LD.03.03.01, EP 2** Planning is hospitalwide, systematic, and involves designated individuals and information sources. **LD.04.03.01, EP 14**	**LD.13.03.01, EP 18** For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities provided by qualified staff to meet the needs of its patients. Note 1: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning. Note 2: The psychological services are provided in

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		For psychiatric distinct part units in critical access hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities. **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 distinct part units in critical access hospitals: The patient's goals include both short- and long-term goals.	accordance with accepted standards of practice, service objectives, and established policies and procedures.
§412.27(d)(6)(ii)	(ii) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each inpatient's active treatment program.	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **LD.03.06.01, EP 2**	**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. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully

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		Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities.	equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date. **NPG.12.03.01, EP 3** For psychiatric distinct part units in critical access hospitals: The number of qualified therapists, support personnel, and consultants is adequate to provide therapeutic activities consistent with each patient's active treatment program.
§412.29	§412.29 Classification criteria for payment under the inpatient rehabilitation facility prospective payment system. To be excluded from the prospective payment systems described in §412.1(a)(1) and to be paid under the prospective payment system specified in §412.1(a)(3), an inpatient rehabilitation hospital or an inpatient rehabilitation unit of a hospital (otherwise referred to as an IRF) must meet the following requirements:		
§412.29(a)	(a) Have (or be part of a hospital that has) a provider agreement under part 489 of this chapter to participate as a hospital.		
§412.29(b)	(b) Except in the case of a "new" IRF or "new" IRF beds, as defined in paragraph (c) of this section, an IRF must show that, during its		

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	most recent, consecutive, and appropriate 12-month time period (as defined by CMS or the Medicare contractor), it served an inpatient population that meets the following criteria:		
§412.29(b)(1)	(1) For cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the IRF served an inpatient population of whom at least 50 percent, and for cost reporting periods beginning on or after July 1, 2005, the IRF served an inpatient population of whom at least 60 percent required intensive rehabilitation services for treatment of one or more of the conditions specified at paragraph (b)(2) of this section. A patient with a comorbidity, as defined at §412.602 of this part, may be included in the inpatient population that counts toward the required applicable percentage if—		
§412.29(b)(1)(i)	(i) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2) of this section;		
§412.29(b)(1)(ii)	(ii) The patient has a comorbidity that falls in one of the conditions		

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	specified in paragraph (b)(2) of this section; and		
§412.29(b)(1)(iii)	(iii) The comorbidity has caused significant decline in functional ability in the individual that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and that cannot be appropriately performed in another care setting covered under this title.		
§412.29(b)(2)	(2) List of conditions.		
§412.29(b)(2)(i)	(i) Stroke.		
§412.29(b)(2)(ii)	(ii) Spinal cord injury.		
§412.29(b)(2)(iii)	(iii) Congenital deformity.		
§412.29(b)(2)(iv)	(iv) Amputation.		
§412.29(b)(2)(v)	(v) Major multiple trauma.		
§412.29(b)(2)(vi)	(vi) Fracture of femur (hip fracture).		
§412.29(b)(2)(vii)	(vii) Brain injury.		
§412.29(b)(2)(viii)	(viii) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.		
§412.29(b)(2)(ix)	(ix) Burns.		
§412.29(b)(2)(x)	(x) Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment		

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	of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.		
§412.29(b)(2)(xi)	(xi) Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.		
§412.29(b)(2)(xii)	(xii) Severe or advanced osteoarthritis (osteoarthrosis or		

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	degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)		
§412.29(b)(2)(xiii)	(xiii) Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:		

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§412.29(b)(2)(xiii)(A)	(A) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.		
§412.29(b)(2)(xiii)(B)	(B) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.		
§412.29(b)(2)(xiii)(C)	(C) The patient is age 85 or older at the time of admission to the IRF.		
§412.29(c)	(c) In the case of new IRFs (as defined in paragraph (c)(1) of this section) or new IRF beds (as defined in paragraph (c)(2)of this section), the IRF must provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b) of this section. This written certification will apply until the end of the IRF's first full 12-month cost reporting period or, in the case of new IRF beds, until the end of the cost reporting period during which the new beds are added to the IRF.		
§412.29(c)(1)	(1) New IRFs. An IRF hospital or IRF unit is considered new if it has not been paid under the IRF PPS in subpart P of this part for at least 5 calendar years. A new IRF will be		

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	considered new from the point that it first participates in Medicare as an IRF until the end of its first full 12-month cost reporting period.		
§412.29(c)(2)	(2) New IRF beds. Any IRF beds that are added to an existing IRF must meet all applicable State Certificate of Need and State licensure laws. New IRF beds may be added one time at any point during a cost reporting period and will be considered new for the rest of that cost reporting period. A full 12-month cost reporting period must elapse between the delicensing or decertification of IRF beds in an IRF hospital or IRF unit and the addition of new IRF beds to that IRF hospital or IRF unit. Before an IRF can add new beds, it must receive written approval from the appropriate CMS RO, so that the CMS RO can verify that a full 12-month cost reporting period has elapsed since the IRF has had beds delicensed or decertified. New IRF beds are included in the compliance review calculations under paragraph (b) of this section from the time that they are added to the IRF.		

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§412.29(c)(3)	(3) Change of ownership or leasing. An IRF hospital or IRF unit that undergoes a change of ownership or leasing, as defined in §489.18 of this chapter, retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the change of ownership or leasing if the new owner(s) of the IRF accept assignment of the previous owners' Medicare provider agreement and the IRF continues to meet all of the requirements for payment under the IRF prospective payment system. If the new owner(s) do not accept assignment of the previous owners' Medicare provider agreement, the IRF is considered to be voluntarily terminated and the new owner(s) may re-apply to participate in the Medicare program. If the IRF does not continue to meet all of the requirements for payment under the IRF prospective payment system, then the IRF loses its excluded status and is paid according to the prospective payment systems described in §412.1(a)(1).		

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§412.29(c)(4)	(4) Mergers. If an IRF hospital (or a hospital with an IRF unit) merges with another hospital and the owner(s) of the merged hospital accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit retains its excluded status and will continue to be paid under the prospective payment system specified in §412.1(a)(3) before and after the merger, as long as the IRF hospital or IRF unit continues to meet all of the requirements for payment under the IRF prospective payment system. If the owner(s) of the merged hospital do not accept assignment of the IRF hospital's provider agreement (or the provider agreement of the hospital with the IRF unit), then the IRF hospital or IRF unit is considered voluntarily terminated and the owner(s) of the merged hospital may reapply to the Medicare program to operate a new IRF.		
§412.29(d)	(d) Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the	**MS.03.01.03, EP 1** Physicians and other licensed practitioners with appropriate privileges manage and coordinate the patient's care, treatment, and services. For rehabilitation and psychiatric distinct part units in critical access	**PC.11.01.01, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a preadmission screening procedure under which each prospective patient's condition and medical

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	patient is likely to benefit significantly from an intensive inpatient hospital program. This procedure must ensure that the preadmission screening for each Medicare Part A Fee-for-Service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.	hospitals: Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.03.01.03, EP 5** Consultation is obtained for the circumstances defined by the organized medical staff. **MS.03.01.03, EP 13** For rehabilitation and psychiatric distinct part units in critical access hospitals: Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital. **PC.01.01.01, EP 2** The critical access 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 Note: For rehabilitation distinct part units in critical access hospitals: A rehabilitation physician reviews and approves the patient's preadmission screening prior to the patient's admission to the unit. **PC.01.02.01, EP 1** The critical access hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. Patient information is collected	history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program. Note: This procedure makes certain that the preadmission screening for each Medicare Part A fee-for-service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the inpatient rehabilitation facility.

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		according to these requirements. Note: 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. **PC.01.02.01, EP 2** The critical access 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.	
§412.29(e)	(e) Have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.	**MS.03.01.03, EP 1** Physicians and other licensed practitioners with appropriate privileges manage and coordinate the patient's care, treatment, and services. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient's care, treatment, and services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). **MS.06.01.05, EP 2** The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a	**PC.11.02.01, EP 5** For rehabilitation distinct part units in critical access hospitals: The critical access hospital develops and implements a process to make certain that patients receive close medical supervision, as evidenced by at least three face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation, to assess the patient both medically and functionally and to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Note: Beginning with the second week, as defined in 42 CFR 412.622, after admission to the inpatient rehabilitation unit, a non-physician practitioner who is determined by the inpatient rehabilitation unit to have specialized training and experience in inpatient rehabilitation may conduct one of the three required

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 critical access 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. **PC.01.02.01, EP 1** The critical access hospital defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. Patient information is collected according to these requirements. Note: 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	face-to-face patient visits per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable state law.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		medical jewelry. **PC.01.02.01, EP 2** The critical access 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. **PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note 1: 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. Note 2: For rehabilitation distinct part units in critical access hospitals: The Centers for Medicare & Medicaid Services requires that a physician with specialized training and experience in inpatient rehabilitation conducts at least three face-to-face patient visits per week. **PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 23**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs. **PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 3** The critical access 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. **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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 critical access 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	
§412.29(f)	(f) Furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities.	**PC.12.01.01, EP 4** If the critical access hospital provides rehabilitation, physical therapy, occupational therapy, speech-

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.	Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **LD.04.03.01, EP 15** When a critical access hospital provides rehabilitation therapy services, these services are provided by staff qualified according to state law and the requirements for therapy services from 42 CFR 409.17.	language pathology, or audiology services, the services are organized and provided in accordance with national accepted standards of practice. Note: For rehabilitation distinct part units in critical access hospitals: The critical access hospital provides rehabilitation nursing, physical therapy, and occupational therapy, and, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services by qualified staff in accordance with national accepted standards of practice.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: Rehabilitation therapy services include physical therapy, occupational therapy, and speech-language pathology.	
§412.29(g)	(g) Have a director of rehabilitation who—	**LD.04.01.05, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: This includes the full-time employee who directs and manages dietary services.	
§412.29(g)(1)	(1) Provides services to the IRF hospital and its inpatients on a full-time basis or, in the case of a rehabilitation unit, at least 20 hours per week;	**LD.04.01.05, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: This includes the full-time employee who directs and manages dietary services.	**MS.17.01.03, EP 7** For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy - Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MS.06.01.03, EP 8 For rehabilitation distinct part units in critical access hospitals: The director of the rehabilitation unit fulfills all of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy - Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services	
§412.29(g)(2)	(2) Is a doctor of medicine or osteopathy;	**LD.04.01.05, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: This includes the full-time employee who directs and manages dietary services. **MS.06.01.03, EP 8** For rehabilitation distinct part units in critical access hospitals: The director of the rehabilitation unit fulfills all	**MS.17.01.03, EP 7** For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy - Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy - Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services	
§412.29(g)(3)	(3) Is licensed under State law to practice medicine or surgery; and	**LD.04.01.05, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: This includes the full-time employee who directs and manages dietary services. **MS.06.01.03, EP 8** For rehabilitation distinct part units in critical access hospitals: The director of the rehabilitation unit fulfills all of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy	**MS.17.01.03, EP 7** For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy - Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services	
§412.29(g)(4)	(4) Has had, after completing a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services.	**LD.04.01.05, EP 2** For rehabilitation and psychiatric distinct part units in critical access hospitals: Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges. **LD.04.01.05, EP 3** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. Note: This includes the full-time employee who directs and manages dietary services. **MS.06.01.03, EP 8** For rehabilitation distinct part units in critical access hospitals: The director of the rehabilitation unit fulfills all of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy - Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in	**MS.17.01.03, EP 7** For rehabilitation distinct part units in critical access hospitals: The critical access hospital has a director of the rehabilitation unit who fulfills all of the following requirements: - Provides services to the unit and to its inpatients for at least 20 hours per week - Is a doctor of medicine or osteopathy - Is licensed under state law to practice medicine or surgery - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the medical management of inpatients requiring rehabilitation services	
§412.29(h)	(h) Have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 5** The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals. Note: For psychiatric distinct part units in critical access hospitals: The patient's goals include both short- and long-term goals. **PC.01.03.01, EP 22** Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care.	**PC.11.03.01, EP 1** The critical access hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as needed by a physician in consultation with other professional staff who provide services to the patient.
§412.29(i)	(i) Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the	**PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner.	**PC.12.01.03, EP 1** The critical access hospital provides care, treatment, and services to the patient in an interdisciplinary, collaborative manner.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment and discharge plans, and that team conferences are held at least once per week to determine the appropriateness of treatment.	**PC.02.01.05, EP 2** For rehabilitation distinct part units in critical access hospitals: The critical access hospital conducts team conferences at least once per week to determine the appropriateness of the patient's treatment. **PC.02.02.01, EP 3** The critical access 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.	Note: For rehabilitation distinct part units in critical access hospitals: The critical access hospital uses a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status related to goal attainment and discharge plans, and team conferences that are held at least once per week to determine the appropriateness of treatment.
§412.29(j)	(j) Retroactive adjustments. If a new IRF (or new beds that are added to an existing IRF) are excluded from the prospective payment systems specified in §412.1(a)(1) and paid under the prospective payment system specified in §412.1(a)(3) for a cost reporting period under paragraph (c) of this section, but the inpatient population actually treated during that period does not meet the requirements of paragraph (b) of this section, we adjust payments to the IRF retroactively in accordance with the provisions in §412.130.		
§485.601	§485.601 Basis and scope.		
§485.601(a)	(a) Statutory basis. This subpart is based on section 1820 of the Act which sets forth the conditions for		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	designating certain hospitals as CAHs.		
§485.601(b)	(b) Scope. This subpart sets forth the conditions that a hospital must meet to be designated as a CAH.		
§485.603	§485.603 Rural health network. A rural health network is an organization that meets the following specifications:	**LD.04.01.01, EP 25** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.	**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(a)	(a) It includes—		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(a)(1)	(1) At least one hospital that the State has designated or plans to designate as a CAH; and		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(a)(2)	(2) At least one hospital that furnishes acute care services.		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.603(b)	(b) The members of the organization have entered into agreements regarding—		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(b)(1)	(1) Patient referral and transfer;		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(b)(2)	(2) The development and use of communications systems, including, where feasible, telemetry systems and systems for electronic sharing of patient data; and		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(b)(3)	(3) The provision of emergency and nonemergency transportation among members.		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(c)	(c) Each CAH has an agreement with respect to credentialing and quality assurance with at least—		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			Note: See the Glossary for a definition of rural health network.
§485.603(c)(1)	(1) One hospital that is a member of the network when applicable;		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(c)(2)	(2) One QIO or equivalent entity; or		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.603(c)(3)	(3) One other appropriate and qualified entity identified in the State rural health care plan.		**LD.13.01.01, EP 6** If the critical access hospital is a member of a rural health network, the network meets the criteria required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.603. Note: See the Glossary for a definition of rural health network.
§485.604	§485.604 Personnel qualifications. Staff that furnish services in a CAH must meet the applicable requirements of this section.	**HR.01.02.05, EP 43** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.	**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.604(a)	(a) Clinical nurse specialist. A clinical nurse specialist must be a person who—		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(a)(1)	(1) Is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed in accordance with State nurse licensing laws and regulations; and		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(a)(2)	(2) Holds a master's or doctoral level degree in a defined clinical area of nursing from an accredited educational institution.		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(b)	(b) Nurse practitioner. A nurse practitioner must be a registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualification of nurse practitioners, and who meets one of the following conditions:		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.604(b)(1)	(1) Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates.		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(b)(2)	(2) Has successfully completed a 1 academic year program that—		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(b)(2)(i)	(i) Prepares registered nurses to perform an expanded role in the delivery of primary care;		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(b)(2)(ii)	(ii) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.604(b)(2)(iii)	(iii) Awards a degree, diploma, or certificate to persons who successfully complete the program.		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(b)(3)	(3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of paragraph (a)(2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding June 25, 1993.		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(c)	(c) Physician assistant. A physician assistant must be a person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(c)(1)	(1) Is currently certified by the National Commission on Certification of Physician		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	Assistants to assist primary care physicians.		at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(c)(2)	(2) Has satisfactorily completed a program for preparing physician assistants that—		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(c)(2)(i)	(i) Was at least one academic year in length;		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(c)(2)(ii)	(ii) Consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(c)(2)(iii)	(iii) Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation.		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.604(c)(3)	(3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements of paragraph (c)(2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding June 25, 1993.		**NPG.12.01.01, EP 2** Staff that provide care, treatment, and services meet the personnel qualifications required by the Centers for Medicare & Medicaid Services' (CMS) regulations at 42 CFR 485.604. Note: The following terms are defined in the Glossary: clinical nurse specialist, nurse practitioner, physician assistant.
§485.606	§485.606 Designation and certification of CAHs.		
§485.606(a)	(a) Criteria for State designation.		
§485.606(a)(1)	(1) A State that has established a Medicare rural hospital flexibility program described in section 1820(c) of the Act may designate one or more facilities as CAHs if each facility meets the CAH conditions of participation in this subpart F.		
§485.606(a)(2)	(2) The State must not deny any hospital that is otherwise eligible for designation as a CAH under this paragraph (a) solely because the hospital has entered into an agreement under which the hospital may provide post hospital SNF care as described in § 482.58 of this chapter.		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.606(b)	(b) Criteria for CMS certification. CMS certifies a facility as a CAH if—		
§485.606(b)(1)	(1) The facility is designated as a CAH by the State in which it is located and has been surveyed by the State survey agency or by CMS and found to meet all conditions of participation in this Part and all other applicable requirements for participation in Part 489 of this chapter.		
§485.606(b)(2)	(2) The facility is a medical assistance facility operating in Montana or a rural primary care hospital designated by CMS before August 5, 1997, and is otherwise eligible to be designated as a CAH by the State under the rules in this subpart.		
§485.608	§485.608 Condition of Participation: Compliance With Federal, State, and Local Laws and Regulations The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.	**LD.04.01.01, EP 1** The critical access 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 critical access 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. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-	**LD.13.01.01, EP 1** The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.01.01, EP 2** The critical access hospital provides care, treatment, and services in accordance with licensure requirements, laws (including state law), and rules and regulations. **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.	
§485.608(a)	§485.608(a) Standard: Compliance With Federal Laws and Regulations The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.	**LD.04.01.01, EP 2** The critical access hospital provides care, treatment, and services in accordance with licensure requirements, laws (including state law), and rules and regulations. **LD.04.01.01, EP 3** Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies.	**LD.13.01.01, EP 1** The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.
§485.608(b)	§485.608(b) Standard: Compliance With State and Local Laws and Regulations All patient care services are furnished in accordance with applicable State and local laws and regulations.	**LD.04.01.01, EP 2** The critical access hospital provides care, treatment, and services in accordance with licensure requirements, laws (including state law), and rules and regulations.	**LD.13.01.01, EP 1** The critical access hospital provides care, treatment, and services in accordance with licensure requirements and federal, state, and local laws, rules, and regulations.
§485.608(c)	§485.608(c) Standard: Licensure of CAH The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.	**LD.04.01.01, EP 1** The critical access 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 critical access hospital is seeking accreditation from The Joint Commission.	**LD.13.01.01, EP 2** The critical access hospital is licensed in accordance with law and regulation to provide the care, treatment, or services for which the critical access hospital is seeking accreditation from The Joint Commission. Note: For rehabilitation or psychiatric distinct part units

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. 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.	in critical access hospitals: The critical access hospital is licensed or approved as meeting the standards for licensing established by the state or responsible locality.
§485.608(d)	§485.608(d) Standard: Licensure, Certification or Registration of Personnel Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.	**HR.01.01.01, EP 2** The critical access 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.	**HR.11.01.03, EP 1** All staff who provide patient care, treatment, and services are qualified and possess a current license, certification, or registration, in accordance with law and regulation. **MS.17.01.03, EP 3** The credentialing process requires that the critical access hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information for the applicant: - Current licensure at the time of initial granting, renewal, and revision of privileges and at the time of license expiration - Relevant training - Current competence **MS.17.02.01, 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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
§485.610	§485.610 Condition of Participation: Status and Location		
§485.610(a)	§485.610(a) Standard: Status The facility is--		
§485.610(a)(1)	(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;		
§485.610(a)(2)	(2) A recently closed facility, provided that the facility--		
§485.610(a)(2)(i)	(i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and		
§485.610(a)(2)(ii)	(ii) Meets the criteria for designation under this subpart as of the effective date of its designation; or		
§485.610(a)(3)	(3) A health clinic or a health center (as defined by the State) that--		
§485.610(a)(3)(i)	(i) Is licensed by the State as a health clinic or a health center;		
§485.610(a)(3)(ii)	(ii) Was a hospital that was downsized to a health clinic or a health center; and		
§485.610(a)(3)(iii)	(iii) As of the effective date of its designation, meets the criteria for		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	designation set forth in this subpart.		
§485.610(b)	§485.610(b) Standard: Location in a rural area or treatment as rural. The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section or the requirements of paragraph (b)(3), (b)(4), or (b)(5) of this section.		
§485.610(b)(1)	(1) The CAH meets the following requirements:		
§485.610(b)(1)(i)	(i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under §412.64(b), excluding paragraph (b)(3) of this chapter;		
§485.610(b)(1)(ii)	(ii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board under §412.230(e) of this chapter, and is not among a group of hospitals that have been redesignated to an adjacent urban area under §412.232 of this chapter.		
§485.610(b)(2)	(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	being treated as being located in a rural area in accordance with §412.103 of this chapter.		
§485.610(b)(3)	(3) Effective for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such a Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on June 3, 2003		
§485.610(b)(4)	(4) Effective for October 1, 2009 through September 30, 2011, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2009, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but, as of FY 2010, was included as part of such a Metropolitan Statistical		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on November 20, 2008.		
§485.610(b)(5)	(5) Effective on or after October 1, 2014, for a period of 2 years beginning with the effective date of the most recent Office of Management and Budget (OMB) standards for delineating statistical areas adopted by CMS, the CAH no longer meets the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, prior to the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, was located in a rural area as defined by OMB, but under the most recent OMB standards for delineating statistical areas adopted by CMS and the most recent Census Bureau data, is located in an urban area.		
§485.610(c)	§485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification		
§485.610(c)(1)	(1) The CAH is located more than a 35-mile drive (or, in the case of		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation after January 1, 2006.		
§485.610(c)(2)	(2) Primary roads of travel for determining the driving distance of a CAH and its proximity to other providers is defined as:		
§485.610(c)(2)(i)	(i) A numbered Federal highway, including interstates, intra-states, expressways, or any other numbered federal highway with 2 or more lanes each way; or		
§485.610(c)(2)(ii)	(ii) A numbered State highway with 2 or more lanes each way.		
§485.610(d)	§485.610(d) Standard: Relocation of CAHs With a Necessary Provider Designation A CAH that has a necessary provider designation from the State that was in effect prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility meets the requirements as specified in paragraph (d)(1) of this section.		
§485.610(d)(1)	(1) If a necessary provider CAH relocates its facility and begins providing services in a new location, the CAH can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the CAH in its new location--		
§485.610(d)(1)(i)	(i) Serves at least 75 percent of the same service area that it served prior to its relocation;		
§485.610(d)(1)(ii)	(ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and		
§485.610(d)(1)(iii)	(iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location.		
§485.610(d)(2)	(2) If a CAH that has been designated as a necessary provider by the State begins providing services at another location after January 1, 2006, and does not meet the requirements in paragraph (d)(1) of this section,		

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	the action will be considered a cessation of business as described in §489.52(b)(3).		
§485.610(e)	§485.610(e) Standard: Off-campus and co-location requirements for CAHs A CAH may continue to meet the location requirements of paragraph (c) of this section only if the CAH meets the following:		
§485.610(e)(1)	(1) If a CAH with a necessary provider designation is co-located (that is, it shares a campus, as defined in §413.65(a)(2) of this chapter, with another hospital or CAH), the necessary provider CAH can continue to meet the location requirement of paragraph (c) of this section only if the co-location arrangement was in effect before January 1, 2008, and the type and scope of services offered by the facility co-located with the necessary provider CAH do not change. A change of ownership of any of the facilities with a co-location arrangement that was in effect before January 1, 2008, will not be considered to be a new co-location arrangement.		
§485.610(e)(2)	(2) If a CAH or a necessary provider CAH operates an off-campus provider-based location,		

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	excluding an RHC as defined in §405.2401(b) of this chapter, but including a department or remote location, as defined in §413.65(a)(2) of this chapter, or an off-campus distinct part psychiatric or rehabilitation unit, as defined in §485.647, that was created or acquired by the CAH on or after January 1, 2008, the CAH can continue to meet the location requirement of paragraph (c) of this section only if the off-campus provider-based location or off-campus distinct part unit is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH.		
§485.610(e)(3)	(3) If either a CAH or a CAH that has been designated as a necessary provider by the State does not meet the requirements in paragraph (e)(1) of this section, by co-locating with another hospital or CAH on or after January 1, 2008, or creates or acquires an off-campus provider-based location or off-campus distinct part unit on or after January 1, 2008, that does not meet the requirements in		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	paragraph (e)(2) of this section, the CAH's provider agreement will be subject to termination in accordance with the provisions of §489.53(a)(3) of this subchapter, unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.		
§485.612	§485.612 Condition of Participation: Compliance With CAH Requirements at the Time of Application Except for recently closed facilities as described in §485.610(a)(2), or health clinics or health centers as described in §485.610(a)(3), the facility is a hospital that has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.		
§485.614	§ 485.614 Condition of participation: Patient's rights. A CAH must protect and promote each patient's rights.	**RI.01.01.01, EP 1** The critical access hospital has written policies on patient rights. Note: The critical access hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.01.01, EP 2** The critical access hospital informs the patient of the patient's rights. Note 1: The critical access hospital informs the patient (or	**RI.11.01.01, EP 1** The critical access hospital develops and implements written policies to protect and promote patient rights.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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: The critical access hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.01.01, EP 4** The critical access hospital treats the patient in a dignified and respectful manner that supports the patient's dignity.	
§485.614(a)	(a) Standard: Notice of rights.		
§485.614(a)(1)	(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.	**RI.01.01.01, EP 2** The critical access hospital informs the patient of the patient's rights. Note 1: The critical access 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: The critical access hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible.	**RI.11.01.01, EP 2** The critical access hospital informs each patient, or when appropriate, the patient's representative (as allowed, under state law) of the patient's rights in advance of providing or discontinuing care, treatment, or services whenever possible.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.614(a)(2)	(2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:	**RI.01.07.01, EP 1** The critical access 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. **RI.01.07.01, EP 20** The process for resolving complaints includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization.	**LD.11.01.01, EP 2** The governing body does the following: - Approves and is responsible for the effective operation of the grievance process - Reviews and resolves grievances, unless it delegates responsibility in writing to a grievance committee For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body also does the following: - Determines, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoints members of the medical staff after considering the recommendations of the existing members of the medical staff - Makes certain that the medical staff has bylaws - Approves medical staff bylaws and other medical staff rules and regulations - Makes certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Makes certain that the criteria for selection to the medical staff are based on individual character, competence, training, experience, and judgment - Makes certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship, or membership in a specialty body or society - Makes certain that the medical staff develops and implements written policies and procedures for appraisal of emergencies, initial treatment, and referral

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			of patients at the locations without emergency services when emergency services are not provided at the critical access hospital, or are provided at the critical access hospital but not at one or more off-campus locations **RI.14.01.01, EP 1** The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. **RI.14.01.01, EP 2** The critical access hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.
§485.614(a)(2)(i)	(i) The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital.	**RI.01.01.03, EP 1** The critical access hospital provides information in a manner tailored to the patient's age, language, and ability to understand. **RI.01.07.01, EP 1** The critical access hospital establishes a complaint resolution process for the prompt resolution of patient complaints that includes a clearly explained procedure for the submission of a patient's written or verbal complaint and informs the patient and the patient's family about it. Note: The governing body is responsible for the effective	**RI.11.02.01, EP 1** The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. **RI.14.01.01, EP 2** The critical access hospital develops and implements policies and procedures for the prompt resolution of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.	patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.
§485.614(a)(2)(ii)	(ii) The grievance process must specify time frames for review of the grievance and the provision of a response.	**RI.01.07.01, EP 19** The critical access hospital determines time frames for complaint review and response.	**RI.14.01.01, EP 2** The critical access hospital develops and implements policies and procedures for the prompt resolution of patient grievances. The policies clearly explain the procedure for patients to submit written or verbal grievances and specify timeframes for the review of and response to the grievance.
§485.614(a)(2)(iii)	(iii) In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	**RI.01.07.01, EP 18** In its resolution of complaints, the critical access hospital provides the individual with a written notice of its decision, which contains the following: -The name of the critical access hospital contact person -The steps taken on behalf of the individual to investigate the complaint -The results of the process -The date of completion of the complaint process	**RI.14.01.01, EP 3** In its resolution of grievances, the critical access hospital provides the patient with a written notice of its decision, which contains the following: -Name of the critical access hospital contact person -Steps taken on behalf of the individual to investigate the grievances -Results of the process -Date of completion of the grievance process
§485.614(b)	(b) Standard: Exercise of rights		
§485.614(b)(1)	(1) The patient has the right to participate in the development and implementation of their plan of care.	**RI.01.02.01, EP 40** The patient has the right to participate in the development and implementation of their plan of care.	**PC.11.03.01, EP 2** The critical access hospital involves the patient in the development and implementation of their plan of care. Note: For swing beds in critical access hospitals: The resident has the right to be informed, in advance, of changes to their plan of care.
§485.614(b)(2)	(2) The patient or their representative (as allowed under State law) has the right to make informed decisions regarding their care. The patient's rights include	**RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the critical access hospital involves a surrogate decision-maker in making these decisions.	**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,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.	Note: For swing beds in critical access hospitals: The selection of the surrogate decision-maker is in accordance with state law. **RI.01.02.01, EP 3** The critical access hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. **RI.01.02.01, EP 4** The critical access hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. **RI.01.02.01, EP 8** The critical access hospital involves the patient's family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation. **RI.01.02.01, EP 40** The patient has the right to participate in the development and implementation of their plan of care. **RI.01.03.01, EP 1** The critical access 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	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.

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		- The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation - How informed consent is documented in the patient record Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent **RI.01.03.01, EP 2** The informed consent process includes a discussion about the following: - The patient's proposed care, treatment, and services - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving their goals; and any potential problems that might occur during recuperation - Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.	
§485.614(b)(3)	(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §§ 489.100 of this part (Definition), 489.102 of this part (Requirements for providers), and 489.104 of this part (Effective dates).	**LD.04.01.01, EP 2** The critical access hospital provides care, treatment, and services in accordance with licensure requirements, laws (including state law), and rules and regulations. **RI.01.05.01, EP 1** The critical access hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:	**RI.12.01.01, EP 5** Staff and licensed practitioners who provide care, treatment, or services in the critical access hospital honor the patient's right to formulate advance directives and comply with these directives, in accordance with law and regulation. Note: Law and regulation includes, at a minimum, 42 CFR 489.100, 489.102, and 489.104.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services. - For outpatient settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Providing the patient upon admission with information on the extent to which the critical access hospital is able, unable, or unwilling to honor advance directives. - Whether the critical access hospital will honor advance directives in its outpatient settings. - That the critical access 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: The patient's right to formulate advance directives and have staff and licensed practitioners comply with these directives is in accordance with 42 CFR 489.100, 489.102, and 489.104. **RI.01.05.01, EP 9** The critical access hospital documents whether or not the patient has an advance directive. **RI.01.05.01, EP 10** Upon request, the critical access hospital refers the patient to resources for assistance in formulating advance directives. **RI.01.05.01, EP 17**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The existence or lack of an advance directive does not determine the patient's right to access care, treatment, and services.	
§485.614(b)(4)	(4) The patient has the right to have a family member or representative of their choice and their own physician notified promptly of their admission to the hospital.	**RI.01.02.01, EP 1** The critical access 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 critical access hospital. Note 1: 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 critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care.	**RI.12.01.01, EP 2** The critical access hospital asks the patient whether they want a family member, representative, or physician or other licensed practitioner notified of their admission to the critical access hospital. The critical access hospital promptly notifies the identified individual(s). Note: The patient is informed, prior to the notification occurring, of any process to automatically notify the patient's established primary care practitioner, primary care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care service providers and suppliers. The critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations.
§485.614(c)	(c) Standard: Privacy and safety.		
§485.614(c)(1)	(1) The patient has the right to personal privacy.	**RI.01.01.01, EP 7** The critical access hospital respects the patient's right to privacy. Note: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy	**RI.11.01.01, EP 5** The critical access hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		of a patient's health information, refer to Standard IM.02.01.01.	Standard IM.12.01.01. Note 2: For swing beds in critical access hospitals: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
§485.614(c)(2)	(2) The patient has the right to receive care in a safe setting.	**EC.01.01.01, EP 4** The critical access hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the critical access hospital's facilities. **EC.01.01.01, EP 5** The critical access hospital has a written plan for managing the following: The security of everyone who enters the critical access hospital's facilities. **EC.02.01.01, EP 3** The critical access hospital takes action to minimize or eliminate identified safety and security risks in the physical environment. **EC.02.06.01, EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	**PE.01.01.01, EP 1** The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.
§485.614(c)(3)	(3) The patient has the right to be free from all forms of abuse or harassment.	**RI.01.06.03, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For critical access hospitals with swing beds: The	**RI.13.01.01, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		critical access hospital protects residents from involuntary seclusion. **RI.01.06.03, EP 2** The critical access hospital evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the critical access hospital. **RI.01.06.03, EP 3** The critical access hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For swing beds in critical access hospitals: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury	For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property.
§485.614(d)	(d) Standard: Confidentiality of patient records.		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.614(d)(1)	(1) The patient has the right to the confidentiality of their clinical records.	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information.	**IM.12.01.01, EP 1** The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.
§485.614(d)(2)	(2) The patient has the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits.	**RI.01.01.01, EP 10** The critical access 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: 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 critical access hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits).	**RI.11.01.01, EP 6** The critical access hospital provides the patient, upon an oral or written request, with access to medical records, including past and current records, in the form and format requested (including in electronic form or format when available). If electronic is unavailable, the medical record is provided in hard copy or another form agreed to by the critical access hospital and patient. The critical access hospital does not impede the legitimate efforts of individuals to gain access to their own medical records and fulfills these electronic or hard-copy requests within a reasonable time frame (that is, as quickly as its recordkeeping system permits).
§485.614(e)	(e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal	**PC.03.05.01, EP 1** The critical access hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others.	**PC.13.02.01, EP 1** The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.	**PC.03.05.01, EP 2** The critical access hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation. **PC.03.05.01, EP 5** The critical access hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order. **RI.01.06.03, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For critical access hospitals with swing beds: The critical access hospital protects residents from involuntary seclusion.	seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **RI.13.01.01, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property.
§485.614(e)(1)	(1) Definitions.		
§485.614(e)(1)(i)	(i) A restraint is—		
§485.614(e)(1)(i)(A)	(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely; or	**PC.03.05.09, EP 3** The critical access hospital has policies and procedures regarding the use of restraint or seclusion that are in accordance with current standards of practice. The policies and procedures also include the following: - Restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. - A definition of restraint in accordance with 42 CFR 485.614 (e)(1)(i)(A–C). - A definition of seclusion in accordance with 42 CFR	**PC.13.02.01, EP 4** The critical access hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or

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		485.614 (e)(1)(ii). Note 1: The definition of restraint per 42 CFR 485.614 (e)(1)(i)(A–C) is as follows: 42 CFR 485.614 (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 485.614 (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 485.614 (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: The definition of seclusion per 42 CFR 485.614 (e)(1)(ii) is as follows: 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.	bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
§485.614(e)(1)(i)(B)	(B) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard	**PC.03.05.09, EP 3** The critical access hospital has policies and procedures regarding the use of restraint or seclusion that are in accordance with current standards of practice. The policies and procedures also include the following:	**PC.13.02.01, EP 4** The critical access hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	treatment or dosage for the patient's condition.	- Restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. - A definition of restraint in accordance with 42 CFR 485.614 (e)(1)(i)(A–C). - A definition of seclusion in accordance with 42 CFR 485.614 (e)(1)(ii). Note 1: The definition of restraint per 42 CFR 485.614 (e)(1)(i)(A–C) is as follows: 42 CFR 485.614 (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 485.614 (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 485.614 (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: The definition of seclusion per 42 CFR 485.614 (e)(1)(ii) is as follows: 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	his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

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		only for the management of violent or self-destructive behavior.	
§485.614(e)(1)(i)(C)	(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).	**PC.03.05.09, EP 3** The critical access hospital has policies and procedures regarding the use of restraint or seclusion that are in accordance with current standards of practice. The policies and procedures also include the following: - Restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. - A definition of restraint in accordance with 42 CFR 485.614 (e)(1)(i)(A–C). - A definition of seclusion in accordance with 42 CFR 485.614 (e)(1)(ii). Note 1: The definition of restraint per 42 CFR 485.614 (e)(1)(i)(A–C) is as follows: 42 CFR 485.614 (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 485.614 (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 485.614 (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	**PC.13.02.01, EP 4** The critical access hospital restraint policies are followed when any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or when a drug or medication is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Note: A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

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		activities without the risk of physical harm (this does not include a physical escort). Note 2: The definition of seclusion per 42 CFR 485.614 (e)(1)(ii) is as follows: 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.	
§485.614(e)(1)(ii)	(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.	**PC.03.05.09, EP 3** The critical access hospital has policies and procedures regarding the use of restraint or seclusion that are in accordance with current standards of practice. The policies and procedures also include the following: - Restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. - A definition of restraint in accordance with 42 CFR 485.614 (e)(1)(i)(A–C). - A definition of seclusion in accordance with 42 CFR 485.614 (e)(1)(ii). Note 1: The definition of restraint per 42 CFR 485.614 (e)(1)(i)(A–C) is as follows: 42 CFR 485.614 (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 485.614 (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.	**PC.13.02.01, EP 5** The critical access hospital seclusion policies are followed when a patient is involuntarily confined alone in a room or area from which the patient is physically prevented from leaving. Note: Seclusion is only used for the management of violent or self-destructive behavior.

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		42 CFR 485.614 (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: The definition of seclusion per 42 CFR 485.614 (e)(1)(ii) is as follows: 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.	
§485.614(e)(2)	(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.	**PC.03.05.09, EP 3** The critical access hospital has policies and procedures regarding the use of restraint or seclusion that are in accordance with current standards of practice. The policies and procedures also include the following: - Restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. - A definition of restraint in accordance with 42 CFR 485.614 (e)(1)(i)(A–C). - A definition of seclusion in accordance with 42 CFR 485.614 (e)(1)(ii). Note 1: The definition of restraint per 42 CFR 485.614 (e)(1)(i)(A–C) is as follows: 42 CFR 485.614 (e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device,	**PC.13.02.01, EP 1** The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order.

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		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 485.614 (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 485.614 (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: The definition of seclusion per 42 CFR 485.614 (e)(1)(ii) is as follows: 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.	
§485.614(e)(3)	(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.	**PC.03.05.01, EP 4** The critical access hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others.	**PC.13.02.01, EP 2** The critical access hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm.
§485.614(e)(4)	(4) The CAH must have written policies and procedures regarding the use of restraint and seclusion	**PC.03.05.09, EP 3** The critical access hospital has policies and procedures regarding the use of restraint or seclusion that are in accordance with current standards of practice. The	**PC.13.02.09, EP 1** The critical access hospital's policies and procedures regarding the use of restraint or seclusion that are consistent with current standards of practice.

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	that are consistent with current standards of practice.	policies and procedures also include the following: - Restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. - A definition of restraint in accordance with 42 CFR 485.614 (e)(1)(i)(A–C). - A definition of seclusion in accordance with 42 CFR 485.614 (e)(1)(ii). Note 1: The definition of restraint per 42 CFR 485.614 (e)(1)(i)(A–C) is as follows: 42 CFR 485.614 (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 485.614 (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 485.614 (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: The definition of seclusion per 42 CFR 485.614 (e)(1)(ii) is as follows: Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is	For rehabilitation and psychiatric distinct part units in critical access hospitals: The policies and procedures include the following: - Definitions for restraint and seclusion that are consistent with state and federal law and regulation - Physician and other licensed practitioner training requirements - Staff training requirements - Who has authority to order restraint or seclusion - Who has authority to discontinue the use of restraint or seclusion - Who can initiate the use of restraint or seclusion - Circumstances under which restraint or seclusion is discontinued - Requirement that restraint or seclusion is discontinued as soon as is safely possible - Who can assess and monitor patients in restraint or seclusion - Time frames for assessing and monitoring patients in restraint or seclusion

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		physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.	
§485.614(f)	(f) Standard: Restraint or seclusion: Staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.	**PC.03.05.03, EP 1** The critical access hospital implements restraint or seclusion using safe techniques identified by the critical access hospital's policies and procedures in accordance with law and regulation. **PC.03.05.17, EP 8** Staff education and training include the following: - Patient-centered, trauma-informed, competency-based training and education of staff, including medical staff and, as applicable, staff providing contract services, on the use of restraint and seclusion - Alternatives to the use of restraint and seclusion	**PC.13.02.03, EP 1** The critical access hospital's use of restraint or seclusion meets the following requirements: - In accordance with a written modification to the patient's plan of care - Implemented by trained staff using safe techniques identified by the critical access hospital's policies and procedures in accordance with law and regulation
§485.614(f)(1)	(1) The CAH must provide patient-centered, trauma informed competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the use of restraint and seclusion.	**PC.03.05.17, EP 8** Staff education and training include the following: - Patient-centered, trauma-informed, competency-based training and education of staff, including medical staff and, as applicable, staff providing contract services, on the use of restraint and seclusion - Alternatives to the use of restraint and seclusion	**PC.13.02.17, EP 2** Staff education and training include the following: - Patient-centered, trauma-informed, competency-based training and education on the use of restraint and seclusion for staff, including medical staff and, as applicable, staff providing contract services - Alternatives to the use of restraint or seclusion
§485.614(f)(2)	(2) The training must include alternatives to the use of restraint/seclusion.	**PC.03.05.17, EP 8** Staff education and training include the following: - Patient-centered, trauma-informed, competency-based training and education of staff, including medical staff and, as applicable, staff providing contract services, on the use of restraint and seclusion - Alternatives to the use of restraint and seclusion	**PC.13.02.17, EP 2** Staff education and training include the following: - Patient-centered, trauma-informed, competency-based training and education on the use of restraint and seclusion for staff, including medical staff and, as applicable, staff providing contract services - Alternatives to the use of restraint or seclusion
§485.614(g)	(g) Standard: Death reporting requirements. Hospitals must	**PC.03.05.19, EP 1** The critical access hospital reports the following	**PC.13.02.19, EP 1** The critical access hospital reports the following

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	report deaths associated with the use of seclusion or restraint.	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 critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death. 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.	information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.
§485.614(g)(1)	(1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death:	**PC.03.05.19, EP 2** The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.	**PC.13.02.19, EP 2** The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.
§485.614(g)(1)(i)	(i) Each death that occurs while a patient is in restraint or seclusion.	**PC.03.05.19, EP 1** The critical access hospital reports the following	**PC.13.02.19, EP 1** The critical access hospital reports the following

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		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 critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death. 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.	information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.
§485.614(g)(1)(ii)	(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.	**PC.03.05.19, EP 1** The critical access 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 critical access hospital that	**PC.13.02.19, EP 1** The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of

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		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.	the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.
§485.614(g)(1)(iii)	(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume'' in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.	**PC.03.05.19, EP 1** The critical access 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 critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death. 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	**PC.13.02.19, EP 1** The critical access hospital reports the following information to the Centers for Medicare & Medicaid Services regarding deaths related to restraint or seclusion: - Each death that occurs while a patient is in restraint or seclusion - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion - Each death known to the critical access hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient's death Note 1: This reporting requirement includes all restraints except soft wrist restraints. For more information on deaths related to the use of soft wrist restraints, refer to EP 3 in this standard. Note 2: In this element of performance "reasonable to assume" includes but is not limited to deaths related to restrictions of movement for prolonged periods of time

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		deaths related to chest compression, restriction of breathing, or asphyxiation.	or deaths related to chest compression, restriction of breathing, or asphyxiation.
§485.614(g)(2)	(2) When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:	**PC.03.05.19, EP 3** 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 critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.	
§485.614(g)(2)(i)	(i) Any death that occurs while a patient is in such restraints.	**PC.03.05.19, EP 3** 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 critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs	**PC.13.02.19, EP 3** When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.

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		within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.	- Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§485.614(g)(2)(ii)	(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.	**PC.03.05.19, EP 3** 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 critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and	**PC.13.02.19, EP 3** When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for

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		primary diagnosis(es). - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.	the patient's care, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§485.614(g)(3)	(3) The staff must document in the patient's medical record the date and time the death was:		
§485.614(g)(3)(i)	(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or	**PC.03.05.19, EP 2** The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.	**PC.13.02.19, EP 2** The deaths addressed in PC.13.02.19, EP 1, are reported to the Centers for Medicare & Medicaid Services by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient's death was reported is documented in the patient's medical record.
§485.614(g)(3)(ii)	(ii) Recorded in the internal log or other systems for deaths described in paragraph (g)(2) of this section.	**PC.03.05.19, EP 3** 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 critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending	**PC.13.02.19, EP 3** When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's

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		physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.	name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§485.614(g)(4)	(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:		
§485.614(g)(4)(i)	(i) Each entry must be made not later than seven days after the date of death of the patient.	**PC.03.05.19, EP 3** 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 critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system	**PC.13.02.19, EP 3** When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es).

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		available to CMS, either electronically or in writing, immediately upon request.	- Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§485.614(g)(4)(ii)	(ii) Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner who is responsible for the care of the patient, medical record number, and primary diagnosis(es).	**PC.03.05.19, EP 3** 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 critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.	**PC.13.02.19, EP 3** When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following: - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§485.614(g)(4)(iii)	(iii) The information must be made available in either written or electronic form to CMS immediately upon request.	**PC.03.05.19, EP 3** 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 critical access hospital does the following:	**PC.13.02.19, EP 3** When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, nonrigid, cloth-like material, the critical access hospital does the following:

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		- Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request.	- Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient. - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient. - Documents in the patient record the date and time that the death was recorded in the log or other system. - Documents in the log or other system the patient's name, date of birth, date of death, name of attending physician or other licensed practitioner responsible for the patient's care, medical record number, and primary diagnosis(es). - Makes the information in the log or other system available to the Centers for Medicare & Medicaid Services, either electronically or in writing, immediately upon request.
§485.614(h)	(h) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. A CAH must meet the following requirements:	**RI.01.01.01, EP 1** The critical access hospital has written policies on patient rights. Note: The critical access hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.	**RI.11.01.01, EP 7** The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: The critical access hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation.

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			Note 2: The critical access hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§485.614(h)(1)	(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, in advance of furnishing patient care whenever possible.	**RI.01.01.01, EP 2** The critical access hospital informs the patient of the patient's rights. Note 1: The critical access 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: The critical access hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible.	**RI.11.01.01, EP 7** The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: The critical access hospital's written policies and procedures include any restrictions or limitations that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: The critical access hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§485.614(h)(2)	(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.	**RI.01.01.01, EP 2** The critical access hospital informs the patient of the patient's rights. Note 1: The critical access 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.	**RI.11.01.01, EP 7** The critical access hospital develops and implements policies and procedures for patient visitation rights. Visitation rights include the right to receive visitors designated by the patient, including but not limited to a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. The patient also has the right to withdraw or deny consent for visitors at any time. Note 1: The critical access hospital's written policies and procedures include any restrictions or limitations

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		Note 2: The critical access hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible.	that are clinically necessary or reasonable that need to be placed on visitation rights and the reasons for the restriction or limitation. Note 2: The critical access hospital informs the patient (or support person, where appropriate) of the patient's visitation rights, including any clinical restriction or limitation on such rights.
§485.614(h)(3)	(3) Not restrict, limit , or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.	**RI.01.01.01, EP 29** The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges.	**RI.11.01.01, EP 4** The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The critical access hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences.
§485.614(h)(4)	(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.	**RI.01.01.01, EP 28** The critical access 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 critical access hospital allows for the presence of a support individual of the patient's choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient's surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EP 8.)	**RI.11.01.01, EP 4** The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges. The critical access hospital allows all visitors to have full and equal visitation privileges consistent with patient preferences.
§485.616	§485.616 Condition of Participation: Agreements		

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§485.616(a)	§485.616(a) Standard: Agreements With Network Hospitals In the case of a CAH that is a member of a rural health network as defined in §485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for:		
§485.616(a)(1)	(1) Patient referral and transfer;	**LD.04.03.09, EP 18** The critical access hospital has an agreement with at least one hospital regarding patient referral and transfer. When the critical access hospital is a member of a rural health network, the agreement is with a member of the network.	**LD.13.03.03, EP 8** If the critical access hospital is a member of a rural health network, it has an agreement with at least one hospital that is a member of the network to address the following: - Patient referral and transfer - Development and use of network communications systems, including electronic sharing of patient data, telemetry, and medical records, if the network has in operation such a system - Provision of emergency and nonemergency transportation between the facility and the hospital
§485.616(a)(2)	(2) The development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and	**IM.01.01.01, EP 5** The critical access hospital has an agreement with at least one hospital for the development and use of its communications systems, including, where feasible, medical records, telemetry systems, and systems for electronic sharing of patient data. When the critical access hospital is a member of a rural health network, the agreement is with a member of the network.	**LD.13.03.03, EP 8** If the critical access hospital is a member of a rural health network, it has an agreement with at least one hospital that is a member of the network to address the following: - Patient referral and transfer - Development and use of network communications systems, including electronic sharing of patient data, telemetry, and medical records, if the network has in operation such a system - Provision of emergency and nonemergency transportation between the facility and the hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.616(a)(3)	(3) The provision of emergency and non-emergency transportation between the facility and the hospital.	**LD.04.03.09, EP 19** The critical access hospital has an agreement with at least one hospital regarding the provision of emergency and non-emergency transportation. When the critical access hospital is a member of a rural health network, the agreement is with a member of the network.	**LD.13.03.03, EP 8** If the critical access hospital is a member of a rural health network, it has an agreement with at least one hospital that is a member of the network to address the following: - Patient referral and transfer - Development and use of network communications systems, including electronic sharing of patient data, telemetry, and medical records, if the network has in operation such a system - Provision of emergency and nonemergency transportation between the facility and the hospital
§485.616(b)	§485.616(b) Standard: Agreements for Credentialing and Quality Assurance Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least--		
§485.616(b)(1)	(1) One hospital that is a member of the network;	**LD.04.01.01, EP 5** The critical access hospital has an agreement with respect to credentialing and quality assurance with at least one of the following: - One hospital that is a member of the network - One quality improvement organization (QIO) or equivalent entity - One other appropriate and qualified entity in the state rural health care plan **LD.04.03.01, EP 12** The critical access hospital's agreement for quality assurance includes medical record review for quality and medical necessity of care.	**LD.13.03.03, EP 9** If the critical access hospital is a member of a rural health network, it has an agreement with respect to credentialing and quality assurance with at least one of the following organizations: - Hospital that is a member of the network - Quality improvement organization (QIO) or equivalent entity - Other appropriate and qualified entity in the state rural health care plan

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.616(b)(2)	(2) One QIO or equivalent entity; or	**LD.04.01.01, EP 5** The critical access hospital has an agreement with respect to credentialing and quality assurance with at least one of the following: - One hospital that is a member of the network - One quality improvement organization (QIO) or equivalent entity - One other appropriate and qualified entity in the state rural health care plan **LD.04.03.01, EP 12** The critical access hospital's agreement for quality assurance includes medical record review for quality and medical necessity of care.	**LD.13.03.03, EP 9** If the critical access hospital is a member of a rural health network, it has an agreement with respect to credentialing and quality assurance with at least one of the following organizations: - Hospital that is a member of the network - Quality improvement organization (QIO) or equivalent entity - Other appropriate and qualified entity in the state rural health care plan
§485.616(b)(3)	(3) One other appropriate and qualified entity identified in the State rural health care plan.	**LD.04.01.01, EP 5** The critical access hospital has an agreement with respect to credentialing and quality assurance with at least one of the following: - One hospital that is a member of the network - One quality improvement organization (QIO) or equivalent entity - One other appropriate and qualified entity in the state rural health care plan **LD.04.03.01, EP 12** The critical access hospital's agreement for quality assurance includes medical record review for quality and medical necessity of care.	**LD.13.03.03, EP 9** If the critical access hospital is a member of a rural health network, it has an agreement with respect to credentialing and quality assurance with at least one of the following organizations: - Hospital that is a member of the network - Quality improvement organization (QIO) or equivalent entity - Other appropriate and qualified entity in the state rural health care plan
§485.616(c)	(c) Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.616(c)(1)	(1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its physicians or practitioners providing telemedicine services:	**LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital’s patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital’s governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 485.616(c)(1)(i) through (c)(1)(vii). 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.	
§485.616(c)(1)(i)	(i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff. **MS.01.01.01, EP 13** The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and other licensed practitioners who are determined to be eligible for appointment by the governing body.	considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
§485.616(c)(1)(ii)	(ii) Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). 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	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the distant site. **MS.01.01.01, EP 1** The organized medical staff develops medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes.) **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.	solely upon certification, fellowship or membership in a specialty body or society
§485.616(c)(1)(iii)	(iii) Assure that the medical staff has bylaws.	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation - The originating site makes certain through the written agreement that all distant-site telemedicine providers'	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.01.01.01, EP 1** The organized medical staff develops medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the "Leadership" [LD] chapter for requirements regarding the governing body's authority and conflict management processes.)	- Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.616(c)(1)(iv)	(iv) Approve medical staff bylaws and other medical staff rules and regulations.	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.01.01.01, EP 1** The organized medical staff develops medical staff bylaws, rules and regulations, and policies.	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.)	
§485.616(c)(1)(v)	(v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.	**LD.01.05.01, EP 6** The organized medical staff is accountable to the governing body for the quality of care provided to patients. **LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). 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	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society
§485.616(c)(1)(vi)	(vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment.	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). 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	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff. **MS.01.01.01, EP 13** The medical staff bylaws include the following requirements: Qualifications for appointment to the medical staff. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 482.12(c)(1) and other licensed practitioners who are determined to be eligible for appointment by the governing body. **MS.01.01.01, EP 27** The medical staff bylaws include the following requirements: The process for appointment and re-appointment to membership on the medical staff.	appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society
§485.616(c)(1)(vii)	(vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the	**LD.13.03.03, EP 4** When telemedicine services are provided to the critical access hospital's patients through an agreement with a distant-site hospital, the critical access hospital's

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	hospital dependent solely upon certification, fellowship or membership in a specialty body or society.	following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.01.01.01, EP 1** The organized medical staff develops medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 2** The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff	governing body makes certain that the written agreement specifies that it is the responsibility of the governing body of the distant-site hospital to do the following with regard to its physicians or other licensed practitioners providing telemedicine services: - Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff - Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff - Assure that the medical staff has bylaws - Approve medical staff bylaws and other medical staff rules and regulations - Make certain that the medical staff is accountable to the governing body for the quality of care provided to patients - Make certain that the criteria for selection for appointment to the medical staff are individual character, competence, training, experience, and judgment - Make certain that under no circumstances is the accordance of staff membership or professional privileges in the critical access hospital dependent solely upon certification, fellowship or membership in a specialty body or society

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.) **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.	
§485.616(c)(2)	(2) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:	**LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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.	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). 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.	- The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - 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	Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		organization, the critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(2)(i)	(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.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	credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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. - 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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital.	agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(2)(ii)	(ii) The individual distant-site physician or practitioner is	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital;	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. - 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	access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies that the distant site made its decision using the process	hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(2)(iii)	(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH is located; and	**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.	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - 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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished	and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.616(c)(2)(iv)	(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.	**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. - 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	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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	- For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		organization, the critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(3)	(3) The governing body of the CAH must ensure that when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with §485.635(c)(4)(ii), furnishes the contracted services in a manner that enables the CAH to comply with all applicable conditions of participation for the contracted	**LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of	**LD.11.01.03, EP 1** The person responsible for the operation of the critical access hospital under 42 CFR 485.627(b)(2) is also responsible for the following: - Services provided in the critical access hospital whether or not they are furnished under arrangements or agreements - Ensuring that contractors of services (including contractors for shared services and joint ventures) provide services that enable the critical access hospital to comply with all applicable Centers for Medicare & Medicaid (CMS) Conditions of Participation and standards for the contracted services **LD.13.03.03, EP 3** When telemedicine services are furnished to the critical

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	services, including, but not limited to, the requirements in this section with regard to its physicians and practitioners providing telemedicine services.	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.	access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with all applicable Medicare Conditions of Participation for the contracted services, in accordance with 42 CFR 485.635(c)(4)(ii). - The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, refer to https://www.ecfr.gov. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.17.01.01 through MS.17.04.01). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. The written agreement includes that it is the responsibility of the governing body of the distant-site

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			hospital to meet the requirements of this element of performance.
§485.616(c)(4)	(4) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met:	**LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 23** When telemedicine services are furnished to the critical access hospital’s patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital.	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital’s process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.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	patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(4)(i)	(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at paragraphs (c)(1)(i) through (c)(1)(vii) of this section.	**LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 23** When telemedicine services are furnished to the critical	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital’s process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access hospital's patients, the originating site has a written agreement with the distant site that specifies the following: - The distant site is a contractor of services to the critical access hospital. - The distant site furnishes services in a manner that permits the originating site to be in compliance with 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 485.616(c)(1)(i) through (c)(1)(vii). Note: For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply: - The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13). - The governing body of the originating site grants privileges to a distant-site physician or other licensed practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site. **MS.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	practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - 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	standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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	

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		Accreditation Manual for Ambulatory Care. Note 2: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(4)(ii)	(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the CAH of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity.	**LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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.	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 2: The leaders who monitor the contracted services are the governing body. **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. - The distant site provides the originating site with a current list of the physician's or other licensed	- The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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	Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		services. Note 1: In the case of an accredited ambulatory care organization, the critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(4)(iii)	(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH whose patients are receiving the telemedicine services is located.	**MS.13.01.01, EP 1** All physicians or other licensed practitioners who are responsible for the patient's care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms: - The originating site fully credentials and privileges the physician or other licensed practitioner according to Standards MS.06.01.03 through MS.06.01.13. Or - The originating site privileges physicians or other licensed practitioners using credentialing information from the distant site if the distant site is a Joint	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - 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	- The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner.

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		information established by applicable law. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.	Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

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		Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.616(c)(4)(iv)	(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.	**LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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 2: The leaders who monitor the contracted services are the governing body. **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	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - 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	practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

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		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Accreditation Manual for Ambulatory Care. Note 2: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.618	§485.618 Condition of Participation: Emergency Services The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.	**LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.03.03.01, EP 2** Planning is hospitalwide, systematic, and involves designated individuals and information sources. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.05, EP 1** Leaders of the program, service, site, or department oversee operations. **LD.04.01.11, EP 5** The leaders provide for equipment, information systems,	**LD.13.03.01, EP 6** The critical access hospital provides emergency medical services that meet the needs of its inpatients and outpatients as a first response to common life-threatening injuries and acute illnesses. Note: Emergency services are available 24-hours a day, 7 days a week.

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		supplies, and other resources. **LD.04.03.01, EP 4** Emergency services are provided on site and are available on a 24-hour basis.	
§485.618(a)	§485.618(a) Standard: Availability Emergency services are available on a 24-hours a day basis.	**LD.04.03.01, EP 4** Emergency services are provided on site and are available on a 24-hour basis.	**LD.13.03.01, EP 6** The critical access hospital provides emergency medical services that meet the needs of its inpatients and outpatients as a first response to common life-threatening injuries and acute illnesses. Note: Emergency services are available 24-hours a day, 7 days a week.
§485.618(b)	§485.618(b) Standard: Equipment, Supplies, and Medication Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:	**MM.03.01.03, EP 1** Critical access 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. **MM.03.01.03, EP 4** Medications available for treating emergency cases include analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. **MM.03.01.03, EP 6** When emergency medications or supplies are used or expired, the critical access hospital replaces them as soon as possible to maintain a full stock. **PC.02.01.09, EP 8**	**PC.12.01.07, EP 1** The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases. Note 1: The drugs and biologicals commonly used in life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures include but are not limited to airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.

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		Medical equipment and supplies available for treating patients with emergencies consist of airways, endotracheal tubes, bag valve masks, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machines, defibrillators, cardiac monitors, chest tubes, and indwelling urinary catheters.	
§485.618(b)(1)	(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.	**MM.03.01.03, EP 4** Medications available for treating emergency cases include analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.	**PC.12.01.07, EP 1** The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases. Note 1: The drugs and biologicals commonly used in life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures include but are not limited to airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.
§485.618(b)(2)	(2) Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization	**PC.02.01.09, EP 8** Medical equipment and supplies available for treating patients with emergencies consist of airways, endotracheal tubes, bag valve masks, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machines,	**PC.12.01.07, EP 1** The critical access hospital maintains equipment, supplies, and drugs and biologicals commonly used in life-saving procedures. These items are kept at the critical access hospital and are available for treating emergency cases.

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	devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.	defibrillators, cardiac monitors, chest tubes, and indwelling urinary catheters.	Note 1: The drugs and biologicals commonly used in life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions. Note 2: Equipment and supplies commonly used life-saving procedures include but are not limited to airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.
§485.618(c)	§485.618(c) Standard: Blood and Blood Products The facility provides, either directly or under arrangements, the following--		
§485.618(c)(1)	(1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis.	**LD.04.03.01, EP 5** The critical access hospital provides services directly or by arrangement, for the procurement, safekeeping, and transfusion of blood, and services for making blood products available for emergencies on a 24-hour basis.	**LD.13.03.01, EP 16** The critical access hospital provides services, directly or by arrangement, for the procurement, safekeeping, and transfusion of blood and provides services for making blood products available for emergencies on a 24-hour basis.
§485.618(c)(2)	(2) Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by	**LD.04.03.01, EP 6** The critical access hospital provides blood storage facilities, either directly or by arrangement, that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. **LD.04.03.09, EP 1** Clinical leaders and medical staff have an opportunity to	**LD.13.03.01, EP 17** The critical access hospital provides blood storage facilities, either directly or by arrangement, that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. Note: If blood banking services are provided under an arrangement, the arrangement is approved by the critical access hospital's medical staff and by the

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	the facility's medical staff and by the persons directly responsible for the operation of the facility.	provide advice about the sources of clinical services to be provided through contractual agreement. **LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements.	persons directly responsible for the operation of the critical access hospitals.
§485.618(d)	§485.618(d) Standard: Personnel		
§485.618(d)(1)	(1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, on call and immediately available by telephone or radio contact, and available on site within the following timeframes:		**NPG.12.01.01, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and they are available on site within 30 minutes, 24 hours a day, 7 days a week . Note: If all of the following criteria are met, these practitioners are available on site within 60 minutes: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the US Census Bureau) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by the Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method for providing emergency care to residents of the area

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			served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.
§485.618(d)(1)(i)	(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or	**HR.01.02.05, EP 4** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and available on-site within 30 minutes, 24 hours a day, if the critical access hospital is located in an area other than an area described in 42 CFR 485.618(d)(1)(ii).	**NPG.12.01.01, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and they are available on site within 30 minutes, 24 hours a day, 7 days a week . Note: If all of the following criteria are met, these practitioners are available on site within 60 minutes: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the US Census Bureau) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by the Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method for providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because

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			other available alternatives would increase the time needed to stabilize a patient in an emergency.
§485.618(d)(1)(ii)	(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:		
§485.618(d)(1)(ii)(A)	(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.	**HR.01.02.05, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and available on site within 60 minutes, 24 hours a day. Note: This element of performance is applicable only if all of the following are met: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.	**NPG.12.01.01, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and they are available on site within 30 minutes, 24 hours a day, 7 days a week . Note: If all of the following criteria are met, these practitioners are available on site within 60 minutes: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the US Census Bureau) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by the Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method for providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

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§485.618(d)(1)(ii)(B)	(B) The State has determined under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.	**HR.01.02.05, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and available on site within 60 minutes, 24 hours a day. Note: This element of performance is applicable only if all of the following are met: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.	**NPG.12.01.01, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and they are available on site within 30 minutes, 24 hours a day, 7 days a week . Note: If all of the following criteria are met, these practitioners are available on site within 60 minutes: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the US Census Bureau) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by the Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method for providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.
§485.618(d)(1)(ii)(C)	(C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available	**HR.01.02.05, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or radio contact, and	**NPG.12.01.01, EP 5** A doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care is on call and immediately available by telephone or

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	alternatives would increase the time needed to stabilize a patient in an emergency.	available on site within 60 minutes, 24 hours a day. Note: This element of performance is applicable only if all of the following are met: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.	radio contact, and they are available on site within 30 minutes, 24 hours a day, 7 days a week . Note: If all of the following criteria are met, these practitioners are available on site within 60 minutes: - The critical access hospital is located in an area designated as a frontier (that is, an area with fewer than six residents per square mile based on the latest population data published by the US Census Bureau) or in an area that meets the criteria for a remote location adopted by the state in its rural health care plan and approved by the Centers for Medicare & Medicaid Services (CMS) under section 1820(b) of the Social Security Act. - The state has determined under criteria in its rural health plan that allowing an emergency response time longer than 30 minutes is the only feasible method for providing emergency care to residents of the area served by the critical access hospital. - The state maintains documentation showing that the response time of up to 60 minutes at a particular designated critical access hospital is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.
§485.618(d)(2)	(2) A registered nurse with training and experience in emergency care can be utilized to conduct specific medical screening examinations only if--		
§485.618(d)(2)(i)	(i) The registered nurse is on site and immediately available at the CAH when a patient requests medical care; and	**HR.01.02.05, EP 16** A registered nurse with training and experience in emergency care can be used to conduct specific medical screening examinations only if both of the following conditions are met:	**HR.11.01.01, EP 2** A registered nurse with training and experience in emergency care is allowed to conduct specific medical screening examinations only if both of the following conditions are met:

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		- The registered nurse is on site and immediately available at the critical access hospital when a patient requests medical care. - The patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable state laws and the critical access hospital's bylaws and rules and regulations.	- The registered nurse is on site and immediately available at the critical access hospital when a patient requests medical care. - The patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable state laws and the critical access hospital's bylaws and rules and regulations.
§485.618(d)(2)(ii)	(ii) The nature of the patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable State laws and the CAH's bylaws or rules and regulations.	**HR.01.02.05, EP 16** A registered nurse with training and experience in emergency care can be used to conduct specific medical screening examinations only if both of the following conditions are met: - The registered nurse is on site and immediately available at the critical access hospital when a patient requests medical care. - The patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable state laws and the critical access hospital's bylaws and rules and regulations.	**HR.11.01.01, EP 2** A registered nurse with training and experience in emergency care is allowed to conduct specific medical screening examinations only if both of the following conditions are met: - The registered nurse is on site and immediately available at the critical access hospital when a patient requests medical care. - The patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable state laws and the critical access hospital's bylaws and rules and regulations.
§485.618(d)(3)	(3) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if--		
§485.618(d)(3)(i)	(i) The CAH has no greater than 10 beds;	**HR.01.02.05, EP 15** A registered nurse satisfies the personnel requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare &	**NPG.12.02.01, EP 8** A registered nurse satisfies the personnel availability requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare

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		Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the State Boards of Medicine and Nursing, and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor must attest that they have consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once a governor submits a letter, as specified in 42 CFR 485.618(d)(3)(ii), a critical access hospital must submit documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using RNs on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.	& Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the state boards of medicine and nursing and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor attests that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor also describes the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once the governor submits a letter, the critical access hospital submits documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.
§485.618(d)(3)(ii)	(ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section;	**HR.01.02.05, EP 15** A registered nurse satisfies the personnel requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A).	**NPG.12.02.01, EP 8** A registered nurse satisfies the personnel availability requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A).

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		- The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the State Boards of Medicine and Nursing, and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor must attest that they have consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once a governor submits a letter, as specified in 42 CFR 485.618(d)(3)(ii), a critical access hospital must submit documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using RNs on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.	- The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the state boards of medicine and nursing and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor attests that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor also describes the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once the governor submits a letter, the critical access hospital submits documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.
§485.618(d)(3)(iii)	(iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural healthcare plan	**HR.01.02.05, EP 15** A registered nurse satisfies the personnel requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area	**NPG.12.02.01, EP 8** A registered nurse satisfies the personnel availability requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section;	designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the State Boards of Medicine and Nursing, and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor must attest that they have consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once a governor submits a letter, as specified in 42 CFR 485.618(d)(3)(ii), a critical access hospital must submit documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using RNs on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.	designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the state boards of medicine and nursing and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor attests that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor also describes the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once the governor submits a letter, the critical access hospital submits documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.
§485.618(d)(3)(iv)	(iv) Once a Governor submits a letter, as specified in paragraph (d)(3)(iii) of this section, a CAH must submit documentation to the	**HR.01.02.05, EP 15** A registered nurse satisfies the personnel requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met:	**NPG.12.02.01, EP 8** A registered nurse satisfies the personnel availability requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met:

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	State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in this paragraph (d).	- The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the State Boards of Medicine and Nursing, and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor must attest that they have consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once a governor submits a letter, as specified in 42 CFR 485.618(d)(3)(ii), a critical access hospital must submit documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using RNs on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.	- The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the state boards of medicine and nursing and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor attests that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor also describes the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once the governor submits a letter, the critical access hospital submits documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.
§485.618(d)(4)	(4) The request, as specified in paragraph(d)(3)(iii) of this section,	**HR.01.02.05, EP 15** A registered nurse satisfies the personnel requirements in	**NPG.12.02.01, EP 8** A registered nurse satisfies the personnel availability

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	and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.	42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the State Boards of Medicine and Nursing, and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor must attest that they have consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once a governor submits a letter, as specified in 42 CFR 485.618(d)(3)(ii), a critical access hospital must submit documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using RNs on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.	requirements in 42 CFR 485.618(d)(1) for a temporary period if all of the following conditions are met: - The critical access hospital has no more than 10 beds. - The critical access hospital is located in an area designated as a frontier area or remote location as described in 42 CFR 485.618(d)(1)(ii)(A). - The state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation on the issue of using registered nurses on a temporary basis as part of its state rural health care plan with the state boards of medicine and nursing and in accordance with state law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in 42 CFR 485.618(d)(1). The letter from the governor attests that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of emergency services in the state. The letter from the governor also describes the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in 42 CFR 485.618(d)(1). - Once the governor submits a letter, the critical access hospital submits documentation to the state survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in 42 CFR 485.618(d). Note: The critical access hospital's request for using registered nurses on a temporary basis or its withdrawal of this request can be submitted to CMS at any time and is effective upon submission.

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§485.618(e)	§485.618(e) Standard: Coordination With Emergency Response Systems The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.	**HR.01.02.05, EP 3** In coordination with area emergency response systems, the critical access hospital establishes procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hour-a-day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the critical access hospital or other appropriate locations for treatment.	**LD.13.01.09, EP 8** In coordination with area emergency response systems, the critical access hospital establishes procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact 24 hours a day, 7 days a week, to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the critical access hospital or other appropriate locations for treatment.
§485.620	§485.620 Condition of Participation: Number of Beds and Length of Stay		
§485.620(a)	§485.620(a) Standard: Number of Beds Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds. Inpatient beds may be used for either inpatient or swing-bed services.	**LD.04.01.01, EP 6** Except as permitted for critical access hospitals having distinct part units under 42 CFR 485.647, the critical access hospital maintains no more than 25 inpatient beds that can be used for either inpatient or swing bed services. Note: Any bed in a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the state for designation as a critical access hospital is not counted in this 25-bed count.	**LD.13.01.01, EP 3** Except as permitted for critical access hospitals having distinct part units under 42 CFR 485.647, the critical access hospital maintains no more than 25 inpatient beds that can be used for either inpatient or swing bed services. Note: Any bed in a unit of the facility that is licensed as a distinct part skilled nursing facility at the time the facility applies to the state for designation as a critical access hospital is not counted in this 25-bed count.
§485.620(b)	§485.620(b) Standard: Length of Stay The CAH provides acute inpatient care for a period that does not exceed, on an annual	**LD.04.01.01, EP 7** The critical access hospital provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.	**LD.13.01.01, EP 5** The critical access hospital provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.

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	average basis, 96 hours per patient.		
§485.623	§485.623 Condition of Participation: Physical Plant and Environment		
§485.623(a)	§485.623(a) Standard: Construction The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services.	**EC.01.01.01, EP 1** Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems, or use errors. **EC.01.01.01, EP 4** The critical access hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the critical access hospital's facilities. **EC.01.01.01, EP 9** The critical access hospital has a written plan for managing the following: Utility systems. Note: In circumstances where the program or service is located in a business occupancy not owned by the accredited organization, the plan may only need to address how routine service and maintenance for their utility systems are obtained. **EC.02.01.01, EP 1** The critical access 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 critical access hospital's	**PE.01.01.01, EP 1** The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.01.01.01, EP 2** The critical access hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.

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		facilities. Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts. **EC.02.01.01, EP 3** The critical access hospital takes action to minimize or eliminate identified safety and security risks in the physical environment. **EC.02.01.01, EP 5** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital maintains all grounds and equipment. **EC.02.01.01, EP 8** The critical access hospital controls access to and from areas it identifies as security sensitive. **EC.02.04.03, EP 1** Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the critical access hospital performs safety, operational, and functional checks. **EC.02.04.03, EP 2** The critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. **EC.02.04.03, EP 3** The critical access hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. **EC.02.04.03, EP 4** The critical access hospital conducts performance testing of and maintains all sterilizers. These activities are documented. **EC.02.04.03, EP 5** The critical access hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. **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) **EC.02.05.03, EP 12**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Equipment designated to be powered by emergency power supply is energized by the critical access hospital's design. Staging of equipment startup is permissible. (For full text, refer to NFPA 99-2012: 6.4.2.2) **EC.02.05.05, EP 2** The critical access hospital tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion dates and test results are documented. **EC.02.05.05, EP 4** The critical access hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate. **EC.02.05.05, EP 5** The critical access 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.	

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		EC.02.05.05, EP 6 The critical access hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented. **EC.02.05.05, EP 7** Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch per NFPA 99-2012: 6.3.2.6.3.6, which activates both visual and audible alarms. For LIM circuits with automated self-testing, a manual test is performed at least annually. LIM circuits are tested per NFPA 99-2012: 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4) **EC.02.05.05, EP 8** The critical access 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: The critical access hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3. **EC.02.05.07, EP 5** At least monthly, the critical access hospital tests each emergency generator beginning with a cold start under load for at least 30 continuous minutes. The cooldown	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.05.07, EP 6** The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the critical access hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1) Note: Tests for non-diesel-powered generators need only be conducted with available load. **EC.02.05.07, EP 7** At least monthly, the critical access hospital tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.06.01, EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. **EC.02.06.01, EP 11**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Lighting is suitable for care, treatment, and services. **EC.02.06.01, EP 26** The critical access hospital keeps furnishings and equipment safe and in good repair. **EC.02.06.01, EP 33** The critical access hospital ensures all pharmaceutical preparation areas have proper ventilation, lighting, and temperature control. **EC.02.06.05, EP 1** When planning for new, altered, or renovated space, the critical access 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. **EC.02.06.05, EP 2** When planning for demolition, construction, renovation, or general maintenance, the critical access 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 and mitigates the identified risks. Note: See LS.01.02.01 for information on fire safety	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		procedures to implement during construction or renovation. **EC.02.06.05, EP 3** The critical access hospital takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance. **EC.04.01.01, EP 1** The critical access hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the critical access 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 - Based on the results of the data analysis, the lab identifies opportunities for improvement and resolves any environmental safety issues. Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. **LD.04.01.11, EP 2** The arrangement and allocation of space supports safe, efficient, and effective care, treatment, and services.	
§485.623(b)	§485.623(b) Standard: Maintenance The CAH has housekeeping and preventive maintenance programs to ensure that--		
§485.623(b)(1)	(1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;	**EC.01.01.01, EP 3** The critical access hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems. Note: This library includes manuals, procedures provided by manufacturers, technical bulletins, and other information. **EC.02.03.05, EP 1** The critical access 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	**PE.04.01.01, EP 2** The critical access hospital maintains essential mechanical, electrical, and patient care equipment in safe operating condition. **PE.04.01.05, EP 1** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		suppression system supervisory initiating devices - Semiannually for valve supervisory switches - Annually for other supervisory initiating devices The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. Note 2: Water storage tanks and associated water storage equipment do not require testing. **EC.02.03.05, EP 2** Every 6 months, the critical access hospital tests vane-type and pressure-type water flow devices and valve tamper switches on the inventory. The results and completion dates are documented. Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. Note 2: Mechanical water flow devices (including, but not limited to, water motor gongs) should be tested quarterly. The results and completion dates are documented. (For full text, refer to NFPA 25-2011: Table 5.1.1.2) **EC.02.03.05, EP 3** Every 12 months, the critical access hospital tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14. **EC.02.03.05, EP 4** Every 12 months, the critical access hospital tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and	measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. **EC.02.03.05, EP 5** Every 12 months, the critical access 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. **EC.02.03.05, EP 6** For automatic sprinkler systems: The critical access hospital tests electric motor–driven fire pumps monthly and diesel engine–driven fire pumps every week under no-flow conditions. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.1; 8.3.2. **EC.02.03.05, EP 9** For automatic sprinkler systems: Every 12 months, the critical access hospital tests main drains at system low point or at all system risers. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. **EC.02.03.05, EP 10** For automatic sprinkler systems: Every quarter, the critical access hospital inspects all fire department water	**PE.04.01.05, EP 3** The individual or team responsible for the water management program manages the following: - Documenting results of all monitoring activities - Corrective actions and procedures to follow if a test result outside of acceptable limits is obtained, including when a probable or confirmed waterborne pathogen(s) indicates action is necessary - Documenting corrective actions taken when control limits are not maintained Note: See PE.07.01.01, EP 1 for the process of monitoring, reporting, and investigating utility system issues. **PE.04.01.05, EP 4** The individual or team responsible for the water management program reviews the program annually and when the following occurs: - Changes have been made to the water system that would add additional risk. - New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the critical access hospital unless required by law or regulation. Note 2: Refer to ASHRAE Standard 188-2018 “Legionellosis: Risk Management for Building Water Systems” and the Centers for Disease Control and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		supply connections. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2. **EC.02.03.05, EP 11** For automatic sprinkler systems: Every 12 months, the critical access 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. **EC.02.03.05, EP 12** Every 5 years, the critical access hospital conducts hydrostatic and water flow tests for standpipe systems. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2. **EC.02.03.05, EP 13** Every 6 months, the critical access hospital inspects any automatic fire-extinguishing system in a kitchen. The results and completion dates are documented. Note 1: Discharge of the fire-extinguishing systems is not required. Note 2: For additional guidance on performing inspections, see NFPA 96-2011: 11.2. **EC.02.03.05, EP 14** The critical access hospital tests automatic fire-extinguishing systems as follows:	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.”

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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. **EC.02.03.05, EP 15** At least monthly, the critical access hospital inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4. **EC.02.03.05, EP 16** Every 12 months, the critical access hospital performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		on extinguishers are certified. The results and completion dates are documented. Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1. **EC.02.03.05, EP 17** The critical access hospital conducts hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter. The results and completion dates are documented. Note: For additional guidance on hydrostatic testing, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6. **EC.02.03.05, EP 18** The critical access hospital operates fire and smoke dampers one year after installation and then at least every six years to verify that they fully close. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5. **EC.02.03.05, EP 19** Every 12 months, the critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		NFPA 90A-2012: 6.4.1. **EC.02.03.05, EP 20** Every 12 months, the critical access 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. **EC.02.03.05, EP 25** The critical access 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: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. Note 3: For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. **EC.02.03.05, EP 27** Elevators with firefighters' emergency operations are tested monthly. The test completion dates and results are	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		documented. (For full text, refer to NFPA 101-2012: 9.4.3; 9.4.6) **EC.02.04.01, EP 2** The critical access hospital maintains a written inventory of all medical equipment. **EC.02.04.01, EP 3** The critical access hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail. Note: High-risk medical equipment includes life-support equipment. **EC.02.04.01, EP 4** The critical access hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. Note: Activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. **EC.02.04.01, EP 11** The critical access hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. **EC.02.04.03, EP 1** Before initial use and after major repairs or upgrades of	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		medical equipment on the medical equipment inventory, the critical access hospital performs safety, operational, and functional checks. **EC.02.04.03, EP 2** The critical access hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate. **EC.02.04.03, EP 3** The critical access hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. **EC.02.04.03, EP 4** The critical access hospital conducts performance testing of and maintains all sterilizers. These activities are documented. **EC.02.04.03, EP 5** The critical access hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. **EC.02.04.03, EP 10** All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14. **EC.02.04.03, EP 26** The critical access 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:	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		11.4.1.3; 11.5.1.3; 11.6.2.5; 11.6.2.6) **EC.02.04.03, EP 27** The critical access 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: The critical access hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5. **EC.02.05.01, EP 1** The critical access hospital designs and installs utility systems according to National Fire Protection Association codes to meet patient care and operational needs. **EC.02.05.01, EP 2** New building systems and modifications to existing building systems are designed to meet the National Fire Protection Association's Categories 1–4 requirements. (For full text, refer to NFPA 99-2012: Chapter 4 for descriptions of the four categories related to gas, vacuum, electrical, and electrical equipment.) **EC.02.05.01, EP 3** The critical access hospital maintains a written inventory of all operating components of utility systems. **EC.02.05.01, EP 4** The critical access 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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: High-risk utility system components include life-support equipment. **EC.02.05.01, EP 5** The critical access hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components of utility systems on the inventory. Note: For guidance on maintenance and testing activities for Essential Electric Systems (Type I), see NFPA 99-2012: 6.4.4. **EC.02.05.01, EP 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: 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/. Note 2: Existing facilities may comply with the 2012 NFPA 99 ventilation requirements or the ventilation requirements in the edition of the NFPA code previously adopted by CMS at the time of installation (for example,1999 NFPA 99). **EC.02.05.01, EP 20** Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. (For full text, refer to NFPA 99-2012: 6.3.2.2.8.4; 6.3.2.2.8.7; 6.4.4.2) **EC.02.05.01, EP 21** Electrical distribution in the critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours. (For full text, refer to NFPA 99-2012: 3.3.138; 6.3.2.2.10; 6.6.2.2.2; 6.6.3.1.1) **EC.02.05.01, EP 22** Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed tamper-resistant cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4; 6.4.2.2.6; 6.5.2.2.4.2; 6.6.2.2.3.2) **EC.02.05.01, EP 23** Power strips in a patient care vicinity are only used for components of movable electrical equipment assemblies used for patient care. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non–patient care rooms, power strips meet other UL standards. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011: 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	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Zone valves are located immediately outside each anesthetizing location for medical gas or vacuum, readily accessible in an emergency, and arranged so shutting off any one anesthetizing location will not affect others. - Area alarm panels are installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch gauge HgV (mercury vacuum). - Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone valve box assemblies. (For full text, refer to NFPA 101-2012: 18/19.3.2.3; NFPA 99-2012: 5.1.4.8.7; 5.1.9.3) **EC.02.05.01, EP 26** Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows: The essential electrical system's (EES) critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits. The EES equipment system supplies power to the ventilation system. (For full text, refer to NFPA 101-2012: 18/19.3.2.3; NFPA 99-2012: 6.4.2.2.4.2) **EC.02.05.01, EP 27** Newly engineered smoke control systems are designed, installed, maintained, and tested per NFPA 92-2012.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Existing smoke control systems are tested and maintained to established engineering principles unless specifically exempted by the authority having jurisdiction. Systems not meeting the performance requirements of the testing specified in NFPA 101-2012: 19.7.7.1 can be continued in operation only with the specific approval of the authority having jurisdiction. (For full text, refer to NFPA 101-2012: 18/19: 7.7; NFPA 92-2012) Note: The smoke plume created by the thermal destruction of tissue by cauterizing equipment and lasers is addressed at Standard EC.02.02.01, EP 9. **EC.02.05.02, EP 1** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **EC.02.05.02, EP 2** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points 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)	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. **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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		issues. **EC.02.05.02, EP 4** The individual or team responsible for the water management program reviews the program annually and when the following occurs: - Changes have been made to the water system that would add additional risk. - New equipment or an at-risk water system(s) has been added that could generate aerosols or be a potential source for Legionella. This includes the commissioning of a new wing or building. Note 1: The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) do not require culturing for Legionella or other waterborne pathogens. Testing protocols are at the discretion of the critical access hospital unless required by law or regulation. Note 2: Refer to ASHRAE Standard 188-2018 “Legionellosis: Risk Management for Building Water Systems” and the Centers for Disease Control and Prevention Toolkit "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" for 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.” **EC.02.05.05, EP 2** The critical access hospital tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion dates and test results are documented.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		EC.02.05.05, EP 4 The critical access hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate. **EC.02.05.05, EP 5** The critical access 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. **EC.02.05.05, EP 6** The critical access hospital inspects, tests, and maintains the following: Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented. **EC.02.05.07, EP 1** At least monthly, the critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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) **EC.02.05.07, EP 2** Every 12 months, the critical access 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) **EC.02.05.07, EP 3** The critical access 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 critical access 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 critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. **EC.02.05.07, EP 5** At least monthly, the critical access hospital tests each emergency generator beginning with a cold start under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.05.07, EP 6** The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1) Note: Tests for non-diesel-powered generators need only be conducted with available load. **EC.02.05.07, EP 7** At least monthly, the critical access hospital tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.05.07, EP 9** At least once every 36 months, critical access hospitals with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010, Chapter 8. **EC.02.05.07, EP 10** The 36-month diesel-powered emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. Note 1: Tests for non-diesel-powered generators need only be conducted with available load. Note 2: For additional guidance, see NFPA 110-2010, Chapter 8. **EC.02.05.09, EP 1**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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) **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) **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. FOR FULL EP MAPPING VIEW CAH CROSSWALK	
§485.623(b)(2)	(2) There is proper routine storage and prompt disposal of trash;	**EC.01.01.01, EP 6** The critical access hospital has a written plan for managing the following: Hazardous materials and waste. **EC.02.02.01, EP 1**	**PE.02.01.01, EP 6** The critical access hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access 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 critical access hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures. **EC.02.02.01, EP 4** The critical access hospital implements its procedures in response to hazardous material and waste spills or exposures. **EC.02.02.01, EP 5** The critical access hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. **EC.02.02.01, EP 6** The critical access hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. **EC.02.02.01, EP 8** The critical access hospital minimizes risks associated with disposing of hazardous medications.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		EC.02.02.01, EP 11 For managing hazardous materials and waste, the critical access hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation. **EC.02.02.01, EP 12** The critical access hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings. * Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements. **EC.02.02.01, EP 19** The critical access hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste. **EC.02.06.01, EP 20** Areas used by patients are clean and free of offensive odors. **EC.02.06.05, EP 3** The critical access hospital takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance. **LS.01.02.01, EP 9** When the critical access hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the critical access	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 critical access hospital's interim life safety measures (ILSM) policy. **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.	
§485.623(b)(3)	(3) Drugs and biologicals are appropriately stored;	**MM.03.01.01, EP 2** The critical access hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 3** The critical access 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	**MM.13.01.01, EP 2** The critical access hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area and locked when necessary to prevent diversion in accordance with law and regulation. Note 1: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. Note 3: Only authorized staff have access to locked areas.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
§485.623(b)(4)	(4) The premises are clean and orderly; and	**EC.02.02.01, EP 4** The critical access hospital implements its procedures in response to hazardous material and waste spills or exposures. **EC.02.06.01, EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. **EC.02.06.01, EP 20** Areas used by patients are clean and free of offensive odors. **LS.01.02.01, EP 9** When the critical access hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the critical access 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 critical access hospital's interim life safety measures (ILSM) policy. **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,	**PE.01.01.01, EP 3** The critical access hospital's premises are clean and orderly. Note: Clean and orderly means an uncluttered physical environment where patients and staff can function. This includes but is not limited to storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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))	
§485.623(b)(5)	(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	**EC.02.02.01, EP 9** The critical access 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)	**PE.04.01.01, EP 3** The critical access hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		EC.02.02.01, EP 10 The critical access hospital monitors levels of hazardous gases and vapors to determine that they are in safe range. Note: Law and regulation determine the frequency of monitoring hazardous gases and vapors as well as acceptable ranges. **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: 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: Existing facilities may comply with the 2012 NFPA	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		99 ventilation requirements or the ventilation requirements in the edition of the NFPA code previously adopted by CMS at the time of installation (for example,1999 NFPA 99). **EC.02.06.01, EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. **EC.02.06.01, EP 11** Lighting is suitable for care, treatment, and services. **EC.02.06.01, EP 20** Areas used by patients are clean and free of offensive odors. **EC.02.06.01, EP 33** The critical access hospital ensures all pharmaceutical preparation areas have proper ventilation, lighting, and temperature control. **EC.02.06.05, EP 1** When planning for new, altered, or renovated space, the critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		standards and guidelines that provide equivalent design criteria.	
§485.623(c)	§485.623(c) Standard: Life Safety From Fire		
§485.623(c)(1)	(1) Except as otherwise provided in this section –		
§485.623(c)(1)(i)	(i) The CAH must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.)	**EC.02.03.03, EP 1** The critical access hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. The critical access 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 critical access 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 critical access hospital occupies. **EC.02.03.03, EP 3** When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions. Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the critical access 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	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		from quarter to quarter, through four consecutive quarters. Note 3: For full text, refer to NFPA 101-2012: 18/19: 7.1; 7.1.7; 7.2; 7.3. **EC.02.03.03, EP 4** Staff who work in buildings where patients are housed or treated participate in drills according to the critical access hospital's fire response plan. **EC.02.03.03, EP 5** The critical access hospital critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. The evaluation is documented. **EC.02.03.03, EP 7** The critical access hospital conducts annual fire exit drills for operating rooms/surgical suites. (For full text, refer to NFPA 99-2012: 15.13.3.10.3) Note 1: This drill involves applicable staff and focuses on prevention as well as simulated extinguishment and evacuation. Note 2: An announced annual fire exit drill cannot be used to meet one of the unannounced quarterly fire drills required by NFPA 101-2012: 18/19.7.1.6. **EC.02.03.03, EP 8** For critical access 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	but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 critical access hospital conducts an unannounced drill, it may serve as one of the required fire drills. **EC.02.03.05, EP 28** Documentation of maintenance, testing, and inspection activities for Standard EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection features) includes the following: - Name of the activity - Date of the activity - Inventory of devices, equipment, or other items - Required frequency of the activity - Name and contact information, including affiliation, of the person who performed the activity - NFPA standard(s) referenced for the activity - Results of the activity Note: For additional guidance on documenting activities, see NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4. **EC.03.01.01, EP 1** Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		competent and receive continuing education and training. **EC.03.01.01, EP 2** Staff can describe or demonstrate actions to take in the event of an environment of care incident. **LS.01.01.01, EP 1** The critical access 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: The critical access hospital complies with the 2012 Life Safety Code. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospitals. **LS.01.02.01, EP 1** The critical access 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 critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		critical access hospital identifies which ILSMs in its policy will be implemented until the issue is corrected. **LS.01.02.01, EP 2** When the critical access hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the critical access hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2) **LS.01.02.01, EP 15** The critical access 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 critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		required by the construction type. (For full text, refer to NFPA 101-2012: 18/19.1.6; 18.3.5.1; 19.3.5.3; 18/19.3.5.4; 18/19.3.5.5; 18.3.5.6) **LS.02.01.10, EP 3** Any building undergoing change of use or change of occupancy classification complies with NFPA 101-2012: 43.7, unless permitted by NFPA 101-2012: 18/19.1.1.4.2. **LS.02.01.10, EP 4** When an addition is made to a building, the building is in compliance with NFPA 101-2012: 43.8 and Chapter 18. **LS.02.01.10, EP 5** Buildings without protection from automatic sprinkler systems comply with NFPA 101-2012: 18.4.3.2; 18.4.3.3; and 18.4.3.8. When a nonsprinklered smoke compartment has undergone major rehabilitation, the automatic sprinkler requirements of Chapter 18.3.5 will apply. Note: Major rehabilitation involves the modification of more than 50 percent, or 4500 square feet, of the area of the smoke compartment. (For full text, refer to NFPA 101-2012: 18/19.1.1.4.3.3) **LS.02.01.10, EP 8** When multiple occupancies are identified, they are in accordance with NFPA 101-2012: 18/19.1.3.2 or 18/19.1.3.4, and the most stringent occupancy requirements are followed throughout the building. Note 1: If a two-hour separation is provided in accordance with NFPA 101-2012: 8.2.1.3, the construction type is determined as follows:	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		(For full text, refer to NFPA 101-2012: 7.1.3.2.1) **LS.02.01.10, EP 11** Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5) **LS.02.01.10, EP 12** Doors requiring a fire rating of 3/4 of an hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs, which are applied with adhesive only. (For full text, refer to NFPA 80-2010: 4.1.4) **LS.02.01.10, EP 13** Ducts penetrating the walls or floors with a fire resistance rating of less than 3 hours are protected by dampers that are fire rated for 1 1/2 hours; ducts penetrating the walls or floors with a fire resistance rating of 3 hours or greater are protected by dampers that are fire rated for 3 hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4.1; 5.4.2) **LS.02.01.10, EP 14**	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.20, EP 3 Horizontal sliding doors permitted by NFPA 101-2012: 7.2.1.14 that are not automatic closing are limited to a single leaf and have a latch or other mechanism to prevent the door from rebounding. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.10.1) **LS.02.01.20, EP 4** Horizontal sliding doors serving an occupant load fewer than 10 are permitted, as long as they comply with NFPA 101-2012: 18/19.2.2.2.10.2 and meet the following criteria: - Area served by the door has no hazards. - Door is operable from either side without special knowledge or effort. - Force required to operate the door in the direction of travel is less than or equal to 30 pounds-force (lbf) to set the door in motion and less than or equal to 15 lbf to close or open to the required width. - Assembly is appropriately fire rated and is self- or automatic-closing by smoke detection per 7.2.1.8; assembly is installed per NFPA 80-2010. - Where required to latch, the door has a latch or other mechanism to prevent the door from rebounding. **LS.02.01.20, EP 5** Walls containing horizontal exits are fire rated for two or more hours, extend from the lowest floor slab to the floor or roof slab above, and extend continuously from exterior wall to exterior wall. (For full text, refer to NFPA 101-2012: 7.2.4.3.1; 18/19.2.2.5) **LS.02.01.20, EP 6**	

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.20, EP 17 Every corridor provides access to at least two approved exits in accordance with NFPA 101-2012: 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. (For full text, refer to NFPA 101-2012: 18/19.2.5.4) **LS.02.01.20, EP 20** Existing exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. (For full text, refer to NFPA 101-2012: 19.2.3.6, 19.2.3.7) **LS.02.01.20, EP 21** New exit access doors and exit doors are of the swinging type and are at least 41 1/2 inches in clear width. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries are at least 32 inches in clear width. If using a pair of doors, the doors have a rabbet, bevel, or astragal at the meeting edge, and at least one of the doors provides 32 inches in clear width, while the inactive leaf of the pair is secured with automatic flush bolts. (For full text, refer to NFPA 101-2012: 18.2.3.6; 18.2.3.7) **LS.02.01.20, EP 22** Exit access doors and exit doors are free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit. (For full text, refer to NFPA 101-2012: 18/19.2.1; 18/19.2.5.1; 7.1.10.2; 7.5.2.2.1)	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.20, EP 23 Doors to new boiler rooms, new heater rooms, and new mechanical equipment rooms located in a means of egress are not held open by an automatic release device. (For full text, refer to NFPA 101-2012: 18.2.2.2.7) **LS.02.01.20, EP 24** The corridor width is not obstructed by wall projections. Note: When corridors are six feet wide or more, it is allowable for certain objects to project into the corridor, such as hand rub dispensers or computer desks that are retractable. The objects must be no more than 36 inches wide and cannot project more than 6 inches into the corridor. These items must be installed at least 48 inches apart and above the handrail height. (For full text, refer to NFPA 101-2012: 18/19.2.3.4) **LS.02.01.20, EP 25** In new buildings, no dead-end corridor is longer than 30 feet, and the common path of travel does not exceed 100 feet. (For full text, refer to NFPA 101-2012: 18.2.5.2) Note: Existing dead-end corridors longer than 30 feet are permitted to be used if it is impractical and unfeasible to alter them. (For full text, refer to NFPA 101-2012: 19.2.5.2) **LS.02.01.20, EP 26** Patient sleeping rooms open directly onto an exit access corridor. Patient sleeping rooms with less than eight beds may have one intervening room to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.2.5.6.1–18/19.2.5.6.4)	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LS.02.01.20, EP 27 Patient sleeping rooms that are larger than 1,000 square feet have at least two exit access doors remotely located from each other. Rooms not used as patient sleeping rooms that are larger than 2,500 square feet have at least two exit access doors remotely located from each other. (For full text, refer to NFPA 101-2012: 18/19.2.5.5) **LS.02.01.20, EP 32** For existing buildings, suites of patient sleeping rooms are limited to 5,000 square feet or less. If the existing building has an approved electrically supervised sprinkler system and total coverage automatic smoke detection system, the suite is permitted to be increased to 7,500 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.3.4; 19.3.5.7; 19.3.5.8.) If the suite is provided with direct visual supervision, an approved electrically supervised sprinkler system, and a total coverage (complete) smoke detection system, the suite is permitted to be increased to 10,000 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.2.5.7.2.1(D)(1)(a); 19.2.5.7.2.3; 19.3.4; 19.3.5.8) **LS.02.01.20, EP 35** For new buildings, sleeping and non-sleeping patient care suites have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is 200 feet. (For full text, refer to NFPA 101-2012: 18.2.5.7.2.4; 18.2.5.7.3.4) **LS.02.01.20, EP 36**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		For existing buildings, sleeping and non-sleeping patient care suites have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is either 150 feet if the building is not protected throughout by an approved electrically supervised sprinkler system or 200 feet if the building is fully protected by an approved electrically supervised sprinkler system. (For full text, refer to NFPA 101-2012: 19.2.5.7.2.4; 19.2.5.7.3.4) **LS.02.01.20, EP 37** Travel distances to exits are measured in accordance with NFPA 101-2012: 7.6. - From any point in the room or suite to the exit is 150 feet or less (200 feet or less if the building is fully sprinklered) - From any point in a room to the room door is 50 feet or less (For full text, refer to NFPA 101-2012: 18/19.2.6) **LS.02.01.20, EP 38** Means of egress are adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text, refer to NFPA 101-2012: 18/19.2.8; 7.8.1.1) **LS.02.01.20, EP 39** Illumination in the means of egress, including exit discharges, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness (less than 0.2 foot candles). Emergency lighting of at least 1½-hours duration is provided automatically in accordance with NFPA 101-2012: 7.9. (For full text, refer to NFPA 101-	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		2012: 18/19.2.8; 18/19.2.9.1; 7.8.1.4; 7.9.2) **LS.02.01.20, EP 40** Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are four or more inches high (or six inches high if externally lit). Exit and directional signs displayed with continuous illumination are also served by the emergency lighting system unless the building is one story with less than 30 occupants, and the line of exit travel is obvious. (For full text, refer to NFPA 101-2012: 18/19.2.10; 7.10.1.4; 7.10.1.5.1; 7.10.5; 7.10.6; 7.10.7) **LS.02.01.20, EP 41** Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to NFPA 101-2012: 18/19.2.10.1; 7.10.8.3) **LS.02.01.20, EP 42** The critical access hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2012: 18/19.2. **LS.02.01.30, EP 1** In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. In existing construction, vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction. Note: These vertical openings include, but are not limited	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		to, shafts (including elevator, light and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases. (For full text, refer to NFPA 101-2012: 8.6; 18/19.3.1; 7.1.3.2.1) **LS.02.01.30, EP 4** Laboratories using quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are in accordance with NFPA 101-2012: 8.7 and NFPA 99 requirements applicable to administration, maintenance, and testing. (For full text refer to NFPA 101-2012: 18/19.3.2.2; NFPA 99-2012: 15.4) **LS.02.01.30, EP 5** Where residential or commercial cooking equipment is used to prepare meals for less than 31 people in a smoke compartment, one cooking facility is permitted to be open to the corridor provided all criteria in NFPA 101-2012: 18/19.3.2.5 are met. Note: The critical access hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-2. **LS.02.01.30, EP 7** Existing wall and ceiling interior finishes are rated Class A or B for limiting smoke development and the spread of flames. Newly installed wall and ceiling interior finishes are rated Class A. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2) **LS.02.01.30, EP 8** Newly installed interior floor finishes in corridors of smoke compartments with an approved automatic	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		sprinkler system is at least Class II. Existing floor finishes are not restricted. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2.7) **LS.02.01.30, EP 11** Within corridors in smoke compartments that are protected throughout with an approved supervised sprinkler system, partitions are allowed to terminate at the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers that penetrate the ceiling, ducted heating, ventilating, and air conditioning (HVAC) supply and return-air diffusers, speakers, and recessed lighting fixtures. (For full text, refer to NFPA 101-2012: 18/19.3.6.2) **LS.02.01.30, EP 14** In smoke compartments without sprinkler systems, fixed fire windows in corridor walls are 25% or less of the size of the corridor walls in which they are installed. Existing window installations that conform to previously accepted Life Safety Code criteria (such as a size of 1,296 square inches or less, made with wired glass or fire-rated glazing, and set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.6.2.7; 8.3.3.8; 8.3.3.9; 8.3.3.11) **LS.02.01.30, EP 15** Openings in vision panels or doors in corridor walls (other than in smoke compartments containing patient sleeping rooms) are installed at or below one half the distance from the floor to the ceiling. These openings may not be	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 purpose. **LS.02.01.30, EP 20** Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 of an inch. In new buildings, undercuts are no larger than 3/4 of an inch, and doors in a means of egress swing in the opposite direction. (For full text, refer to NFPA 101-2012: 18.3.7.6; 18/19.3.7.8; 8.5.4.1; NFPA 80-2010: 4.8.4.1; 6.3.1.7.1) **LS.02.01.30, EP 21** In smoke compartments without sprinkler systems, fixed fire windows in smoke barrier doors are 25% or less of the size of the doors in which they are installed. Existing window installations that conform to previously accepted Life Safety Code criteria (such as 1,296 square inches or less, wired glass or fire-rated glazing, and are set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.7.6; 8.3.3; 8.5.4.5)	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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) **LS.02.01.30, EP 23** Approved smoke dampers protect air transfer openings extending through smoke barriers in ceiling spaces that are used as an unducted common plenum for either supply or return air. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.5.5.2) **LS.02.01.30, EP 26** The critical access hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 18/19.3. **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. FOR FULL EP MAPPING VIEW CAH CROSSWALK	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.623(c)(1)(ii)	(ii) Notwithstanding paragraph (c)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.	**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: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors. **LS.02.01.30, EP 3** All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistive rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories employing flammable or combustible materials deemed less than a severe hazard, and storage rooms greater than 50 square	**PE.03.01.01, EP 6** Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors. **LS.02.01.30, EP 12** In new buildings, all corridor doors are constructed to resist the passage of smoke, hinged so that they swing, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Undercuts are no larger than one inch. Positive latching hardware is required. Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 18.3.6.3.1; 18.3.6.3.5; 18.3.6.4; 18.3.6.5; 18.3.6.3.10; 18.3.6.3.11) **LS.02.01.30, EP 13** In existing buildings, all corridor doors are constructed to resist the passage of smoke and constructed of 1 3/4-inch or thicker solid bonded wood core or constructed of material that resists fire for not less than 20 minutes, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Positive latching hardware is required. Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 19.3.6.3.1; 19.3.6.3.2; 19.3.6.3.5) Note 1: Powered corridor doors are equipped with positive latching hardware unless the organization can verify that this equipment is not an option provided by the	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials are not required to have a device capable of keeping the door fully closed if a force of 5 lbf is applied at the latch edge. In these cases, roller latches are permissible. **LS.05.01.30, EP 1** All hazardous areas are enclosed with one-hour fire-rated walls with ¾-hour fire-rated doors; or hazardous areas have sprinkler systems and are constructed to resist the passage of smoke with doors equipped with self-closing or automatic-closing devices. (For full text, refer to NFPA 101-2012: 38/39.3.2; 8.7; NFPA 80-2010: 4.8.4.1; 6.3.1.7; 6.5) **LS.05.01.30, EP 4** The critical access hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 38/39.3.	
§485.623(c)(2)	(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate,	**LS.01.01.01, EP 2** In time frames defined by the critical access hospital, the critical access hospital performs a building assessment to determine compliance with the "Life Safety" (LS) chapter.	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a CAH, but only if the waiver will not adversely affect the health and safety of the patients.	**LS.01.01.01, EP 4** When the critical access hospital plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the critical access hospital meets the 60-day time frame. Note 1: If the corrective action will exceed the 60-day time frame, the critical access 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 critical access hospital may submit an equivalency request using its Statement of Conditions (SOC). Note 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/ and NFPA 101-2012: 1.4.	provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(c)(3)	(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly		**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients.		and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(c)(4)	(4) The CAH maintains written evidence of regular inspection and	**LS.01.01.01, EP 5** The critical access hospital maintains documentation of	**PE.03.01.01, EP 5** The critical access hospital maintains written evidence

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	approval by State or local fire control agencies.	any inspections and approvals made by state or local fire control agencies.	of regular inspection and approval by state or local fire control agencies.
§485.623(c)(5)	(5) A CAH may install alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against inappropriate access.	**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. **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.	**PE.03.01.01, EP 7** When the critical access hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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. **LS.05.01.30, EP 4** The critical access hospital meets all other Life Safety Code fire and smoke protection requirements related to NFPA 101-2012: 38/39.3.	
§485.623(c)(6)	(6) When a sprinkler system is shut down for more than 10 hours, the CAH must:		
§485.623(c)(6)(i)	(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or	**LS.01.02.01, EP 2** When the critical access hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the critical access 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	**PE.03.01.01, EP 8** When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service, or the critical access hospital establishes a fire watch until the system is back in service.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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)	
§485.623(c)(6)(ii)	(ii) Establish a fire watch until the system is back in service.	**LS.01.02.01, EP 2** When the critical access hospital identifies Life Safety Code deficiencies that cannot be immediately corrected or during periods of construction, the critical access hospital evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)	**PE.03.01.01, EP 8** When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service, or the critical access hospital establishes a fire watch until the system is back in service.
§485.623(c)(7)	(7) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows for the purposes of this requirement.	**LS.02.01.30, EP 24** Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24-hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department). Note: Windows in atrium walls are considered outside windows. **LS.02.01.30, EP 25** In new buildings constructed after July 5, 2016, the window sill height in patient sleeping rooms does not exceed 36 inches from the floor, except in special nursing care areas (for example, intensive care units, coronary care units, hemodialysis units, and neonatal intensive	**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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		care units), where window sill height does not exceed 60 inches above the floor.	
§485.623(c)(7)(i)	(i) The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours.	**LS.02.01.30, EP 24** Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24-hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department). Note: Windows in atrium walls are considered outside windows.	**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.
§485.623(c)(7)(ii)	(ii) Special nursing care areas of new occupancies shall not exceed 60 inches.	**LS.02.01.30, EP 25** In new buildings constructed after July 5, 2016, the window sill height in patient sleeping rooms does not exceed 36 inches from the floor, except in special nursing care areas (for example, intensive care units, coronary care units, hemodialysis units, and neonatal intensive care units), where window sill height does not exceed 60 inches above the floor.	**PE.03.01.01, EP 9** Buildings have an outside window or outside door in every sleeping room. For any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.
§485.623(d)	§485.623(d) Standard: Building Safety Except as otherwise provided in this section, the CAH must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6).	**EC.02.01.03, EP 4** Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within the site of intentional expulsion (within 1 foot). When other oxygen delivery equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area of administration (within 15 feet). Solid fuel–burning appliances are not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. (For full text, refer to NFPA 99-2012: 11.5.1.1; Tentative Interim Amendment [TIA] 12-6) **EC.02.03.01, EP 13** The critical access hospital meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012: Chapter 15. **EC.02.04.03, EP 27** The critical access 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: The critical access hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5. **EC.02.05.05, EP 8** The critical access hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning	Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		(HVAC). (For full text, refer to NFPA 99-2012: Chapters 6 and 9) Note: The critical access hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3. **EC.02.05.09, EP 14** The critical access 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: The critical access hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-4 and 12-6.	
§485.623(d)(1)	(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a CAH.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(d)(2)	(2) If application of the Health Care Facilities Code required under paragraph (d) of this section would result in unreasonable hardship for the CAH, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.	**EC.01.01.01, EP 1** Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. Note: Deficiencies include injuries, problems, or use errors.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)	§485.623(e) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National		

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	Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.		
§485.623(e)(1)	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.		
§485.623(e)(1)(i)	(i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(ii)	(ii) TIA 12–2 to NFPA 99, issued August 11, 2011.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(iii)	(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(iv)	(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(v)	(v) TIA 12–5 to NFPA 99, issued August 1, 2013.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012	**PE.04.01.01, EP 1** The critical access hospital meets the applicable

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(vi)	(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(vii)	(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011;	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the

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			health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(viii)	(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in

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			unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(ix)	(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency

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			findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(x)	(x) TIA 12–3 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.623(e)(1)(xi)	(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable

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			hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625	§485.625 Condition of Participation: Emergency Preparedness The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness plan must include, but not be limited to, the following elements:	**EM.09.01.01, EP 1** The critical access hospital has a written comprehensive emergency management program that utilizes an all-hazards approach. The program includes, but is not limited to, the following: - Leadership structure and program accountability - Hazard vulnerability analysis - Mitigation and preparedness activities - Emergency operations plan and policies and procedures - Education and training - Exercises and testing - Continuity of operations plan - Disaster recovery - Program evaluation **EM.09.01.01, EP 3** The critical access hospital complies with all applicable	**EM.09.01.01, EP 1** The critical access hospital has a written comprehensive emergency management program that utilizes an all-hazards approach. The program includes, but is not limited to, the following: - Leadership structure and program accountability - Hazard vulnerability analysis - Mitigation and preparedness activities - Emergency operations plan and policies and procedures - Education and training - Exercises and testing - Continuity of operations plan - Disaster recovery - Program evaluation **EM.09.01.01, EP 3** The critical access hospital complies with all applicable

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		federal, state, and local emergency preparedness laws and regulations.	federal, state, and local emergency preparedness laws and regulations.
§485.625(a)	(a) Emergency plan. The CAH must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do all of the following:	**EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program	**EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- Education and training program - Testing program
§485.625(a)(1)	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	**EM.11.01.01, EP 1** The critical access hospital conducts a facility-based hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following: - Hazards that are likely to impact the critical access hospital's geographic region, community, facility, and patient population - A community-based risk assessment (such as those developed by external emergency management agencies) - Separate HVAs for its other accredited facilities if they significantly differ from the main site The findings are documented. Note: A separate HVA is only required if the accredited facilities are in different geographic locations, experience different hazards or threats, or the patient population and services offered are unique to this facility. **EM.11.01.01, EP 2** The critical access hospital's hazard vulnerability analysis includes the following: - Natural hazards (such as flooding, wildfires) - Human-caused hazards (such as bomb threats or cyber/information technology crimes) - Technological hazards (such as utility or information technology outages) - Hazardous materials (such as radiological, nuclear, chemical) - Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)	**EM.11.01.01, EP 1** The critical access hospital conducts a facility-based hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following: - Hazards that are likely to impact the critical access hospital's geographic region, community, facility, and patient population - A community-based risk assessment (such as those developed by external emergency management agencies) - Separate HVAs for its other accredited facilities if they significantly differ from the main site The findings are documented. Note: A separate HVA is only required if the accredited facilities are in different geographic locations, experience different hazards or threats, or the patient population and services offered are unique to this facility. **EM.11.01.01, EP 2** The critical access hospital's hazard vulnerability analysis includes the following: - Natural hazards (such as flooding, wildfires) - Human-caused hazards (such as bomb threats or cyber/information technology crimes) - Technological hazards (such as utility or information technology outages) - Hazardous materials (such as radiological, nuclear, chemical) - Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)

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§485.625(a)(2)	(2) Include strategies for addressing emergency events identified by the risk assessment.	**EM.11.01.01, EP 3** The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4** The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions.	**EM.11.01.01, EP 3** The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4** The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions.
§485.625(a)(3)	(3) Address patient population, including, but not limited to, persons at-risk; the type of services the CAH has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	**EM.12.01.01, EP 2** The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence. **EM.13.01.01, EP 1** The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and	**EM.12.01.01, EP 2** The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence. **EM.13.01.01, EP 1** The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and

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		finance leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. **EM.13.01.01, EP 2** The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3** The critical access hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform	finance leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. **EM.13.01.01, EP 2** The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3** The critical access hospital has a written order of succession plan that identifies who is authorized to

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		their duties. **EM.13.01.01, EP 4** The critical access hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.	assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. **EM.13.01.01, EP 4** The critical access hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.
§485.625(a)(4)	(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.	**EM.12.01.01, EP 6** The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.	**EM.12.01.01, EP 6** The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident.
§485.625(b)	(b) Policies and procedures. The CAH must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	**EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures	**EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and

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	assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:	include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program	procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program
§485.625(b)(1)	(1) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to--		

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§485.625(b)(1)(i)	(i) Food, water, medical, and pharmaceutical supplies;	**EM.12.01.01, EP 4** The emergency operations plan includes written procedures for how the critical access hospital will provide essential needs for its staff, volunteers, and patients, whether they shelter in place or evacuate, that includes, but is not limited to, the following: - Food and other nutritional supplies - Medications and related supplies - Medical/surgical supplies - Medical oxygen and supplies - Potable or bottled water	**EM.12.01.01, EP 4** The emergency operations plan includes written procedures for how the critical access hospital will provide essential needs for its staff, volunteers, and patients, whether they shelter in place or evacuate, that includes, but is not limited to, the following: - Food and other nutritional supplies - Medications and related supplies - Medical/surgical supplies - Medical oxygen and supplies - Potable or bottled water
§485.625(b)(1)(ii)	(ii) Alternate sources of energy to maintain:		
§485.625(b)(1)(ii)(A)	(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions;	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.
§485.625(b)(1)(ii)(B)	(B) Emergency lighting;	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following:	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following:

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		- Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.	- Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.
§485.625(b)(1)(ii)(C)	(C) Fire detection, extinguishing, and alarm systems; and	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.
§485.625(b)(1)(ii)(D)	(D) Sewage and waste disposal.	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and	**EM.12.02.11, EP 4** The critical access hospital's plan for managing utilities includes alternate sources for maintaining energy to the following: - Temperatures to protect patient health and safety and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.	for the safe and sanitary storage of provisions - Emergency lighting - Fire detection, extinguishing, and alarm systems - Sewage and waste disposal Note: It is important for critical access hospitals to consider alternative means for maintaining temperatures at a level that protects the health and safety of all persons within the facility. For example, when safe temperature levels cannot be maintained, the critical access hospital considers partial or full evacuation or closure.
§485.625(b)(2)	(2) A system to track the location of on-duty staff and sheltered patients in the CAH's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the CAH must document the specific name and location of the receiving facility or other location.	**EM.12.02.07, EP 2** The critical access hospital's plan for safety and security measures includes a system to track the location of its on-duty staff and volunteers and patients when sheltered in place, relocated, or evacuated. If on-duty staff and volunteers and patients are relocated during an emergency, the critical access hospital documents the specific name and location of the receiving facility or evacuation location. Note: Examples of systems used for tracking purposes include the use of established technology or tracking systems or taking head counts at defined intervals.	**EM.12.02.07, EP 2** The critical access hospital's plan for safety and security measures includes a system to track the location of its on-duty staff and volunteers and patients when sheltered in place, relocated, or evacuated. If on-duty staff and volunteers and patients are relocated during an emergency, the critical access hospital documents the specific name and location of the receiving facility or evacuation location. Note: Examples of systems used for tracking purposes include the use of established technology or tracking systems or taking head counts at defined intervals.
§485.625(b)(3)	(3) Safe evacuation from the CAH, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.	**EM.12.01.01, EP 3** The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and service	**EM.12.01.01, EP 3** The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		needs of evacuees, staff responsibilities, and transportation. **EM.12.02.01, EP 6** The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with - Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.	service needs of evacuees, staff responsibilities, and transportation. **EM.12.02.01, EP 5** The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with - Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.
§485.625(b)(4)	(4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.	**EM.12.01.01, EP 3** The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and service	**EM.12.01.01, EP 3** The critical access hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, volunteers, and patients. Note 1: Shelter-in-place plans may vary by department and facility and may vary based on the type of emergency or situation. Note 2: Safe evacuation from the critical access hospital includes consideration of care, treatment, and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		needs of evacuees, staff responsibilities, and transportation.	service needs of evacuees, staff responsibilities, and transportation.
§485.625(b)(5)	(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.	**IM.01.01.03, EP 1** The critical access hospital follows a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic). **IM.01.01.03, EP 2** The critical access hospital's plan for managing interruptions to information processes addresses the following: - Scheduled and unscheduled interruptions of electronic information systems - Training for staff on alternative procedures to follow when electronic information systems are unavailable - Backup of electronic information systems **IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 4** The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **IM.02.01.03, EP 1** The critical access hospital follows a written policy that addresses the security of health information, including access, use, and disclosure.	**IM.11.01.01, EP 1** The critical access hospital develops and implements policies and procedures regarding medical documentation and patient information during emergencies and other interruptions to information management systems, including security and availability of patient records to support continuity of care. Note: These policies and procedures are based on the emergency plan, risk assessment, and emergency communication plan and are reviewed and updated at least every 2 years.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		IM.02.01.03, EP 5 The critical access hospital protects against unauthorized access, use, and disclosure of health information.	
§485.625(b)(6)	(6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency.	**EM.12.02.03, EP 1** The critical access hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following: - Methods for contacting off-duty staff - Acquisition of staff from its other health care facilities - Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams Note: If the critical access hospital determines that it will never use volunteers during disasters, this is documented in its plan. **EM.12.02.03, EP 2** The critical access hospital's staffing plan addresses the management of all staff and volunteers as follows: - Reporting processes - Roles and responsibilities for essential functions - Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities	**EM.12.02.03, EP 1** The critical access hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following: - Methods for contacting off-duty staff - Acquisition of staff from its other health care facilities - Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams Note: If the critical access hospital determines that it will never use volunteers during disasters, this is documented in its plan. **EM.12.02.03, EP 2** The critical access hospital's staffing plan addresses the management of all staff and volunteers as follows: - Reporting processes - Roles and responsibilities for essential functions - Integration of staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities
§485.625(b)(7)	(7) The development of arrangements with other CAHs or other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to CAH patients.	**EM.12.02.05, EP 1** The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.	**EM.12.02.05, EP 1** The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			to other health care facilities to maintain continuity of care.
§485.625(b)(8)	(8) The role of the CAH under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	**EM.12.01.01, EP 9** The critical access hospital must develop and implement emergency preparedness policies and procedures that address the role of the critical access hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Note 1: This element of performance is applicable only to critical access hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/about-cms/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.	**EM.12.01.01, EP 7** The critical access hospital must develop and implement emergency preparedness policies and procedures that address the role of the critical access hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Social Security Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Note 1: This element of performance is applicable only to critical access hospitals that receive Medicare, Medicaid, or Children's Health Insurance Program reimbursement. Note 2: For more information on 1135 waivers, visit https://www.cms.gov/about-cms/what-we-do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-information/emergency/downloads/consolidated_medicare_ffs_emergency_qsas.pdf.
§485.625(c)	(c) Communication plan. The CAH must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:	**EM.09.01.01, EP 3** The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures	**EM.09.01.01, EP 3** The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program	procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program
§485.625(c)(1)	(1) Names and contact information for the following:		
§485.625(c)(1)(i)	(i) Staff.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§485.625(c)(1)(ii)	(ii) Entities providing services under arrangement.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff)

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	- Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§485.625(c)(1)(iii)	(iii) Patients' physicians.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§485.625(c)(1)(iv)	(iv) Other CAHs and hospitals.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	- Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§485.625(c)(1)(v)	(v) Volunteers.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what

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		organizations/individuals need to be contacted to assist with the emergency or disaster incident.	organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§485.625(c)(2)	(2) Contact information for the following:		
§485.625(c)(2)(i)	(i) Federal, State, tribal, regional, and local emergency preparedness staff.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers - Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§485.625(c)(2)(ii)	(ii) Other sources of assistance.	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers	**EM.12.02.01, EP 1** The critical access hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following: - Staff - Physicians and other licensed practitioners - Volunteers

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.	- Other health care organizations - Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies - Relevant community partners (such as fire, police, local incident command, public health departments) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Other sources of assistance (such as health care coalitions) Note: The type of emergency will determine what organizations/individuals need to be contacted to assist with the emergency or disaster incident.
§485.625(c)(3)	(3) Primary and alternate means for communicating with the following:		
§485.625(c)(3)(i)	(i) CAH's staff.	**EM.12.02.01, EP 6** The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with - Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-	**EM.12.02.01, EP 5** The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with - Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication

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		based notifications, cell and satellite phones, and reverse 911 notification systems.	systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.
§485.625(c)(3)(ii)	(ii) Federal, State, tribal, regional, and local emergency management agencies.	**EM.12.02.01, EP 6** The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with - Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.	**EM.12.02.01, EP 5** The critical access hospital's communications plan identifies its primary and alternate means for communicating with staff and relevant authorities (such as federal, state, tribal, regional, and local emergency preparedness staff). The plan includes procedures for the following: - How and when alternate/backup communication methods are used - Verifying that its communications systems are compatible with those of community partners and relevant authorities the critical access hospital plans to communicate with - Testing the functionality of the critical access hospital's alternate/backup communication systems or equipment Note: Examples of alternate/backup communication systems include amateur radios, portable radios, text-based notifications, cell and satellite phones, and reverse 911 notification systems.
§485.625(c)(4)	(4) A method for sharing information and medical documentation for patients under the CAH's care, as necessary, with other health care providers to maintain the continuity of care.	**EM.12.02.01, EP 5** In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities	**EM.12.02.01, EP 4** In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). **EM.12.02.05, EP 1** The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.	- Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4). **EM.12.02.05, EP 1** The critical access hospital's plan for providing patient care and clinical support includes written procedures and arrangements with other hospitals and providers for how it will share patient care information and medical documentation and how it will transfer patients to other health care facilities to maintain continuity of care.
§485.625(c)(5)	(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).	**EM.12.02.01, EP 5** In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).	**EM.12.02.01, EP 4** In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§485.625(c)(6)	(6) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).	**EM.12.02.01, EP 5** In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in the	**EM.12.02.01, EP 4** In the event of an emergency or evacuation, the critical access hospital's communications plan includes a method for sharing and/or releasing location information and medical documentation for patients under the hospital's care to the following individuals or entities, in accordance with law and regulation: - Patient's family, representative, or others involved in

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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).	the care of the patient - Disaster relief organizations and relevant authorities - Other health care providers Note: Sharing and releasing of patient information is consistent with 45 CFR 164.510(b)(1)(ii) and (b)(4).
§485.625(c)(7)	(7) A means of providing information about the CAH's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.	**EM.12.02.01, EP 3** The critical access hospital's communication plan describes how the critical access hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities. Note: Examples of critical access hospital needs include shortages in personal protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function.	**EM.12.02.01, EP 3** The critical access hospital's communication plan describes how the critical access hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities. Note: Examples of critical access hospital needs include shortages in personal protective equipment, staffing shortages, evacuation or transfer of patients, and temporary loss of part or all organization function.
§485.625(d)	(d) Training and testing. The CAH must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.	**EM.15.01.01, EP 1** The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs. **EM.16.01.01, EP 1** The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: - Likely emergencies or disaster scenarios	**EM.15.01.01, EP 1** The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs. **EM.16.01.01, EP 1** The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: - Likely emergencies or disaster scenarios

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- EOP and policies and procedures - After-action reports (AAR) and improvement plans - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program	- EOP and policies and procedures - After-action reports (AAR) and improvement plans - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program
§485.625(d)(1)	(1) Training program. The CAH must do all of the following:		
§485.625(d)(1)(i)	(i) Initial training in emergency preparedness policies and	**EC.02.03.01, EP 9** The written fire response plan describes the specific roles	**EM.15.01.01, EP 2** The critical access hospital provides initial education

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	procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	of staff at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, how to evacuate to areas of refuge, and how staff will cooperate with firefighting authorities. Staff are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting and disaster authorities. A copy of the plan is readily available with the telephone operator or security. Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2. **EM.15.01.01, EP 2** The critical access hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required.	and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures - Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **PE.03.01.01, EP 4** The critical access hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities.
§485.625(d)(1)(ii)	(ii) Provide emergency preparedness training at least every 2 years.	**EM.15.01.01, EP 3** The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The	**EM.15.01.01, EP 3** The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.	The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.
§485.625(d)(1)(iii)	(iii) Maintain documentation of the training.	**EM.15.01.01, EP 2** The critical access hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures	**EM.15.01.01, EP 2** The critical access hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The initial education and training include the following: - Activation and deactivation of the emergency operations plan - Communications plan - Emergency response policies and procedures - Evacuation, shelter-in-place, lockdown, and surge procedures

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **EM.15.01.01, EP 3** The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.	- Where and how to obtain resources and supplies for emergencies (such as procedure manuals or equipment) Documentation is required. **EM.15.01.01, EP 3** The critical access hospital provides ongoing education and training to all staff, individuals providing services under arrangement, and volunteers that are consistent with their roles and responsibilities in an emergency. The education and training occur at the following times: - At least every two years - When roles or responsibilities change - When there are significant revisions to the emergency operations plan, policies, and/or procedures - When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training. Documentation is required. Note 1: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization. Note 2: Critical access hospitals are not required to retrain staff on the entire emergency operations plan but can choose to provide education and training specific to the new or revised elements of the emergency management program.
§485.625(d)(1)(iv)	(iv) Demonstrate staff knowledge of emergency procedures.	**EM.15.01.01, EP 2** The critical access hospital provides initial education and training in emergency management to all new and existing	**EM.15.01.01, EP 2** The critical access hospital provides initial education and training in emergency management to all new and

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(d)(2)	(2) Testing. The CAH must conduct exercises to test the emergency plan at least twice per year. The CAH must do the following:	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(d)(2)(i)	(i) Participate in an annual full-scale exercise that is community-based; or	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(d)(2)(i)(A)	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(d)(2)(i)(B)	(B) If the CAH experiences an actual natural or man-made emergency that requires activation of the emergency plan, the CAH is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(d)(2)(ii)	(ii) Conduct an additional exercise that may include, but is not limited to the following:		
§485.625(d)(2)(ii)(A)	(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.
§485.625(d)(2)(ii)(B)	(B) A mock disaster drill; or	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.
§485.625(d)(2)(ii)(C)	(B) A tabletop exercise or workshop that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan. Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.	**EM.16.01.01, EP 2** The critical access hospital is required to conduct two exercises per year to test the emergency operations plan. - One of the annual exercises must consist of an operations-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise when a community-based exercise is not possible - The other annual exercise must consist of either an operations-based or discussion-based exercise as follows: - Full-scale, community-based exercise; or - Functional, facility-based exercise; or - Mock disaster drill; or - Tabletop, seminar, or workshop that is led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. Exercises and actual emergency or disaster incidents are documented (after-action reports). Note 1: The critical access hospital would be exempt from conducting its next annual operations-based exercise if it experiences an actual emergency or disaster incident (discussion-based exercises are excluded from exemption). An exemption only applies if the critical access hospital provides documentation that it activated its emergency operations plan.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			Note 2: See the Glossary for the definitions of operations-based and discussion-based exercises.
§485.625(d)(2)(iii)	(iii) Analyze the CAH's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the CAH's emergency plan, as needed.	**EM.17.01.01, EP 1** The multidisciplinary committee that oversees the emergency management program reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews after-action reports (AARs), identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented. Note 1: The review and evaluation address the effectiveness of its emergency response procedure, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients. Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or an actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan	**EM.17.01.01, EP 1** The multidisciplinary committee that oversees the emergency management program reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews after-action reports (AARs), identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented. Note 1: The review and evaluation address the effectiveness of its emergency response procedure, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients. Note 2: An AAR provides a detailed critical summary or analysis of a planned exercise or an actual emergency or disaster incident. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Continuity of operations plan - Education and training program - Testing program	- Continuity of operations plan - Education and training program - Testing program
§485.625(e)	(e) Emergency and standby power systems. The CAH must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.	**EM.12.02.11, EP 1** The critical access hospital's plan for managing utilities describes in writing the utility systems that it considers as essential or critical to provide care, treatment, and services. Note: Essential or critical utilities to consider may include systems for electrical distribution; emergency power; vertical and horizontal transport; heating, ventilation, and air conditioning; plumbing and steam boilers; medical gas; medical/surgical vacuum; and network or communication systems. **EM.12.02.11, EP 2** The critical access hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident. **EM.12.02.11, EP 3** The critical access hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators.	**EM.12.02.11, EP 1** The critical access hospital's plan for managing utilities describes in writing the utility systems that it considers as essential or critical to provide care, treatment, and services. Note: Essential or critical utilities to consider may include systems for electrical distribution; emergency power; vertical and horizontal transport; heating, ventilation, and air conditioning; plumbing and steam boilers; medical gas; medical/surgical vacuum; and network or communication systems. **EM.12.02.11, EP 2** The critical access hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident. **EM.12.02.11, EP 3** The critical access hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators.
§485.625(e)(1)	(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the

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	12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	**EC.02.05.07, EP 11** The critical access 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. **EC.02.06.05, EP 1** When planning for new, altered, or renovated space, the critical access 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. **LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health

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			Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. **PE.04.01.03, EP 3** The critical access hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.
§485.625(e)(2)	(2) Emergency generator inspection and testing. The CAH must implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.	**EC.02.05.07, EP 3** The critical access 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 critical access hospital performs an annual test at full load for 60% of the full duration of its class. The test results and	**PE.04.01.03, EP 3** The critical access hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		completion dates are documented. Note 1: Non–SEPSS battery backup emergency power systems that the critical access 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. **EC.02.05.07, EP 4** Every week, the critical access hospital inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of the inspections are documented. (For full text, refer to NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.3.7; 8.4.1) **EC.02.05.07, EP 5** At least monthly, the critical access hospital tests each	

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		emergency generator beginning with a cold start under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.05.07, EP 6** The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the critical access hospital does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1) Note: Tests for non-diesel-powered generators need only be conducted with available load. **EC.02.05.07, EP 7** At least monthly, the critical access hospital tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1) **EC.02.05.07, EP 8** At least annually, the critical access hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented.	

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		Note: For additional guidance, see NFPA 110-2010: 8.3.8. **EC.02.05.07, EP 9** At least once every 36 months, critical access hospitals with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The test results and completion dates are documented. Note: For additional guidance, see NFPA 110-2010, Chapter 8. **EC.02.05.07, EP 10** The 36-month diesel-powered emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. Note 1: Tests for non-diesel-powered generators need only be conducted with available load. Note 2: For additional guidance, see NFPA 110-2010, Chapter 8. **EC.02.05.07, EP 11** The critical access 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.	
§485.625(e)(3)	(3) Emergency generator fuel. CAHs that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power	**EM.12.02.09, EP 1** The critical access hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets	**EM.12.02.09, EP 1** The critical access hospital's plan for managing its resources and assets describes in writing how it will document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	systems operational during the emergency, unless it evacuates.	during and after an emergency or disaster incident: - Medications and related supplies - Medical/surgical supplies - Medical gases including oxygen and supplies - Potable or bottled water and nutrition - Non-potable water - Laboratory equipment and supplies - Personal protective equipment - Fuel for operations - Equipment and nonmedical supplies to sustain operations Note: The critical access hospital should be aware of the resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency or disaster incident. **EM.12.02.09, EP 2** The critical access hospital's plan for managing its resources and assets describes in writing how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident, including the following: - If part of a health care system, coordinating within the system to request resources - Coordinating with local supply chains or vendors - Coordinating with local, state, or federal agencies for additional resources - Coordinating with regional health care coalitions for additional resources - Managing donations (such as food, water, equipment, materials) Note: High priority should be given to resources that are known to deplete quickly and are extremely competitive	during and after an emergency or disaster incident: - Medications and related supplies - Medical/surgical supplies - Medical gases, including oxygen and supplies - Potable or bottled water and nutrition - Non-potable water - Laboratory equipment and supplies - Personal protective equipment - Fuel for operations - Equipment and nonmedical supplies to sustain operations Note: The critical access hospital should be aware of the resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency or disaster incident. **EM.12.02.09, EP 2** The critical access hospital's plan for managing its resources and assets describes in writing how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident, including the following: - If part of a health care system, coordinating within the system to request resources - Coordinating with local supply chains or vendors - Coordinating with local, state, or federal agencies for additional resources - Coordinating with regional health care coalitions for additional resources - Managing donations (such as food, water, equipment, materials) Note: High priority should be given to resources that are

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		to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications). **EM.12.02.11, EP 2** The critical access hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident. **EM.12.02.11, EP 3** The critical access hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators.	known to deplete quickly and are extremely competitive to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications). **EM.12.02.11, EP 2** The critical access hospital's plan for managing utilities describes in writing how it will continue to maintain essential or critical utility systems if one or more are impacted during an emergency or disaster incident. **EM.12.02.11, EP 3** The critical access hospital's plan for managing utilities describes in writing alternative means for providing essential or critical utilities, such as water supply, emergency power supply systems, fuel storage tanks, and emergency generators.
§485.625(f)	(f) Integrated healthcare systems. If a CAH is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the CAH may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:		
§485.625(f)(1)	(1) Demonstrate that each separately certified facility within	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program	program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program
§485.625(f)(3)	(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency

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		that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program	management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program
§485.625(f)(4)	(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include—	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient

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		capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program **EM.11.01.01, EP 3** The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4** The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions. **EM.12.01.01, EP 2** The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve,	population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program **EM.11.01.01, EP 3** The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented. **EM.11.01.01, EP 4** The critical access hospital uses its prioritized hazards from the hazard vulnerability analysis to identify and implement mitigation and preparedness actions to increase the resilience of the critical access hospital and helps reduce disruption of essential services or functions.

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		including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence. **EM.12.01.01, EP 6** The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident. **EM.13.01.01, EP 1** The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology,	**EM.12.01.01, EP 2** The critical access hospital's emergency operations plan identifies the patient population(s) that it will serve, including at-risk populations, and the types of services it would have the ability to provide in an emergency or disaster event. Note: At-risk populations such as the elderly, dialysis patients, or persons with physical or mental disabilities may have additional needs to be addressed during an emergency or disaster incident such as medical care, communication, transportation, supervision, and maintaining independence. **EM.12.01.01, EP 6** The critical access hospital's emergency operations plan includes a process for cooperating and collaborating with other health care facilities; health care coalitions; and local, tribal, regional, state, and federal emergency preparedness officials' efforts to leverage support and resources and to provide an integrated response during an emergency or disaster incident. **EM.13.01.01, EP 1** The critical access hospital has a written continuity of operations plan (COOP) that is developed with the participation of key executive leaders, business and finance leaders, and other department leaders as determined by the critical access hospital. These key leaders identify and prioritize the services and functions that are considered essential or critical for maintaining operations. Note: The COOP provides guidance on how the critical

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		financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. **EM.13.01.01, EP 2** The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3** The critical access hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. **EM.13.01.01, EP 4** The critical access hospital has a written delegation of authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be	access hospital will continue to perform its essential business functions to deliver essential or critical services. Essential business functions to consider include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption. **EM.13.01.01, EP 2** The critical access hospital's continuity of operations plan identifies in writing how and where it will continue to provide its essential business functions when the location of the essential or critical service has been compromised due to an emergency or disaster incident. Note: Example of options to consider for providing essential services include use of off-site locations, space maintained by another organization, existing facilities or space, telework (remote work), or telehealth. **EM.13.01.01, EP 3** The critical access hospital has a written order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties. **EM.13.01.01, EP 4** The critical access hospital has a written delegation of

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		sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.	authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access hospital for specified purposes and to carry out specific duties. Note: Delegations of authority are an essential part of an organization's continuity program and should be sufficiently detailed to make certain the critical access hospital can perform its essential functions. Delegations of authority will specify a particular function that an individual is authorized to perform and includes restrictions and limitations associated with that authority.
§485.625(f)(4)(i)	(i) A documented community–based risk assessment, utilizing an all-hazards approach.	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program	- Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program
§485.625(f)(4)(ii)	(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Coordinated communication plan - Training and testing program	- Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program
§485.625(f)(5)	(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program **EM.09.01.01, EP 3**	**EM.09.01.01, EP 2** If the critical access hospital is part of a health care system that has a unified and integrated emergency management program and it chooses to participate in the program, the following must be demonstrated within the coordinated emergency management program: - Each separately certified critical access hospital within the system actively participates in the development of the unified and integrated emergency management program - The program is developed and maintained in a manner that takes into account each separately certified critical access hospital's unique circumstances, patient population, and services offered - Each separately certified critical access hospital is capable of actively using the unified and integrated emergency management program and is in compliance with the program - Documented community-based risk assessment utilizing an all-hazards approach - Documented individual, facility-based risk assessment utilizing an all-hazards approach for each separately certified critical access hospital within the health care system - Unified and integrated emergency plan - Integrated policies and procedures - Coordinated communication plan - Training and testing program

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.15.01.01, EP 1** The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and	**EM.09.01.01, EP 3** The critical access hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations. **EM.12.01.01, EP 1** The critical access hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff and volunteers on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following: - Mobilizing incident command - Communications plan - Maintaining, expanding, curtailing, or closing operations - Protecting critical systems and infrastructure - Conserving and/or supplementing resources - Surge plans (such as flu or pandemic plans) - Identifying alternate treatment areas or locations - Sheltering in place - Evacuating (partial or complete) or relocating services - Safety and security - Securing information and records **EM.15.01.01, EP 1** The critical access hospital has a written education and training program in emergency management that is based on the critical access hospital's prioritized risks identified as part of its hazard vulnerability analysis, emergency operations plan, communications plan, and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		training for those facilities are specific to their needs. **EM.16.01.01, EP 1** The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: - Likely emergencies or disaster scenarios - EOP and policies and procedures - After-action reports (AAR) and improvement plans - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures	policies and procedures. Note: If the critical access hospital has developed multiple hazard vulnerability analyses based on the location of other services offered, the education and training for those facilities are specific to their needs. **EM.16.01.01, EP 1** The critical access hospital describes in writing a plan for when and how it will conduct annual testing of its emergency operations plan (EOP). The planned exercises are based on the following: - Likely emergencies or disaster scenarios - EOP and policies and procedures - After-action reports (AAR) and improvement plans - Six critical areas (communications, staffing, patient care and clinical support, safety and security, resources and assets, utilities) Note 1: The planned exercises should attempt to stress the limits of its emergency response procedures to assess how prepared the critical access hospital may be if a real event or disaster were to occur based on past experiences. Note 2: An AAR is a detailed critical summary or analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement. **EM.17.01.01, EP 3** The critical access hospital reviews and makes necessary updates based on after-action reports or opportunities for improvement to the following items

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Communications plan - Continuity of operations plan - Education and training program - Testing program	every two years, or more frequently if necessary: - Hazard vulnerability analysis - Emergency management program - Emergency operations plan, policies, and procedures - Communications plan - Continuity of operations plan - Education and training program - Testing program
§485.625(g)	(g) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(g)(1)	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.		
§485.625(g)(1)(i)	(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(ii)	(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(iii)	(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(iv)	(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012	**PE.04.01.01, EP 1** The critical access hospital meets the applicable

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(v)	(v) TIA 12-5 to NFPA 99, issued August 1, 2013.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(vi)	(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.	**EC.01.01.01, EP 12** The critical access hospital complies with the 2012 edition of NFPA 99: Health Care Facilities Code, including Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	**PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(vii)	(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(viii)	(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(ix)	(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(x)	(x) TIA 12-3 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety	**PE.03.01.01, EP 3** The critical access hospital meets the applicable

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(g)(1)(xi)	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.	**LS.01.01.01, EP 8** The critical access hospital complies with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	**PE.03.01.01, EP 3** The critical access hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in critical access hospitals. Note 3: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a critical access hospital, but only if the waiver will not adversely affect the health and safety of the patients. Note 4: After consideration of state survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the critical access hospital, but only if the waiver does not adversely affect the health and safety of patients. Note 5: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.625(g)(1)(xii)	(xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.	**EC.02.05.07, EP 11** The critical access hospital meets all other emergency power system requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.	**PE.04.01.03, EP 3** The critical access hospital meets the emergency power system and generator requirements found in NFPA 99-2012 Health Care Facilities Code, NFPA 110-2010 Standard for Emergency and Standby Power Systems, and NFPA 101-2012 Life Safety Code requirements.
§485.625(g)(2)	(2) [Reserved]		
§485.627	§485.627 Condition of Participation: Organizational Structure		
§485.627(a)	§485.627(a) Standard: Governing Body or Responsible Individual The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.	**LD.01.03.01, EP 1** The governing body defines in writing its responsibilities. **LD.01.03.01, EP 5** The governing body provides for the resources needed to maintain safe, quality care, treatment, and services. **LD.01.03.01, EP 6** The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the critical access hospital's performance in relation to its mission, vision, and goals. **LD.01.03.01, EP 12** The critical access hospital has a governing body that assumes full legal responsibility for the operation of the critical access hospital. **LD.03.01.01, EP 5** Leaders create and implement a process for managing	**LD.11.01.01, EP 1** The critical access hospital has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the critical access hospital's total operation and for administering those policies to provide quality health care in a safe environment.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		behaviors that undermine a culture of safety. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.01, EP 3** Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies. **LD.04.01.05, EP 1** Leaders of the program, service, site, or department oversee operations. **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.	
§485.627(b)	§485.627(b) Standard: Disclosure The CAH discloses the names and addresses of--		
§485.627(b)(1)	(1) The person principally responsible for the operation of the CAH; and	**LD.04.02.03, EP 23** The critical access hospital discloses the names and addresses of the following: - The person principally responsible for the operation of the critical access hospital - The person responsible for medical direction of the critical access hospital	**LD.13.02.01, EP 1** The critical access hospital discloses the names and addresses of the following: - Person principally responsible for the operation of the critical access hospital - Person responsible for medical direction of the critical access hospital

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§485.627(b)(2)	(2) The person responsible for medical direction.	**LD.04.02.03, EP 23** The critical access hospital discloses the names and addresses of the following: - The person principally responsible for the operation of the critical access hospital - The person responsible for medical direction of the critical access hospital	**LD.13.02.01, EP 1** The critical access hospital discloses the names and addresses of the following: - Person principally responsible for the operation of the critical access hospital - Person responsible for medical direction of the critical access hospital
§485.631	§485.631 Condition of Participation: Staffing and Staff Responsibilities		
§485.631(a)	§485.631(a) Standard: Staffing		
§485.631(a)(1)	(1) The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.	**HR.01.02.05, EP 6** The critical access hospital has a professional health care staff that includes one or more doctors of medicine or osteopathy and that may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.	**NPG.12.01.01, EP 3** The critical access hospital has a professional health care staff that includes one or more doctors of medicine or osteopathy and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.
§485.631(a)(2)	(2) Any ancillary personnel are supervised by the professional staff.	**HR.01.03.01, EP 11** Professional staff supervise ancillary personnel.	**HR.11.01.03, EP 2** Professional staff supervise ancillary staff.
§485.631(a)(3)	(3) The staff is sufficient to provide the services essential to the operation of the CAH.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.	**NPG.12.01.01, EP 1** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services

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			- Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date.
§485.631(a)(4)	(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.	**HR.01.02.05, EP 7** A doctor of medicine or osteopathy, physician's assistant, nurse practitioner, or clinical nurse specialist is available to provide patient care when the critical access hospital is in operation.	**NPG.12.01.01, EP 4** A doctor of medicine or osteopathy, physician's assistant, nurse practitioner, or clinical nurse specialist is available to provide patient care at all times when the critical access hospital is in operation.
§485.631(a)(5)	(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.	**HR.01.02.05, EP 14** A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the critical access hospital has one or more patients.	**NPG.12.02.01, EP 3** A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the critical access hospital has one or more inpatients.
§485.631(b)	§485.631(b) Standard: Responsibilities of the Doctor of Medicine or Osteopathy		
§485.631(b)(1)	(1) The doctor of medicine or osteopathy--		
§485.631(b)(1)(i)	(i) Provides medical direction for the CAH'S health care activities and consultation for, and medical	**MS.03.01.03, EP 7** The doctor of medicine or osteopathy provides medical direction for the critical access hospital's health care	**MS.16.01.03, EP 6** The doctor of medicine or osteopathy provides medical direction for the critical access hospital's health care

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	supervision of, the health care staff;	activities and consultation for, and medical staff supervision of, the health care staff.	activities and consultation for, and medical staff supervision of, the health care staff.
§485.631(b)(1)(ii)	(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH'S written policies governing the services it furnishes.	**LD.04.01.07, EP 4** The doctor of medicine or osteopathy, in conjunction with the physician assistant, nurse practitioner, or clinical nurse specialist, participates in developing, executing, and periodically reviewing the critical access hospital's written policies governing the services furnished.	**LD.13.01.09, EP 2** The doctor of medicine or osteopathy, in conjunction with the physician assistant, nurse practitioner, or clinical nurse specialist, participates in developing, executing, and periodically reviewing the critical access hospital's written policies governing the services provided.
§485.631(b)(1)(iii)	(iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH'S patient records, provides medical orders, and provides medical care services to the patients of the CAH; and	**MS.03.01.03, EP 8** The doctor of medicine or osteopathy, in conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the critical access hospital's patient records, provides medical orders, and provides medical care services to the patients of the critical access hospital.	**MS.16.01.03, EP 8** The doctor of medicine or osteopathy, in conjunction with the physician assistant and/or nurse practitioner members of the critical access hospital staff, provides medical orders and medical care services to the critical access hospital's patients. **MS.16.01.03, EP 10** The doctor of medicine or osteopathy, in conjunction with the physician assistant, the nurse practitioner, and/or clinical nurse specialist members of the critical access hospital staff, periodically review the patients' records.
§485.631(b)(1)(iv)	(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.	**MS.03.01.03, EP 9** The doctor of medicine or osteopathy periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.	**MS.16.01.03, EP 11** The doctor of medicine or osteopathy periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.
§485.631(b)(1)(v)	(v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse	**MS.03.01.03, EP 11** When state law requires outpatient record reviews, or co-signatures, or both, by a collaborating physician, a doctor of medicine or osteopathy periodically reviews and signs a sample of outpatient records of patients cared for by	**MS.16.01.03, EP 12** The doctor of medicine or osteopathy periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician

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	midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.	nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants. Note: When state law requires review of such outpatient records, the critical access hospital determines by policy the size of the sample reviewed and signed.	assistants. Note: Outpatient records are reviewed to the extent required by state law where state law requires outpatient record reviews, cosignatures, or both by a collaborating physician.
§485.631(b)(2)	(2) A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral.	**MS.03.01.03, EP 10** A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the critical access hospital, and is available through direct radio, telephone, or electronic communication for consultation, assistance with medical emergencies, or patient referral.	**MS.16.01.03, EP 13** A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the critical access hospital, and is available through direct radio, telephone, or electronic communication for consultation, assistance with medical emergencies, or patient referral.
§485.631(c)	§485.631(c) Standard: Physician Assistant, Nurse Practitioner, and Clinical Nurse Specialist Responsibilities		
§485.631(c)(1)	(1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH'S staff--		
§485.631(c)(1)(i)	(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and	**LD.04.01.07, EP 4** The doctor of medicine or osteopathy, in conjunction with the physician assistant, nurse practitioner, or clinical nurse specialist, participates in developing, executing, and periodically reviewing the critical access hospital's written policies governing the services furnished.	**LD.13.01.09, EP 2** The doctor of medicine or osteopathy, in conjunction with the physician assistant, nurse practitioner, or clinical nurse specialist, participates in developing, executing, and periodically reviewing the critical access hospital's written policies governing the services provided.

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§485.631(c)(1)(ii)	(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.	**MS.03.01.03, EP 8** The doctor of medicine or osteopathy, in conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the critical access hospital's patient records, provides medical orders, and provides medical care services to the patients of the critical access hospital.	**MS.16.01.03, EP 10** The doctor of medicine or osteopathy, in conjunction with the physician assistant, the nurse practitioner, and/or clinical nurse specialist members of the critical access hospital staff, periodically review the patients' records.
§485.631(c)(2)	(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:	**LD.04.01.07, EP 4** The doctor of medicine or osteopathy, in conjunction with the physician assistant, nurse practitioner, or clinical nurse specialist, participates in developing, executing, and periodically reviewing the critical access hospital's written policies governing the services furnished.	
§485.631(c)(2)(i)	(i) Provides services in accordance with the CAH'S policies.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.	**MS.16.01.03, EP 9** If not being performed by a doctor of medicine or osteopathy, the physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions: - Provides services in accordance with the critical access hospital's policies - Arranges for, or refers patients to, needed services that cannot be furnished at the critical access hospital - Maintains and transfers patient records when patients are referred
§485.631(c)(2)(ii)	(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.	**PC.04.01.03, EP 2** The critical access hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. **PC.04.01.03, EP 4** Prior to discharge, the critical access hospital arranges or assists in arranging the services required by the patient after discharge in order to meet the patient's ongoing	**MS.16.01.03, EP 9** If not being performed by a doctor of medicine or osteopathy, the physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions: - Provides services in accordance with the critical access hospital's policies - Arranges for, or refers patients to, needed services that cannot be furnished at the critical access hospital

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		needs for care and services. **PC.04.01.05, EP 2** Before the patient is discharged, the critical access 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. **PC.04.01.05, EP 7** The critical access 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. **PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed	- Maintains and transfers patient records when patients are referred

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		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	
§485.631(c)(3)	(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.	**LD.04.01.07, EP 5** Whenever a patient is admitted to the critical access hospital by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff is notified of the admission.	**MS.16.01.03, EP 7** Whenever a patient is admitted to the critical access hospital by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff is notified of the admission.
§485.631(d)	(d) Standard: Periodic review of clinical privileges and performance. The CAH requires that—		
§485.631(d)(1)	(1) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialist, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH.	**MS.05.01.01, EP 12** The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants are evaluated by a member of the organization staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the organization.	**MS.17.01.03, EP 8** The quality and appropriateness of the diagnosis and treatment provided by nurse practitioners, clinical nurse specialists, and physician assistants are evaluated by a member of the critical access hospital's medical staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the organization.
§485.631(d)(2)	(2) The quality and appropriateness of the diagnosis and treatment furnished by		

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	doctors of medicine or osteopathy at the CAH are evaluated by—		
§485.631(d)(2)(i)	(i) One hospital that is a member of the network, when applicable;	**MS.05.01.01, EP 13** The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A Quality Improvement Organization (QIO) or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan	**MS.17.01.03, EP 9** The quality and appropriateness of the diagnosis and treatment provided by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A quality improvement organization or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan Note: In the case of distant-site physicians and practitioners providing telemedicine services to the critical access hospital's patients under an agreement between the critical access hospital and a distant hospital or between the critical access hospital and a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment provided is evaluated by one of the entities listed in this element of performance.
§485.631(d)(2)(ii)	(ii) One Quality Improvement Organization (QIO) or equivalent entity;	**MS.05.01.01, EP 13** The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A Quality Improvement Organization (QIO) or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan	**MS.17.01.03, EP 9** The quality and appropriateness of the diagnosis and treatment provided by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A quality improvement organization or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan

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			Note: In the case of distant-site physicians and practitioners providing telemedicine services to the critical access hospital's patients under an agreement between the critical access hospital and a distant hospital or between the critical access hospital and a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment provided is evaluated by one of the entities listed in this element of performance.
§485.631(d)(2)(iii)	(iii) One other appropriate and qualified entity identified in the State rural health care plan;	**MS.05.01.01, EP 13** The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A Quality Improvement Organization (QIO) or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan	**MS.17.01.03, EP 9** The quality and appropriateness of the diagnosis and treatment provided by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A quality improvement organization or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan Note: In the case of distant-site physicians and practitioners providing telemedicine services to the critical access hospital's patients under an agreement between the critical access hospital and a distant hospital or between the critical access hospital and a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment provided is evaluated by one of the entities listed in this element of performance.
§485.631(d)(2)(iv)	(iv) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patient under an	**LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services.	**MS.17.01.03, EP 9** The quality and appropriateness of the diagnosis and treatment provided by doctors of medicine or osteopathy at the critical access hospital are evaluated

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	agreement between the CAH and a distant-site hospital, the distant-site hospital; or	Note 1: When the critical access 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 2: The leaders who monitor the contracted services are the governing body. **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.	by one of the following: - A hospital that is a member of the network, when applicable - A quality improvement organization or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan Note: In the case of distant-site physicians and practitioners providing telemedicine services to the critical access hospital's patients under an agreement between the critical access hospital and a distant hospital or between the critical access hospital and a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment provided is evaluated by one of the entities listed in this element of performance.

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		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. - 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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished	

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		in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	

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§485.631(d)(2)(v)	(v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (d)(2)(i) through (iii) of this section.	**LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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 2: The leaders who monitor the contracted services are the governing body. **MS.05.01.01, EP 13** The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A Quality Improvement Organization (QIO) or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan **MS.13.01.01, EP 1** All physicians or other licensed practitioners who are	**MS.17.01.03, EP 9** The quality and appropriateness of the diagnosis and treatment provided by doctors of medicine or osteopathy at the critical access hospital are evaluated by one of the following: - A hospital that is a member of the network, when applicable - A quality improvement organization or equivalent entity - Another appropriate and qualified entity identified in the state's rural health care plan Note: In the case of distant-site physicians and practitioners providing telemedicine services to the critical access hospital's patients under an agreement between the critical access hospital and a distant hospital or between the critical access hospital and a distant-site telemedicine entity, the quality and appropriateness of the diagnosis and treatment provided is evaluated by one of the entities listed in this element of performance.

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies that the distant site made its decision using the process	

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		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: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.631(d)(3)	(3) The CAH staff consider the findings of the evaluation and make the necessary changes as specified in paragraphs (b) through (d) of this section.	**MS.05.01.01, EP 14** The critical access hospital staff reviews the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.	**MS.17.01.03, EP 10** The critical access hospital's medical staff reviews the findings from the evaluations of doctors of medicine or osteopathy, including any findings or recommendations of the quality improvement organization, and makes the necessary changes as specified in 42 CFR 485.631 paragraphs (b) through (d).
§485.631(e)	(e) Standard: Unified and integrated medical staff for a CAH in a multifacility system. If a CAH is part of a system consisting of multiple separately certified hospitals, CAHs, and/or REHs, and the system elects to have a unified and integrated medical staff for its member hospitals, CAHs, and/or REHs after determining that such a decision is in accordance with all		

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	applicable State and local laws, each separately certified CAH must demonstrate that:		
§485.631(e)(1)	(1) The medical staff members of each separately certified CAH in the system (that is, all medical staff members who hold specific privileges to practice at that CAH) have voted by majority, in accordance with medical staff bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective CAH;	**MS.01.01.01, EP 12** The medical staff bylaws include the following requirements: The structure of the medical staff. **MS.01.01.01, EP 17** The medical staff bylaws include the following requirements: A description of those members of the medical staff who are eligible to vote. **MS.01.01.05, EP 1** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals and chooses to establish a unified and integrated medical staff, the following occurs: Each separately accredited critical access hospital demonstrates that its medical staff members (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their critical access hospital.	**MS.14.03.01, EP 1** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, in accordance with state and local laws, the following occurs: Each separately accredited critical access hospital demonstrates that its medical staff members (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority, in accordance with medical staff bylaws, either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their critical access hospital.
§485.631(e)(2)	(2) The unified and integrated medical staff has bylaws, rules, and requirements that describe its processes for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees, and	**MS.01.01.01, EP 5** The medical staff complies with the medical staff bylaws, rules and regulations, and policies. **MS.01.01.01, EP 14** The medical staff bylaws include the following requirements: The process for privileging and re-privileging physicians and other licensed practitioners.	**MS.14.03.01, EP 4** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the unified and integrated medical staff bylaws, rules, and requirements include the following:

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	which include a process for the members of the medical staff of each separately certified CAH (that is, all medical staff members who hold specific privileges to practice at that CAH) to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their CAH;	**MS.01.01.01, EP 26** The medical staff bylaws include the following requirements: The process for credentialing and re-credentialing physicians and other licensed practitioners. **MS.01.01.01, EP 27** The medical staff bylaws include the following requirements: The process for appointment and re-appointment to membership on the medical staff. **MS.01.01.01, EP 34** The medical staff bylaws include the following requirements: The process for fair hearings and appeals (refer to Standard MS.10.01.01), which at a minimum, includes the following: - The process for scheduling hearings and appeals - The process for conducting hearings and appeals **MS.01.01.01, EP 37** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals and chooses to establish a unified and integrated medical staff, the medical staff bylaws include the following requirements: A description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital.	- Process for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees - Description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective critical access hospital

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§485.631(e)(3)	(3) The unified and integrated medical staff is established in a manner that takes into account each member CAH's unique circumstances and any significant differences in patient populations and services offered in each hospital, CAH, and REH; and	**MS.01.01.05, EP 2** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals and 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, critical access hospital, and rural emergency hospital.	**MS.14.03.01, EP 2** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff takes into account each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital, critical access hospital, and rural emergency hospital.
§485.631(e)(4)	(4) The unified and integrated medical staff establishes and implements policies and procedures to ensure that the needs and concerns expressed by members of the medical staff, at each of its separately certified hospitals, CAHs, and REHs, regardless of practice or location, are given due consideration, and that the unified and integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals, CAHs, and REHs are duly considered and addressed.	**MS.01.01.05, EP 3** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals and 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, critical access hospitals, and/or rural emergency hospitals, regardless of practice or location, are given due consideration. **MS.01.01.05, EP 4** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals and 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, critical	**MS.14.03.01, EP 3** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the following occurs: The unified and integrated medical staff develops and implements policies and procedures and mechanisms to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, regardless of practice or location, are duly considered and addressed.

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		access hospitals, and/or rural emergency hospitals within the system are duly considered and addressed.	
§485.635	§485.635 Condition of Participation: Provision of Services		
§485.635(a)	§485.635(a) Standard: Patient Care Policies		
§485.635(a)(1)	(1) The CAH'S health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.	**LD.04.01.01, EP 2** The critical access hospital provides care, treatment, and services in accordance with licensure requirements, laws (including state law), and rules and regulations. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.	**LD.13.01.09, EP 1** The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.
§485.635(a)(2)	(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more	**LD.04.01.07, EP 6** Health care service policies are developed with the advice of members of the critical access hospital's professional health care staff, including one or more	**LD.13.01.09, EP 3** The critical access hospital develops health care service policies and procedures with the advice of members of its professional health care staff, including

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	doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of § 485.631(a)(1).	doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists if they are on staff.	one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists if they are on staff.
§485.635(a)(3)	(3) The policies include the following:		
§485.635(a)(3)(i)	(i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement.	**LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. **LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements.	**LD.13.01.09, EP 1** The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.
§485.635(a)(3)(ii)	(ii) Policies and procedures for emergency medical services.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the	**LD.13.01.09, EP 1** The critical access hospital develops and implements

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		implementation of policies and procedures that guide and support patient care, treatment, and services.	written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.
§485.635(a)(3)(iii)	(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **MS.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. **PC.01.01.01, EP 2**	**LD.13.01.09, EP 1** The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access 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 Note: For rehabilitation distinct part units in critical access hospitals: A rehabilitation physician reviews and approves the patient's preadmission screening prior to the patient's admission to the unit. **RC.01.01.01, EP 1** The critical access hospital defines the components of a complete medical record.	health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.
§485.635(a)(3)(iv)	(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **LD.04.01.05, EP 1** Leaders of the program, service, site, or department oversee operations. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services.	**LD.13.01.09, EP 1** The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MM.01.01.03, EP 1 The critical access hospital identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. **MM.01.01.03, EP 2** The critical access hospital follows a process for managing high-alert and hazardous medications. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 2** The critical access hospital stores medications according to the manufacturers' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 3** The critical access 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	provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated. **MM.13.01.01, EP 1** The critical access hospital maintains current and accurate records of the receipt and disposition of all scheduled drugs. **MM.13.01.01, EP 4** The critical access hospital removes all expired, damaged, mislabeled, contaminated, or otherwise unusable medications and stores them separately from medications available for patient use. Note: This element of performance is also applicable to sample medications. **MM.15.01.03, 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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Prevention and Control Act of 1970. Note 2: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 4** The critical access hospital follows a written policy addressing the control of medication between receipt by a staff member and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 6** The critical access hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 7** All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings. Note: This element of performance is also applicable to sample medications. **MM.03.01.01, EP 8** The critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		sample medications. **MM.03.01.01, EP 18** The critical access hospital periodically inspects all medication storage areas. Note: This element of performance is also applicable to sample medications. **MM.03.01.03, EP 1** Critical access 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. **MM.03.01.03, EP 6** When emergency medications or supplies are used or expired, the critical access hospital replaces them as soon as possible to maintain a full stock. **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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		intended to minimize treatment delays and patient backup. The first exception allows medications ordered by a physician or other licensed practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A physician or other licensed practitioner is not required to remain at the bedside when the medication is administered. However, a physician or other licensed practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient. Note 2: A critical access hospital's radiology service (including critical access 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's or other licensed practitioner's timely intervention in the event of a patient emergency. **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 critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MM.05.01.07, EP 1 A pharmacist or other staff authorized in accordance with state and federal law and regulation compounds, labels, and dispenses drugs or biologicals, regardless of whether the services are provided by critical access hospital staff or under arrangement. Note 1: When an on-site licensed pharmacist is available, a pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: A pharmacist supervises all compounding, packaging, and dispensing of drugs and biologicals except in urgent situations in which a delay could harm the patient or when the product's stability is short. **MM.05.01.07, EP 2** The critical access hospital develops and implements policies and procedures for sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation. Note: All compounded medications are prepared in accordance with the orders of a physician or other licensed practitioner. **MM.05.01.07, EP 3** The critical access hospital assesses competency of staff who conduct sterile medication compounding of nonhazardous and hazardous medications in accordance with state and federal law and regulation and the critical access hospital policies.	

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		MM.05.01.07, EP 4 The critical access hospital conducts sterile medication compounding of nonhazardous and hazardous medications within a proper environment in accordance with state and federal law and regulation and critical access hospital policies. Note: Aspects of a proper environment include but are not limited to air exchanges and pressures, ISO designations, viable testing, and cleaning/disinfecting. **MM.05.01.07, EP 5** The critical access hospital properly stores compounded sterile preparations of nonhazardous and hazardous medications and labels them with beyond-use dates in accordance with state and federal law and regulation and critical access hospital policies. **MM.05.01.07, EP 6** The critical access hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and critical access hospital policies. **MM.05.01.07, EP 7** For rehabilitation and psychiatric distinct part units in critical access hospitals: An appropriately trained registered pharmacist or doctor of medicine or osteopathy performs or supervises in-house preparation of radiopharmaceuticals. **MM.05.01.09, EP 1**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. **MM.05.01.09, EP 2** Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice. Note: This element of performance is also applicable to sample medications. **MM.05.01.09, EP 3** All medications prepared in the critical access hospital are correctly labeled with the following: - Medication name, strength, and amount (if not apparent from the container) Note: This is also applicable to sample medications. - Expiration date when not used within 24 hours - Expiration date and time when expiration occurs in less than 24 hours - The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas **MM.05.01.11, EP 2** The critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		antidiversion strategies. Note 2: This element of performance is also applicable to sample medications. **MM.05.01.15, EP 1** If the critical access hospital does not operate a pharmacy, the critical access hospital follows a process for obtaining medications from a pharmacy or licensed pharmaceutical supplier to meet patient needs. **MM.05.01.15, EP 2** If the critical access hospital obtains medications from a pharmacy that is not open 24 hours a day, 7 days a week, the critical access hospital follows a process for obtaining medications from another source for urgent or emergent conditions when the pharmacy is closed. **MM.05.01.19, EP 2** When the critical access hospital accepts unused, expired, or returned medications, it follows a process for returning medications to the pharmacy's or critical access hospital's control which includes procedures for preventing diversion. Note: This element of performance is also applicable to sample medications. **MM.06.01.05, EP 2** If the critical access hospital operates a pharmacy, the process for the use of investigational medications specifies that the pharmacy controls the storage, dispensing, labeling, and distribution of investigational medications.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MM.07.01.01, EP 1 The critical access hospital monitors the patient's perception of side effects and the effectiveness of the patient's medication(s). Note: This element of performance is also applicable to sample medications. **MM.07.01.01, EP 2** The critical access hospital monitors the patient's response to their medication(s) by taking into account clinical information from the medical record, relevant lab values, clinical response, and medication profile. Note 1: Monitoring the patient's response to medications is an important assessment activity for nurses, pharmacists, physicians, and other licensed practitioners. In particular, monitoring the patient's response to the first dose of a new medication is essential to the safety of the patient because any adverse reactions, including serious ones, are more unpredictable if the medication has never been used before with the patient. Note 2: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 1** The critical access hospital follows a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors. Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 3** The critical access hospital complies with internal and	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
§485.635(a)(3)(v)	(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.	**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. **MM.07.01.01, EP 1** The critical access hospital monitors the patient's perception of side effects and the effectiveness of the patient's medication(s). Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 1** The critical access hospital follows a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors. Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 2** The critical access hospital follows a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or	**MM.17.01.01, EP 1** The critical access hospital develops and implements policies and procedures for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs. Note: This element of performance is also applicable to sample medications.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		medication error. Note: This element of performance is also applicable to sample medications. **MM.07.01.03, EP 3** The critical access 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. **PI.01.01.01, EP 5** The critical access hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia. **PI.01.01.01, EP 12** The critical access hospital collects data on the following: Significant medication errors. **PI.01.01.01, EP 13** The critical access hospital collects data on the following: Significant adverse drug reactions.	
§485.635(a)(3)(vi)	(vi) Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices. All patient diets, including therapeutic diets, must be ordered by the practitioner responsible for the care of the patients or by a qualified dietitian or qualified	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **PC.02.01.03, EP 1** Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner	**PC.12.01.01, EP 1** Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory

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	nutrition professional as authorized by the medical staff in accordance with State law governing dietitians and nutrition professionals and that the requirement of § 483.25(i) of this chapter is met with respect to inpatients receiving post CAH SNF care.	in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care. **PC.02.02.03, EP 6** The critical access hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.	services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care. **PC.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 1: Diet menus meet the needs of the patients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to inpatients receiving posthospital skilled nursing facility care.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.02.02.03, EP 7 Food and nutrition products are consistent with each patient's care, treatment, and services. Note 1: The nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the physician or other licensed practitioner responsible for the care of inpatients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to inpatients receiving posthospital skilled nursing facility care. **PC.02.02.03, EP 11** The critical access hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.	
§485.635(a)(3)(vii)	(viii) Policies and procedures that address the post-acute care needs of patients receiving CAH services.	**PC.04.01.01, EP 26** The critical access hospital has written discharge planning policies and procedures applicable to all patients.	**LD.13.01.09, EP 1** The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.
§485.635(a)(4)	(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (a)(2) of this section, and updated as necessary by the CAH.	**LD.04.01.07, EP 7** The critical access hospital's policies are reviewed at least every two years by the group of professional personnel required under LD.04.01.07, EP 6, and reviewed as necessary by the critical access hospital.	**LD.13.01.09, EP 4** The critical access hospital's policies are reviewed at least every two years by the group of professional personnel required under LD.13.01.09, EP 3, and updated as necessary.
§485.635(b)	§485.635(b) Standard: Patient Services		
§485.635(b)(1)(i)	(1) General: (i) The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.	**LD.01.03.01, EP 3** The governing body approves the critical access hospital's written scope of services. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **LD.04.03.01, EP 1** The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements. **LD.04.03.01, EP 4** Emergency services are provided on site and are available	**LD.13.03.01, EP 4** The critical access hospital provides basic outpatient services (diagnostic and therapeutic services and supplies that are commonly provided in a physician's office or at another entry point into the health care delivery system, such as low intensity hospital outpatient department or emergency department). These services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		on a 24-hour basis. **LD.04.03.01, EP 7** The critical access hospital provides outpatient services. **LD.04.03.01, EP 8** The critical access hospital furnishes services that include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions. **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 rehabilitation and psychiatric distinct part units in critical access hospitals: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead. Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text. **PC.01.02.15, EP 2** Diagnostic testing and procedures are performed as ordered within time frames defined by the critical access hospital. **PC.01.03.01, EP 1**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.	
§485.635(b)(1)(ii)	(1)(ii) The CAH furnishes acute care inpatient services.	**LD.04.03.01, EP 27** The critical access hospital provides acute care inpatient services.	**LD.13.03.01, EP 3** The critical access hospital provides acute care inpatient services.
§485.635(b)(2)	(2) Laboratory Services The CAH provides basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include the following:		
§485.635(b)(2)(i)	(i) Chemical examination of urine by stick or tablet method or both (including urine ketones).	**LD.04.01.01, EP 1** The critical access 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 critical access 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. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.	**LD.13.03.01, EP 12** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.04.03.01, EP 9 The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - The chemical examination of urine by the stick method, the tablet method, or both - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory	specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.
§485.635(b)(2)(ii)	(ii) Hemoglobin or hematocrit.	**LD.04.01.01, EP 1** The critical access 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 critical access 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. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.03.01, EP 9** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - The chemical examination of urine by the stick method,	**LD.13.03.01, EP 12** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the tablet method, or both - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory	certified laboratory that meets the requirements of 42 CFR 493.
§485.635(b)(2)(iii)	(iii) Blood glucose.	**LD.04.01.01, EP 1** The critical access 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 critical access 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. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.03.01, EP 9** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - The chemical examination of urine by the stick method, the tablet method, or both - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory	**LD.13.03.01, EP 12** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.635(b)(2)(iv)	(iv) Examination of stool specimens for occult blood.	**LD.04.01.01, EP 1** The critical access 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 critical access 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. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.03.01, EP 9** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - The chemical examination of urine by the stick method, the tablet method, or both - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory	**LD.13.03.01, EP 12** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.
§485.635(b)(2)(v)	(v) Pregnancy tests.	**LD.04.01.01, EP 1** The critical access 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 critical access hospital is seeking accreditation from The Joint Commission.	**LD.13.03.01, EP 12** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones)

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.03.01, EP 9** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - The chemical examination of urine by the stick method, the tablet method, or both - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory	- Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.
§485.635(b)(2)(vi)	(vi) Primary culturing for transmittal to a certified laboratory.	**LD.04.01.01, EP 1** The critical access 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 critical access 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. Note 2: For more information on how to obtain a CLIA	**LD.13.03.01, EP 12** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - Chemical examination of urine by the stick method, the tablet method, or both (including urine ketones) - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html. **LD.04.03.01, EP 9** The critical access hospital provides the following basic laboratory services essential to the immediate diagnosis and treatment of the patient: - The chemical examination of urine by the stick method, the tablet method, or both - Hemoglobin or hematocrit tests - Blood glucose tests - Examination of stool specimens for occult blood - Pregnancy tests - Primary culturing for transmittal to a certified laboratory	Note 1: The laboratory meets the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493) Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has laboratory services available, either directly or through a contractual agreement with a Clinical Laboratory Improvement Amendments (CLIA)–certified laboratory that meets the requirements of 42 CFR 493.
§485.635(b)(3)	(3) Radiology services. Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards.	**EC.01.01.01, EP 4** The critical access hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the critical access hospital's facilities. **EC.01.01.01, EP 8** The critical access hospital has a written plan for managing the following: Medical equipment. **EC.02.02.01, EP 6** The critical access hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials. **HR.01.04.01, EP 3** The critical access hospital orients staff on the following:	**LD.13.03.01, EP 1** The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Relevant critical access 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. **LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **LD.04.03.01, EP 10** The critical access hospital provides radiology services by staff qualified in accordance with state law. These services do not expose patients or staff to radiation hazards. **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.	- Dietetic **NPG.12.01.01, EP 1** Leaders provide for an adequate number and mix of qualified individuals to support safe, quality care, treatment, and services. Note 1: The number and mix of individuals is appropriate to the scope and complexity of the services offered. Services may include but are not limited to the following: - Rehabilitation services - Emergency services - Outpatient services - Respiratory services - Pharmaceutical services, including emergency pharmaceutical services - Diagnostic and therapeutic radiology services Note 2: Emergency services staff are qualified in emergency care. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: As of the first day of the first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient psychiatric or rehabilitation care regardless of whether there are any inpatients in the unit on that date. **PE.02.01.01, EP 4** The critical access hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- 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) **PE.02.01.01, EP 5** Radiation workers are checked periodically, using exposure meters or badge tests, for the amount of radiation exposure.
§485.635(b)(4)	(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides medical services as a first response to common life-	**LD.04.03.01, EP 11** The critical access hospital provides medical services as a first response to common life-threatening injuries and acute illnesses.	**LD.13.03.01, EP 6** The critical access hospital provides emergency medical services that meet the needs of its inpatients and outpatients as a first response to common life-threatening injuries and acute illnesses.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	threatening injuries and acute illness.		Note: Emergency services are available 24-hours a day, 7 days a week.
§485.635(c)	§485.635(c) Standard: Services Provided Through Agreements or Arrangements		
§485.635(c)(1)	(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including--		
§485.635(c)(1)(i)	(i) Services of doctors of medicine or osteopathy;	**LD.04.03.09, EP 1** Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. **LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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	**LD.13.03.03, EP 7** The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish services not directly provided by the critical access hospital to its patients, including but not limited to the following: - Services of doctors of medicine or osteopathy - Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the critical access hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.04.03.09, EP 18 The critical access hospital has an agreement with at least one hospital regarding patient referral and transfer. When the critical access hospital is a member of a rural health network, the agreement is with a member of the network. **LD.04.03.09, EP 20** The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including the following: - Services of doctors of medicine or osteopathy - Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital **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 critical access hospitals that elect The Joint	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 critical access 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	
§485.635(c)(1)(ii)	(ii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and	**LD.04.03.09, EP 1** Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. **LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements. **LD.04.03.09, EP 4**	**LD.13.03.03, EP 7** The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish services not directly provided by the critical access hospital to its patients, including but not limited to the following: - Services of doctors of medicine or osteopathy - Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the critical access hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract **LD.04.03.09, EP 18** The critical access hospital has an agreement with at least one hospital regarding patient referral and transfer. When the critical access hospital is a member of a rural health network, the agreement is with a member of the network. **LD.04.03.09, EP 20** The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including the following: - Services of doctors of medicine or osteopathy - Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital **RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and services - The patient's initial diagnosis, diagnostic impression(s), or condition(s) - Any findings of assessments and reassessments - Any allergies to food - Any allergies to medications - Any conclusions or impressions drawn from the patient's medical history and physical examination - Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 critical access 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	
§485.635(c)(1)(iii)	(iii) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.	**LD.04.03.09, EP 20** The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including the following: - Services of doctors of medicine or osteopathy	**LD.13.03.03, EP 7** The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish services not directly provided by the critical access hospital to its patients, including but not limited

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital	to the following: - Services of doctors of medicine or osteopathy - Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital
§485.635(c)(2)	(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.	**LD.04.03.09, EP 1** Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. **LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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.	**LD.13.01.09, EP 1** The critical access hospital develops and implements written policies and procedures that guide health care services. The policies and procedures are consistent with state law and include the following: - Description of the services furnished by the critical access hospital, including those provided through agreement or arrangement - Emergency medical services - Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services provided by the critical access hospital - Rules for the storage, handling, dispensation, and administration of drugs and biologicals - Guidelines for addressing post–acute care needs of the patients receiving critical access hospital services Note: If patients are transferred or discharged to a provider for which there is no agreement or arrangement, the critical access hospital verifies that the patient has been accepted and treated.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the critical access hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract **LD.04.03.09, EP 18** The critical access hospital has an agreement with at	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		least one hospital regarding patient referral and transfer. When the critical access hospital is a member of a rural health network, the agreement is with a member of the network. **LD.04.03.09, EP 20** The critical access hospital has agreements or arrangements, as appropriate, with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including the following: - Services of doctors of medicine or osteopathy - Additional or specialized diagnostic and clinical laboratory services not available at the critical access hospital - Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the critical access hospital **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 critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 1: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. 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	
§485.635(c)(3)	(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.	**LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements.	**LD.13.03.03, EP 1** The critical access hospital maintains a current list of all patient care services provided under contract, arrangement, or agreement. The list describes nature and scope of services provided.
§485.635(c)(4)	(4) The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following:		
§485.635(c)(4)(i)	(i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.	**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. **LD.01.03.01, EP 1** The governing body defines in writing its responsibilities.	**LD.11.01.03, EP 1** The person responsible for the operation of the critical access hospital under 42 CFR 485.627(b)(2) is also responsible for the following: - Services provided in the critical access hospital whether or not they are furnished under arrangements or agreements

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.01.03.01, EP 3 The governing body approves the critical access hospital's written scope of services. **LD.01.04.01, EP 1** The chief executive provides for the following: - Information and support systems - Physical and financial assets **LD.04.03.09, EP 1** Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement. **LD.04.03.09, EP 2** The critical access hospital describes, in writing, the nature and scope of services provided through contractual agreements. **LD.04.03.09, EP 3** Designated leaders approve contractual agreements. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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,	- Ensuring that contractors of services (including contractors for shared services and joint ventures) provide services that enable the critical access hospital to comply with all applicable Centers for Medicare & Medicaid (CMS) Conditions of Participation and standards for the contracted services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges. - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by physicians and other licensed practitioners will be within the scope of their privileges. Note 2: The leaders who monitor the contracted services are the governing body.	
§485.635(c)(4)(ii)	(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.	**LD.01.04.01, EP 1** The chief executive provides for the following: - Information and support systems - Physical and financial assets **LD.04.01.01, EP 2** The critical access hospital provides care, treatment, and services in accordance with licensure requirements, laws (including state law), and rules and regulations. **LD.04.03.09, EP 4** Leaders monitor contracted services by establishing expectations for the performance of the contracted services. Note 1: When the critical access 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	**LD.11.01.03, EP 1** The person responsible for the operation of the critical access hospital under 42 CFR 485.627(b)(2) is also responsible for the following: - Services provided in the critical access hospital whether or not they are furnished under arrangements or agreements - Ensuring that contractors of services (including contractors for shared services and joint ventures) provide services that enable the critical access hospital to comply with all applicable Centers for Medicare & Medicaid (CMS) Conditions of Participation and standards for the contracted services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		will be within the scope of their privileges. Note 2: The leaders who monitor the contracted services are the governing body. **LD.04.03.09, EP 5** Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services. Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it. **LD.04.03.09, EP 6** Leaders monitor contracted services by evaluating these services in relation to the critical access hospital's expectations. **LD.04.03.09, EP 7** Leaders take steps to improve contracted services that do not meet expectations. Note: Examples of improvement efforts to consider include the following: - Increase monitoring of the contracted services - Provide consultation or training to the contractor - Renegotiate the contract terms - Apply defined penalties - Terminate the contract	
§485.635(c)(5)	(5) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity,	**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:	**MS.20.01.01, EP 1** When telemedicine services are furnished to the critical access hospital's patients through an agreement with a distant-site hospital or telemedicine entity, the governing body of the originating critical access hospital may choose to rely upon the credentialing and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.	- 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. - 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	privileging decisions made by the distant-site hospital or telemedicine entity for the individual distant-site physicians and other licensed practitioners providing such services if the critical access hospital's governing body includes all of the following provisions in its written agreement with the distant-site hospital or telemedicine entity: - The distant site telemedicine entity provides services in accordance with contract service requirements. - The distant-site telemedicine entity's medical staff credentialing and privileging process and standards is consistent with the critical access hospital's process and standards, at a minimum. - The distant-site hospital providing the telemedicine services is a Medicare-participating hospital. - The individual distant-site physician or other licensed practitioner is privileged at the distant-site hospital or telemedicine entity providing the telemedicine services, and the distant-site hospital or telemedicine entity provides a current list of the distant-site physician's or practitioner's privileges at the distant-site hospital or telemedicine entity. - The individual distant-site physician or other licensed practitioner holds a license issued or recognized by the state in which the critical access hospital whose patients are receiving the telemedicine services is located. - For distant-site physicians or other licensed practitioners privileged by the originating critical access hospital, the originating critical access hospital internally reviews services provided by the distant-site physician or other licensed practitioner and sends the distant-site hospital or telemedicine entity information

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		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. - When telemedicine services are provided by a distant-site Medicare-participating hospital, the distant-site hospital evaluates the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital. - When telemedicine services are provided by a distant-site telemedicine entity (a non-Medicare-participating provider or supplier), the quality and appropriateness of the diagnosis, treatment, and treatment outcomes furnished in the critical access hospital are evaluated by a hospital that is a member of the network, a QIO or equivalent entity, or an appropriate and qualified entity identified in the state rural health plan. - 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 critical access hospital verifies 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.	for use in the periodic evaluation of the practitioner. At a minimum, this information includes adverse events that result from the telemedicine services provided by the distant-site physician or other licensed practitioner to the critical access hospital's patients and complaints the critical access hospital has received about the distant-site physician or other licensed practitioner. Note 1: In the case of distant-site physicians and licensed practitioners providing telemedicine services to the critical access hospital's patients under a written agreement between the critical access hospital and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare participating provider or supplier. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 2: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 485.616(c)(1)(i) through (c)(1)(vii). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A. Note 3: A distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier. (For more information, see 42 CFR 485.635(c)(5) in Appendix A.)	
§485.635(d)	§485.635(d) Standard: Nursing Services Nursing services must meet the needs of patients.	**LD.01.04.01, EP 5** The chief executive identifies a nurse leader at the executive level who participates in decision making. **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. **NR.02.01.01, EP 2** The nurse executive coordinates the following: - The development of organizationwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.01.01, EP 4**	**LD.13.03.01, EP 2** The critical access hospital has an organized nursing service, with a plan of administrative authority and delineation of responsibility for patient care, that provides nursing services to meet the needs of its patients. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The nurse executive directs the following: - The implementation of organizationwide plans to provide nursing care, treatment, and services. - The implementation of organizationwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.02.01, 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 critical access hospital - Nursing standards of patient care, treatment, and services - Nursing policies and procedures - Nurse staffing plan(s) **NR.02.03.01, EP 2** The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. **NR.02.03.01, EP 5** The nurse executive is responsible for monitoring the effectiveness of the nurse staffing plan.	

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		NR.02.03.01, EP 6 The nurse executive or designee exercises final authority over staff who provide nursing care, treatment, and services.	
§485.635(d)(1)	(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.	**LD.01.04.01, EP 5** The chief executive identifies a nurse leader at the executive level who participates in decision making. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **NR.02.01.01, EP 2** The nurse executive coordinates the following: - The development of organizationwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.01.01, EP 4** The nurse executive directs the following: - The implementation of organizationwide plans to provide nursing care, treatment, and services. - The implementation of organizationwide programs, policies, and procedures that address how nursing care	**NPG.12.02.01, EP 4** A registered nurse provides (or assign to other staff) the nursing care of each patient, including patients at a skilled nursing facility level of care in a swing-bed critical access hospital. The care is provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: A registered nurse directly provides or supervises the nursing services provided by other staff to patients 24 hours a day, 7 days a week. The critical access hospital has a licensed practical nurse or registered nurse on duty at all times. Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Rural hospitals with a 24-hour nursing waiver granted under 42 CFR 488.54(c) are not required to have 24-hour nursing services.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. **PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note 1: 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. Note 2: For rehabilitation distinct part units in critical access hospitals: The Centers for Medicare & Medicaid Services requires that a physician with specialized training and experience in inpatient rehabilitation conducts at least three face-to-face patient visits per week. **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 critical access hospital policy and law and regulation. Note: Physician assistants may assess the patient’s need for nursing care where permitted by state law. **PC.01.03.01, EP 1** The critical access hospital plans the patient’s care,	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.	
§485.635(d)(2)	(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.	**LD.01.04.01, EP 5** The chief executive identifies a nurse leader at the executive level who participates in decision making. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **NR.02.01.01, EP 2** The nurse executive coordinates the following: - The development of organizationwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.01.01, EP 4** The nurse executive directs the following: - The implementation of organizationwide plans to provide nursing care, treatment, and services. - The implementation of organizationwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and	**NR.11.01.01, EP 4** A registered nurse (or physician assistant, when permitted by state law) supervises and evaluates the nursing care for each patient, including patients at a skilled nursing facility-level of care in a swing-bed critical access hospital.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		evaluated. Note: Examples of patient populations include pediatric, diabetic, and geriatric patients. - The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. **NR.02.03.01, EP 6** The nurse executive or designee exercises final authority over staff who provide nursing care, treatment, and services. **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 critical access hospital policy and law and regulation. Note: Physician assistants may assess the patient's need for nursing care where permitted by state law.	
§485.635(d)(3)	(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.	**LD.04.01.07, EP 1** Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **MM.05.01.07, EP 4** The critical access hospital conducts sterile medication compounding of nonhazardous and hazardous medications within a proper environment in accordance with state and federal law and regulation and critical access hospital policies. Note: Aspects of a proper environment include but are not limited to air exchanges and pressures, ISO designations, viable testing, and cleaning/disinfecting.	**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. **MM.16.01.01, EP 2** Drugs, biologicals, and intravenous medications are administered by, or under the supervision of, a registered nurse, a doctor of medicine or osteopathy, or, where permitted by state law, a physician assistant. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Drugs and biologicals are administered by, or under supervision of, nursing or other staff in accordance with federal and state laws

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MM.05.01.07, EP 5 The critical access hospital properly stores compounded sterile preparations of nonhazardous and hazardous medications and labels them with beyond-use dates in accordance with state and federal law and regulation and critical access hospital policies. **MM.05.01.07, EP 6** The critical access hospital conducts quality assurance of compounded sterile preparations of nonhazardous and hazardous medications in accordance with state and federal law and regulation and critical access hospital policies. **MM.06.01.01, EP 1** Only authorized clinical staff administer medications. The critical access hospital defines, in writing, those who are authorized to administer medication, with or without supervision, in accordance with law and regulation. Note: This does not prohibit self-administration of medications by patients, when indicated. **MM.06.01.01, EP 3** Before administration, the individual administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity - Verifies that the medication has not expired - Verifies that no contraindications exist - Verifies that the medication is being administered at the	and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 **PC.02.01.03, EP 1** Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner	

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		responsible for the patient's care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care. **RC.02.03.07, EP 3** Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders. **RC.02.03.07, EP 4** Verbal orders are authenticated within the time frame specified by law and regulation.	
§485.635(d)(4)	(4) A nursing care plan must be developed and kept current for each inpatient.	**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 critical access hospital policy and law and regulation. Note: Physician assistants may assess the patient's need for nursing care where permitted by state law. **PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 5** The written plan of care is based on the patient's goals and the time frames, settings, and services required to	**PC.11.03.01, EP 1** The critical access hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as

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		meet those goals. Note: For psychiatric distinct part units in critical access hospitals: The patient's goals include both short- and long-term goals.	needed by a physician in consultation with other professional staff who provide services to the patient.
§485.635(e)	§485.635(e) Standard: Rehabilitation Therapy Services. Physical therapy, occupational therapy, and speech-language pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17 of this subpart.	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **HR.01.01.01, EP 2** The critical access 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	**HR.11.02.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing.

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		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. **HR.01.01.01, EP 3** The critical access hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **HR.01.01.01, EP 4** The critical access hospital obtains a criminal background check on the applicant as required by law and regulation or critical access hospital policy. Criminal background checks are documented. **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.	

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		LD.04.03.01, EP 15 When a critical access hospital provides rehabilitation therapy services, these services are provided by staff qualified according to state law and the requirements for therapy services from 42 CFR 409.17. Note: Rehabilitation therapy services include physical therapy, occupational therapy, and speech-language pathology.	
§485.638	§485.638 Condition of Participation: Clinical Records		
§485.638(a)	§485.638(a) Standard: Records System		
§485.638(a)(1)	(1) The CAH maintains a clinical records system in accordance with written policies and procedures.	**IM.01.01.01, EP 2** The critical access hospital identifies how data and information enter, flow within, and leave the organization. **IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The critical access hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **IM.02.01.01, EP 4** The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **IM.02.01.03, EP 1**	**RC.11.01.01, EP 7** The critical access hospital develops and implements policies and procedures for the maintenance of its medical records system(s). A designated member of the professional staff is responsible for maintaining the records.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access hospital follows a written policy that addresses the security of health information, including access, use, and disclosure. **IM.02.01.03, EP 2** The critical access 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 critical access hospital's control. **IM.02.01.03, EP 5** The critical access hospital protects against unauthorized access, use, and disclosure of health information. **IM.02.01.03, EP 6** The critical access hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction. **IM.02.01.03, EP 7** The critical access hospital controls the intentional destruction of health information. **RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.01.01.01, EP 7** All entries in the medical record are dated. **RC.01.02.01, EP 1** Only authorized individuals make entries in the medical record. **RC.01.02.01, EP 2** The critical access hospital defines the types of entries in the medical record made by licensed practitioners that require countersigning, in accordance with law and regulation. **RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 critical access hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders. **RC.01.03.01, EP 2** The critical access hospital follows its written policy requiring timely entry of information into the patient's medical record. **RC.01.05.01, EP 2** The medical record is retained for at least six years from the date of its last entry and longer if required by state statute or if the record is needed in any pending proceeding. **RC.02.01.01, EP 2** The medical record contains the following clinical information: - The reason(s) for admission for care, treatment, and	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	
§485.638(a)(2)	(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.	**IM.02.02.03, EP 2** The critical access hospital's storage and retrieval systems make health information accessible when needed for patient care, treatment, and services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical records system allows for timely retrieval of patient information by diagnosis and procedure. **IM.02.02.03, EP 3** The critical access hospital disseminates data and information in useful formats within time frames that are defined by the critical access hospital and consistent with law and regulation. **RC.01.04.01, EP 1** The critical access hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information.	**RC.11.01.01, EP 4** The critical access hospital develops and implements policies and procedures for accurate, legible, complete, signed, dated, and timed medical record entries that are authenticated by the person responsible for providing or evaluating the service provided. Medical records are promptly completed, systematically organized, and readily accessible.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.638(a)(3)	(3) A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.	**HR.01.02.05, EP 17** The critical access hospital designates an individual who is responsible for medical record services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.04.01.05, EP 1** Leaders of the program, service, site, or department oversee operations.	**RC.11.01.01, EP 7** The critical access hospital develops and implements policies and procedures for the maintenance of its medical records system(s). A designated member of the professional staff is responsible for maintaining the records.
§485.638(a)(4)	(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable--		
§485.638(a)(4)(i)	(i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;	**LD.04.01.01, EP 2** The critical access hospital provides care, treatment, and services in accordance with licensure requirements, laws (including state law), and rules and regulations. **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	**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 - Communication needs, including preferred language for discussing health care - Race and ethnicity Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the clinical record.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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	**RC.12.01.01, EP 2** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate)

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation **RC.02.01.01, 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 critical access hospital policy Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 **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 discharge summary that includes the following:	- Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis. **RC.12.01.01, EP 3** The medical record contains any informed consent, when required by critical access hospital policy or federal or state law or regulation. Note: The properly executed informed consent is placed in the patient's medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient's mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access 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. **RI.01.03.01, EP 1** The critical access 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.01.05.01, EP 1** The critical access 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. - For outpatient settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Providing the patient upon admission with information on the extent to which the critical access hospital is able, unable, or unwilling to honor advance directives. - Whether the critical access hospital will honor advance directives in its outpatient settings. - That the critical access 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: 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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.638(a)(4)(ii)	(ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;	**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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary,	**RC.12.01.01, EP 2** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate)

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. Note 2: For the definition and a further explanation of block charting, refer to the Glossary. - Any access site for medication, administration devices used, and rate of administration - Any adverse drug reactions - Treatment goals, plan of care, and revisions to the plan of care - Results of diagnostic and therapeutic tests and procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	- Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§485.638(a)(4)(iii)	(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment; and	**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 distinct part units in critical	**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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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	- All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services - Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§485.638(a)(4)(iv)	(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.	**RC.01.01.01, EP 7** All entries in the medical record are dated. **RC.01.02.01, EP 3** The author of each medical record entry is identified in the medical record. **RC.01.02.01, EP 4** Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or critical access hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: 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 critical access hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.	**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 critical access hospital policy, law and regulation, and medical staff bylaws, rules, and regulations.
§485.638(b)	§485.638(b) Standard: Protection of Record Information		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.638(b)(1)	(1) The CAH maintains the confidentially of record information and provides safeguards against loss, destruction, or unauthorized use.	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.03, EP 2** The critical access 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 critical access hospital's control. **IM.02.01.03, EP 6** The critical access hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction. **IM.02.01.03, EP 7** The critical access hospital controls the intentional destruction of health information.	**IM.12.01.01, EP 1** The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.
§485.638(b)(2)	(2) Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.03, EP 1** The critical access hospital follows a written policy that addresses the security of health information, including	**IM.12.01.01, EP 3** The critical access hospital develops and implements policies and procedures for the release of medical records. The policies and procedures are in accordance with law and regulation, court orders, or subpoenas. Note: Information from or copies of records may be released only to authorized individuals, and the critical access hospital makes certain that unauthorized

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access, use, and disclosure. **IM.02.01.03, EP 2** The critical access 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 critical access hospital's control. **IM.02.01.03, EP 6** The critical access hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction. **IM.02.01.03, EP 7** The critical access hospital controls the intentional destruction of health information.	individuals cannot gain access to or alter patient records. **IM.12.01.03, EP 1** The critical access hospital develops and implements a written policy that addresses the security of health information, including the following: - Access and use - Integrity of health information against loss, damage, unauthorized alteration or use, unintentional change, and accidental destruction - Intentional destruction of health information - When and by whom the removal of health information is permitted Note: Removal refers to those actions that place health information outside the critical access hospital's control.
§485.638(b)(3)	(3) The patient's written consent is required for release of information not required by law.	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The critical access hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy.	**IM.12.01.01, EP 2** The critical access hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For swing beds in critical access hospitals: The critical access hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.

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		IM.02.01.01, EP 4 The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.	
§485.638(c)	§485.638(c) Standard: Retention of Records The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.	**RC.01.05.01, EP 2** The medical record is retained for at least six years from the date of its last entry and longer if required by state statute or if the record is needed in any pending proceeding.	**RC.11.03.01, EP 2** The medical record is retained for at least six years from the date of its last entry and longer if required by state statute or if the record is needed in any pending proceeding.
§485.638(d)	§485.638(d) Standard: Electronic notifications. If the CAH utilizes an electronic medical records system or other electronic administrative system, which is conformant with the content exchange standard at 45 CFR 170.205(d)(2), then the CAH must demonstrate that—		
§485.638(d)(1)	(1) The system's notification capacity is fully operational and the CAH uses it in accordance with all State and Federal statutes and regulations applicable to the CAH's exchange of patient health information.	**IM.02.02.07, EP 1** The critical access 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.	**IM.13.01.05, EP 1** The critical access hospital demonstrates that its electronic health records system's (or other electronic administrative system's) notification capacity is fully operational and is used in accordance with applicable state and federal laws and regulations for the exchange of patient health information.
§485.638(d)(2)	(2) The system sends notifications that must include at least patient name, treating practitioner name, and sending institution name.	**IM.02.02.07, EP 2** The critical access hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include at least the patient's name, treating licensed practitioner's name, and sending institution's name.	**IM.13.01.05, EP 2** The critical access hospital demonstrates that its electronic health records system (or other electronic administrative system) sends notifications that include, at a minimum, the patient's name, treating licensed practitioner's name, and sending institution's name.

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§485.638(d)(3)	(3) To the extent permissible under applicable federal and state law and regulations, and not inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of:	**IM.02.02.07, EP 3** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of the patient's emergency department registration or inpatient admission.	**IM.13.01.05, EP 3** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission
§485.638(d)(3)(i)	(i) The patient's registration in the CAH's emergency department (if applicable).	**IM.02.02.07, EP 3** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of the patient's emergency department registration or inpatient admission.	**IM.13.01.05, EP 3** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission
§485.638(d)(3)(ii)	(ii) The patient's admission to the CAH's inpatient services (if applicable).	**IM.02.02.07, EP 3** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the time of the patient's emergency department registration or inpatient admission.	**IM.13.01.05, EP 3** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, at the following times, when applicable: - The patient's emergency department registration - The patient's inpatient admission
§485.638(d)(4)	(4) To the extent permissible under applicable federal and state law and regulations, and not	**IM.02.02.07, EP 4** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the	**IM.13.01.05, EP 4** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	inconsistent with the patient's expressed privacy preferences, the system sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to, or at the time of:	critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.	critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.
§485.638(d)(4)(i)	(i) The patient's discharge or transfer from the CAH's emergency department (if applicable).	**IM.02.02.07, EP 4** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.	**IM.13.01.05, EP 4** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.
§485.638(d)(4)(ii)	(ii) The patient's discharge or transfer from the CAH's inpatient services (if applicable).	**IM.02.02.07, EP 4** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.	**IM.13.01.05, EP 4** In accordance with the patient's expressed privacy preferences and applicable laws and regulations, the critical access hospital's electronic health records system (or other electronic administrative system) sends notifications directly, or through an intermediary that facilitates exchange of health information, either immediately prior to or at the time of the patient's discharge or transfer from the critical access hospital's emergency department or inpatient services.
§485.638(d)(5)	(5) The CAH has made a reasonable effort to ensure that the system sends the notifications to all applicable post- acute care services providers and suppliers,	**IM.02.02.07, EP 5** The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post-acute care services providers and	**IM.13.01.05, EP 5** The critical access hospital makes a reasonable effort to confirm that its electronic health records system (or other electronic administrative system) sends the notifications to all applicable post–acute care service

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		to receive patient event notifications in a manner consistent with a critical access hospital system's capabilities.	identifying recipients. In addition, some recipients may not be able to receive patient event notifications in a manner consistent with the critical access hospital system's capabilities.
§485.639	§485.639 Condition of Participation: Surgical Services. If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section.	**EC.02.03.01, EP 11** Periodic evaluations, as determined by the critical access 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. **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) **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	**LD.13.03.01, EP 1** The critical access hospital provides services directly or through referral, consultation, contractual arrangements, or other agreements that meet the needs of the population(s) served, are organized appropriate to the scope and complexity of services offered, and are in accordance with accepted standards of practice. Services may include but are not limited to the following: - Outpatient - Emergency - Medical records - Diagnostic and therapeutic radiology - Nuclear medicine - Surgical - Anesthesia - Laboratory - Respiratory - Dietetic **LD.13.03.01, EP 10** If the critical access hospital provides outpatient surgical services, the services are consistent with the quality of inpatient surgical care. **MS.17.02.01, EP 6** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		documented. **HR.01.06.01, EP 1** The critical access hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **HR.01.06.01, EP 3** An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the critical access hospital can utilize an outside individual for this task. If a suitable individual inside or outside the critical access hospital cannot be found, the critical access hospital may consult the competency guidelines from an appropriate professional organization to make its assessment. **HR.01.06.01, EP 5** Staff competence is initially assessed and documented as part of orientation. **HR.01.06.01, EP 6** Staff competence is assessed and documented once every three years, or more frequently as required by critical access hospital policy or in accordance with law and regulation. **IC.05.01.01, EP 1** The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **IC.06.01.01, EP 3** The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital. **LD.01.03.01, EP 3** The governing body approves the critical access hospital's written scope of services. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.04.01.07, EP 1 Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, and services. **LD.04.03.07, EP 3** The quality of the outpatient surgical services at a critical access hospital is consistent with its inpatient surgical services. **MS.06.01.05, EP 2** The critical access 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 critical access hospital **MS.06.01.05, EP 3**	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		All of the criteria used are consistently evaluated for all physicians and other licensed practitioners holding that privilege.	
§485.639(a)	§485.639(a) Standard: Designation of Qualified Practitioners The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by--		**MS.17.02.01, EP 6** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine
§485.639(a)(1)	(1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;	**MS.06.01.05, EP 13** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine **MS.06.01.05, EP 15** The following are available in the surgical suite and area/location where the scheduling of surgical procedures is done: - A current roster listing each practitioner's specific surgical privileges - A current list of surgeons suspended from surgical	**MS.17.02.01, EP 6** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		privileges or whose surgical privileges have been restricted	
§485.639(a)(2)	(2) A doctor of dental surgery or dental medicine; or	**MS.06.01.05, EP 13** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine **MS.06.01.05, EP 15** The following are available in the surgical suite and area/location where the scheduling of surgical procedures is done: - A current roster listing each practitioner's specific surgical privileges - A current list of surgeons suspended from surgical privileges or whose surgical privileges have been restricted	**MS.17.02.01, EP 6** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine - A doctor of podiatric medicine
§485.639(a)(3)	(3) A doctor of podiatric medicine.	**MS.06.01.05, EP 13** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act - A doctor of dental surgery or dental medicine	**MS.17.02.01, EP 6** The critical access hospital designates the practitioners who are allowed to perform surgery, in accordance with appropriate policies and procedures, and with scope of practice laws and regulations. Surgery is performed only by the following: - A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- A doctor of podiatric medicine **MS.06.01.05, EP 15** The following are available in the surgical suite and area/location where the scheduling of surgical procedures is done: - A current roster listing each practitioner's specific surgical privileges - A current list of surgeons suspended from surgical privileges or whose surgical privileges have been restricted	- A doctor of dental surgery or dental medicine - A doctor of podiatric medicine
§485.639(b)	§485.639(b) Standard: Anesthetic Risk and Evaluation		
§485.639(b)(1)	(1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.	**PC.03.01.03, EP 8** A qualified physician or other licensed practitioner reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. Note: The reevaluation is performed by a qualified physician or other licensed practitioner in accordance with 42 CFR 485.639(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.	**PC.13.01.03, EP 3** A qualified physician or other licensed practitioner, in accordance with 42 CFR 485.639(a), reevaluates the patient immediately before surgery, to evaluate the risk of the procedure to be performed.
§485.639(b)(2)	(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.	**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 critical access hospital conducts a presedation or preanesthesia patient assessment.	**PC.13.01.03, EP 1** A qualified physician or other licensed practitioner, in accordance with 42 CFR 485.639(c), conducts a preanesthesia patient assessment to evaluate the risk of anesthesia.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.639(b)(3)	(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.	**PC.03.01.07, EP 1** The critical access hospital assesses the patient's physiological status immediately after the operative or other high-risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia. **PC.03.01.07, EP 4** A qualified physician or other licensed practitioner discharges the patient from the recovery area or from the critical access hospital. In the absence of a qualified individual, patients are discharged according to criteria approved by clinical leaders. **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 critical access hospital. Note 2: If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care. **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	**PC.13.01.03, EP 6** A qualified physician or other licensed practitioner evaluates the patient for proper anesthesia recovery, as specified in 42 CFR 485.639(c), before discharging the patient from the recovery area or from the critical access hospital.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		practitioner(s) who performed the procedure and their assistant(s) - The name of the procedure performed - A description of the procedure - Findings of the procedure - Any estimated blood loss - Any specimen(s) removed - The postoperative diagnosis **RC.02.01.03, EP 7** When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and their assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis. **RC.02.01.03, EP 8** The medical record contains the following postoperative information: - The patient's vital signs and level of consciousness - Any medications, including intravenous fluids and any administered blood, blood products, and blood components - Any unanticipated events or complications (including blood transfusion reactions) and the management of those events **RC.02.01.03, EP 9** The medical record contains documentation that the	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
§485.639(c)	§485.639(c) Standard: Administration of Anesthesia The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope-of-practice laws.	**MS.06.01.05, EP 2** The critical access 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 critical access 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. **MS.06.01.05, EP 12** Information regarding each physician's or other licensed	**MS.17.02.01, EP 1** The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, develops and implements criteria that determine if a physician or other licensed practitioner is allowed to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria: - Current licensure and/or certification, as appropriate, verified with the primary source - Specific relevant training, verified with the primary source - Evidence of physical ability to perform the requested privilege - Data from professional practice review by an organization(s) that currently privileges the applicant (if available) - Peer and/or faculty recommendation - When renewing privileges, review of the physician's or other licensed practitioner's performance within the critical access hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		practitioner's scope of privileges is updated as changes in clinical privileges are made.	
§485.639(c)(1)	(1) Anesthesia must be administered by only--		
§485.639(c)(1)(i)	(i) A qualified anesthesiologist;	**PC.03.01.01, EP 9** In accordance with the critical access 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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(c)(1)(ii)	(ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;	**PC.03.01.01, EP 9** In accordance with the critical access 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	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to	recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(c)(1)(iii)	(iii) A doctor of dental surgery or dental medicine;	**PC.03.01.01, EP 9** In accordance with the critical access 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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this

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		program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision

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			requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(c)(1)(iv)	(iv) A doctor of podiatric medicine;	**PC.03.01.01, EP 9** In accordance with the critical access 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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such

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		Commission. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(c)(1)(v)	(v) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter;	**PC.03.01.01, EP 9** In accordance with the critical access hospital's policy and state scope of practice laws, anesthesia is	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals:

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		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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy	- A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(c)(1)(vi)	(vi) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or	**PC.03.01.01, EP 9** In accordance with the critical access 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 485.639(e) regarding the state exemption for this supervision *	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as

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		- An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the	defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia

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		request may be submitted at any time and are effective upon submission.	services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(c)(1)(vii)	(vii) A supervised trainee in an approved educational program, as described in §413.85 or §§ 413.76 through 413.83 of this chapter.	**PC.03.01.01, EP 9** In accordance with the critical access 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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.

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§485.639(c)(2)	(2) In those cases in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.	**PC.03.01.01, EP 9** In accordance with the critical access 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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS)	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(d)	§485.639(d) Standard: Discharge All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.	**PC.03.01.07, EP 4** A qualified physician or other licensed practitioner discharges the patient from the recovery area or from the critical access hospital. In the absence of a qualified individual, patients are discharged according to criteria approved by clinical leaders. **PC.03.01.07, EP 6** Patients who have received sedation or anesthesia as	**PC.13.01.03, EP 7** The critical access hospital discharges patients following the surgical procedure in the company of a responsible adult, except in situations where the practitioner who performed the surgical procedure determines the patient may leave unaccompanied.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		outpatients are discharged in the company of an individual who accepts responsibility for the patient.	
§485.639(e)	§485.639(e) Standard: State Exemption		
§485.639(e)(1)	(1) A CAH may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from MD/DO supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current MD/DO supervision requirement, and that the opt-out is consistent with State law.	**PC.03.01.01, EP 9** In accordance with the critical access 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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.	Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.639(e)(2)	(2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.	**PC.03.01.01, EP 9** In accordance with the critical access 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	**PC.13.01.01, EP 1** Anesthesia is administered only by the following individuals: - A qualified anesthesiologist - A doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 485.639(e) regarding the state exemption for this supervision * - An anesthesiologist's assistant supervised by an anesthesiologist - A supervised trainee in an approved educational program Note: 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. Footnote *: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state's Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state Boards of Medicine and Nursing about issues related to access to	recognized under section 1101(a)(7) of the Social Security Act - A doctor of dental surgery or dental medicine, who is qualified to administer anesthesia under state law - A doctor of podiatric medicine, who is qualified to administer anesthesia under state law - A certified registered nurse anesthetist (CRNA), as defined in 42 CFR 410.69(b) of this chapter, supervised by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this supervision - An anesthesiologist's assistant, as defined in 42 CFR 410.69(b), supervised by an anesthesiologist - A supervised trainee in an approved educational program Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law, or if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission. Note 2: See Glossary for the definition of certified registered nurse anesthetist (CRNA) and anesthesiologist assistant. Note 3: The CoP at 42 CFR 485.639(e) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid

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		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.	Services (CMS) signed by the governor, following consultation with the state's boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor must attest that they have consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state's citizens to opt out of the current doctor of medicine or osteopathy supervision requirement and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission. Note 4: Only the above individuals can administer deep sedation/analgesia.
§485.640	§485.640 Condition of participation: Infection prevention and control and antibiotic stewardship programs. The CAH must have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable,	**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: Existing facilities may elect to implement a Centers for Medicare & Medicaid Services (CMS) categorical waiver to reduce their relative humidity to 20%	**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 critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application

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	and for reducing the development and transmission of HAIs and antibiotic-resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program.	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: Existing facilities may comply with the 2012 NFPA 99 ventilation requirements or the ventilation requirements in the edition of the NFPA code previously adopted by CMS at the time of installation (for example,1999 NFPA 99). **IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital staff on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components	- Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1). **IC.04.01.01, EP 3** The critical access hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation.

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		of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6). **IC.04.01.01, EP 3** The critical access hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert	b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its

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		consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 5** The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff.	policies and procedures. **IC.04.01.01, EP 5** The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff. **IC.05.01.01, EP 1** The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **IC.05.01.01, EP 2** The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and

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		IC.05.01.01, EP 1 The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **IC.05.01.01, EP 2** The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). **IC.06.01.01, EP 3** The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by	administrative leaders). **IC.06.01.01, EP 3** The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital. **MM.18.01.01, EP 1** The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided. **MM.18.01.01, EP 3** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. - All documentation, written or electronic, of antibiotic stewardship program activities. - Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. - Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing

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		public health authorities that could impact the critical access hospital. **MM.09.01.01, EP 10** The critical access hospital allocates financial resources for staffing and information technology to support the antibiotic stewardship program. **MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the critical access 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	contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures. **PE.04.01.01, EP 1** The critical access hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
§485.640(a)	(a) Standard: Infection prevention and control program organization and policies. The CAH must demonstrate that:		
§485.640(a)(1)	(1) An individual (or individuals), who is qualified through education, training, experience, or certification in infection	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met	**HR.11.02.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met

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	prevention and control, is appointed by the governing body, or responsible individual, as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership;	through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **IC.04.01.01, EP 1** The critical access hospital's governing body, or responsible individual, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program.	through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists, as defined in 42 CFR 484, provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital. See Glossary for definitions of physical therapist, physical therapist assistant, occupational therapist, occupational therapy assistant, speech-language pathologist, and audiologist. Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: If respiratory care services are provided, staff qualified to perform specific respiratory care procedures and the amount of supervision required to carry out the specific procedures is designated in writing. **NPG.12.01.01, EP 12** The critical access hospital's governing body, or responsible individual, based on the recommendation of the medical staff and nursing leaders, appoints an infection preventionist(s) or infection control professional(s) qualified through education, training, experience, or certification in infection prevention to be responsible for the infection prevention and control program.
§485.640(a)(2)	(2) The infection prevention and control program, as documented	**IC.04.01.01, EP 3** The critical access hospital’s infection prevention and	**IC.04.01.01, EP 3** The critical access hospital’s infection prevention and

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	in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings;	control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to	control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the critical access hospital and between the critical access hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: a. Applicable law and regulation. b. Manufacturers' instructions for use. c. Nationally recognized evidence-based guidelines and standards of practice, including the Centers for Disease Control and Prevention's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services' Conditions of Participation, Food and Drug Administration's regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR 1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. Note 2: For full details on the CDC's Core Infection

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		https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 4** The critical access hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions - Use of disinfectants registered by the Environmental Protection Agency for noncritical devices and equipment according to the directions on the product labeling, including but not limited to indication, specified use dilution, contact time, and method of application - Use of FDA-approved liquid chemical sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with FDA-cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection - Resolution of conflicts or discrepancies between a	Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/introduction-methods-definition-of-terms.html. Note 3: The critical access hospital determines which evidence-based guidelines, expert recommendations, best practices, or a combination thereof it adopts in its policies and procedures. **IC.04.01.01, EP 4** The critical access hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions - Use of disinfectants registered by the Environmental Protection Agency for noncritical devices and equipment according to the directions on the product labeling, including but not limited to indication, specified use dilution, contact time, and method of application - Use of FDA-approved liquid chemical sterilants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with FDA-cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and

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		medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.	the results of testing for appropriate concentration for chemicals used in high-level disinfection - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note 1: The Spaulding classification system classifies medical and surgical devices as critical, semicritical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate-level disinfection, and low-level disinfection) to be used for the three classes of devices. Note 2: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.
§485.640(a)(3)	(3) The infection prevention and control program includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities; and	**EC.02.05.02, EP 1** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **EC.02.05.02, EP 2** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources,	**IC.06.01.01, EP 3** The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital.

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		treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water) Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range. **EC.02.06.05, EP 2**	**IC.06.01.01, EP 4** The critical access hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Investigating an outbreak - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate **IC.06.01.01, EP 5** The critical access hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following: - Screening and medical evaluations for infectious diseases - Immunizations - Staff education and training - Management of staff with potentially infectious exposures or communicable illnesses **PE.01.01.01, EP 1** The critical access hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided.

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		When planning for demolition, construction, renovation, or general maintenance, the critical access 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 and mitigates the identified risks. Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation. **EC.02.06.05, EP 3** The critical access hospital takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance. **IC.06.01.01, EP 3** The critical access hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the critical access hospital. **IC.06.01.01, EP 4** The critical access hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities	Note 2: When planning for new, altered, or renovated space, the critical access hospital uses state rules and regulations or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the critical access hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. **PE.04.01.05, EP 1** The water management program has an individual or a team responsible for the oversight and implementation of the program, including but not limited to development, management, and maintenance activities. **PE.04.01.05, EP 2** The individual or team responsible for the water management program develops the following: - A basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points Note: An example would be a flow chart with symbols showing sinks, showers, water fountains, ice machines, and so forth. - A water risk management plan based on the diagram that includes an evaluation of the physical and chemical conditions of each step of the water flow diagram to identify any areas where potentially hazardous conditions may occur (these conditions are most likely to occur in areas with slow or stagnant water)

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		- Reporting an outbreak in accordance with state and local public health authorities' requirements - Investigating an outbreak - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate **IC.06.01.01, EP 5** The critical access hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following: - Screening and medical evaluations for infectious diseases - Immunizations - Staff education and training - Management of staff with potentially infectious exposures or communicable illnesses	Note: Refer to the Centers for Disease Control and Prevention's "Water Infection Control Risk Assessment (WICRA) for Healthcare Settings" tool as an example for conducting a water-related risk assessment. - A plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time (for example, unoccupied or temporarily closed areas) - An evaluation of the patient populations served to identify patients who are immunocompromised - Monitoring protocols and acceptable ranges for control measures Note: Critical access hospitals should consider incorporating basic practices for water monitoring within their water management programs that include monitoring of water temperature, residual disinfectant, and pH. In addition, protocols should include specificity around the parameters measured, locations where measurements are made, and appropriate corrective actions taken when parameters are out of range.
§485.640(a)(4)	(4) The infection prevention and control program reflects the scope and complexity of the CAH services provided.	**IC.04.01.01, EP 5** The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff.	**IC.04.01.01, EP 5** The infection prevention and control program reflects the scope and complexity of the critical access hospital services provided by addressing all locations, patient populations, and staff.
§485.640(b)	(b) Standard: Antibiotic stewardship program organization and policies. The CAH must demonstrate that:		
§485.640(b)(1)	(1) An individual (or individuals), who is qualified through education, training, or experience	**MM.09.01.01, EP 11** The governing body appoints a physician and/or pharmacist who is qualified through education, training,	**MM.18.01.01, EP 2** The critical access hospital demonstrates that an individual (or individuals), who is qualified through

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	in infectious diseases and/or antibiotic stewardship, is appointed by the governing body, or responsible individual, as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership;	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.	education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body, or responsible individual, as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.
§485.640(b)(2)	(2) The facility-wide antibiotic stewardship program:		
§485.640(b)(2)(i)	(i) Demonstrates coordination among all components of the CAH responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services;	**MM.09.01.01, EP 14** The antibiotic stewardship program demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.	**MM.18.01.01, EP 5** The critical access hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. - Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.
§485.640(b)(2)(ii)	(ii) Documents the evidence-based use of antibiotics in all departments and services of the CAH; and	**MM.09.01.01, EP 15** The antibiotic stewardship program documents the evidence-based use of antibiotics in all departments and services of the critical access hospital.	**MM.18.01.01, EP 5** The critical access hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI

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			program, the medical staff, nursing services, and pharmacy services. - Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.
§485.640(b)(2)(iii)	(iii) Documents any improvements, including sustained improvements, in proper antibiotic use;	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - 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 critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 20** The antibiotic stewardship program collects, analyzes, and reports data to critical access hospital leaders and prescribers. Note: Examples of antibiotic stewardship program data include antibiotic resistance patterns, antibiotic prescribing practices, or an evaluation of antibiotic stewardship activities.	**MM.18.01.01, EP 5** The critical access hospitalwide antibiotic stewardship program: - Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services. - Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital. - Documents any improvements, including sustained improvements, in proper antibiotic use.

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		MM.09.01.01, EP 21 The critical access hospital takes action on improvement opportunities identified by the antibiotic stewardship program.	
§485.640(b)(3)	(3) The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and	**MM.09.01.01, EP 17** The antibiotic stewardship program implements one or both of the following strategies to optimize antibiotic prescribing: - Preauthorization for specific antibiotics that includes an internal review and approval process prior to use - Prospective review and feedback regarding antibiotic prescribing practices, including the treatment of positive blood cultures, by a member of the antibiotic stewardship program **MM.09.01.01, EP 18** The antibiotic stewardship program implements at least two evidence-based guidelines to improve antibiotic use for the most common indications. Note 1: Examples include, but are not limited to, the following: - Community-acquired pneumonia - Urinary tract infections - Skin and soft tissue infections - Clostridioides difficile colitis - Asymptomatic bacteriuria - Plan for parenteral to oral antibiotic conversion - Use of surgical prophylactic antibiotics Note 2: Evidence-based guidelines must be based on national guidelines and also reflect local susceptibilities, formulary options, and the patients served, as needed.	**MM.18.01.01, EP 6** The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.

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		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 critical access hospital implements. Note 1: The critical access hospital may measure adherence at the group level (that is, departmental, unit, clinician subgroup) or at the individual prescriber level. Note 2: The critical access hospital may obtain adherence data for a sample of patients from relevant clinical areas by analyzing electronic health records or by conducting chart reviews.	
§485.640(b)(4)	(4) The antibiotic stewardship program reflects the scope and complexity of the CAH services provided.	**MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is responsible for the following: - Developing and implementing a hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics - Documenting antibiotic stewardship activities, including any new or sustained improvements - Communicating and collaborating with the medical staff, nursing leaders, and pharmacy leaders, as well as with the critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 15** The antibiotic stewardship program documents the	**MM.18.01.01, EP 1** The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.

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		evidence-based use of antibiotics in all departments and services of the critical access hospital.	
§485.640(c)	(c) Standard: Leadership responsibilities.		
§485.640(c)(1)	(1) The governing body, or responsible individual, must ensure all of the following:		
§485.640(c)(1)(i)	(i) Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities.	**IC.05.01.01, EP 1** The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **MM.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	**IC.05.01.01, EP 1** The critical access hospital's governing body, or responsible individual, is responsible for the implementation, performance, and sustainability of the infection prevention and control program and provides resources to support and track the implementation, success, and sustainability of the program's activities. Note: To make certain that systems are in place and operational to support the program, the governing body, or responsible individual, provides access to information technology; laboratory services; equipment and supplies; local, state, and federal public health authorities' advisories and alerts, such as the CDC's Health Alert Network (HAN); FDA alerts; manufacturers' instructions for use; and guidelines used to inform policies. **MM.18.01.01, EP 7** The governing body, or responsible individual, ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities.

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		staff, nursing leaders, and pharmacy leaders, as well as with the critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 20** The antibiotic stewardship program collects, analyzes, and reports data to critical access hospital leaders and prescribers. Note: Examples of antibiotic stewardship program data include antibiotic resistance patterns, antibiotic prescribing practices, or an evaluation of antibiotic stewardship activities. **MM.09.01.01, EP 21** The critical access hospital takes action on improvement opportunities identified by the antibiotic stewardship program.	
§485.640(c)(1)(ii)	(ii) All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with CAH QAPI leadership.	**IC.05.01.01, EP 2** The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). **MM.09.01.01, EP 12** The leader(s) of the antibiotic stewardship program is	**IC.05.01.01, EP 2** The critical access hospital's governing body, or responsible individual, ensures that the problems identified by the infection prevention and control program are addressed in collaboration with critical access hospital quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders). **MM.18.01.01, EP 4** The governing body, or responsible individual, ensures

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		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 critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures **MM.09.01.01, EP 14** The antibiotic stewardship program demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.	all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the critical access hospital's QAPI leadership.
§485.640(c)(2)	(2) The infection preventionist(s)/infection control professional(s) is responsible for:		
§485.640(c)(2)(i)	(i) The development and implementation of facility-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.	**IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and	**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

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		nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital staff on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6).	nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1).

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

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		information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6).	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).
§485.640(c)(2)(iii)	(iii) Communication and collaboration with the CAH's QAPI program on infection prevention and control issues.	**IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital staff on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific	**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 critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance

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		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).	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).
§485.640(c)(2)(iv)	(iv) Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the practical applications of infection prevention and control guidelines, policies, and procedures.	**HR.01.05.03, EP 1** Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. **HR.01.06.01, EP 1** The critical access hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. **HR.01.06.01, EP 3** An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence. Note: When a suitable individual cannot be found to assess staff competence, the critical access hospital can utilize an outside individual for this task. If a suitable individual inside or outside the critical access hospital cannot be found, the critical access hospital may consult the competency guidelines from an appropriate professional organization to make its assessment.	**HR.11.03.01, EP 1** Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. **HR.11.04.01, EP 1** Staff competence is initially assessed and documented as part of orientation and once every three years, or more frequently as required by critical access hospital policy or in accordance with law and regulation. **IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical

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		HR.01.06.01, EP 5 Staff competence is initially assessed and documented as part of orientation. **HR.01.06.01, EP 6** Staff competence is assessed and documented once every three years, or more frequently as required by critical access hospital policy or in accordance with law and regulation. **IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital staff on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical	access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1).

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		access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6).	
§485.640(c)(2)(v)	(v) The prevention and control of HAIs, including auditing of adherence to infection prevention and control policies and procedures by CAH personnel.	**IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital staff on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program	**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 critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in

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		- Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6).	infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1).
§485.640(c)(2)(vi)	(vi) Communication and collaboration with the antibiotic stewardship program.	**IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital staff on infection prevention and control policies and procedures and their application - Prevention and control of health care–associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures	**IC.04.01.01, EP 2** The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of critical access hospital personnel and staff, including medical staff and, as applicable, personnel providing contracted services in the critical access hospital, on infection prevention and control guidelines, policies and procedures and their application - Prevention and control of health care–associated

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		- Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.01.06.01 EPs 1, 3, 5, 6).	infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures - Communication and collaboration with all components of the critical access hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and water management program - Communication and collaboration with the critical access hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection. (For more information on competency requirements, refer to HR.11.04.01 EP 1).
§485.640(c)(3)	(3) The leader(s) of the antibiotic stewardship program is responsible for:		
§485.640(c)(3)(i)	(i) The development and implementation of a facility-wide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics.	**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	**MM.18.01.01, EP 3** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. - All documentation, written or electronic, of antibiotic stewardship program activities.

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

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	prevention and control and QAPI programs, on antibiotic use issues.	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 critical access 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	hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. - All documentation, written or electronic, of antibiotic stewardship program activities. - Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. - Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.
§485.640(c)(3)(iv)	(iv) Competency-based training and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.	**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 critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues - Providing competency-based training and education for staff on the practical applications of antibiotic stewardship guidelines, policies, and procedures	**MM.18.01.01, EP 3** The leader(s) of the antibiotic stewardship program is responsible for the following: - Development and implementation a critical access hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics. - All documentation, written or electronic, of antibiotic stewardship program activities. - Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and QAPI programs, on antibiotic use issues. - Competency-based training and education of critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on

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			the practical applications of antibiotic stewardship guidelines, policies, and procedures.
§485.640(g)	(g) Standard: Unified and integrated infection prevention and control and antibiotic stewardship programs for a CAH in a multi-facility system. If a CAH is part of a system consisting of multiple separately certified hospitals, CAHs, and/or REHs using a system governing body that is legally responsible for the conduct of two or more hospitals, CAHs, and/or REHs, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with all applicable State and local laws. The system governing body is responsible and accountable for ensuring that each of its separately certified CAHs meets all of the requirements of this section. Each separately certified CAH subject to the system governing body must demonstrate that:	**LD.01.03.01, EP 27** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered at each critical access hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed	**LD.11.01.01, EP 10** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as

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		- Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff	responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g).
§485.640(g)(1)	(1) The unified and integrated infection prevention and control and antibiotic stewardship programs are established in a manner that takes into account each member CAH's unique circumstances and any significant differences in patient populations and services offered in each CAH;	**LD.01.03.01, EP 27** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the	**LD.11.01.01, EP 10** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's

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		following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered at each critical access hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff	unique circumstances and any significant differences in patient populations and services offered - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g).
§485.640(g)(2)	(2) The unified and integrated infection prevention and control and antibiotic stewardship programs establish and implement policies and procedures to ensure that the needs and concerns of each of its	**LD.01.03.01, EP 27** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system	**LD.11.01.01, EP 10** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency

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	separately certified CAHs, regardless of practice or location, are given due consideration;	governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered at each critical access hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic	hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic

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		stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff	stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g).
§485.640(g)(3)	(3) The unified and integrated infection prevention and control and antibiotic stewardship programs have mechanisms in place to ensure that issues localized to particular CAHs are duly considered and addressed; and	**LD.01.03.01, EP 27** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered at each critical access hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration	**LD.11.01.01, EP 10** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff	- Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g).
§485.640(g)(4)	(4) A qualified individual (or individuals) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the CAH as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, for implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship as directed by the unified infection prevention and control and antibiotic stewardship programs,	**LD.01.03.01, EP 27** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g). Each separately certified critical access hospital subject	**LD.11.01.01, EP 10** If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member facilities after determining that such a decision is in accordance with applicable law and regulation. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and

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	and for providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to CAH staff.	to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered at each critical access hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff	control program and the antibiotic stewardship program do the following: - Account for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified critical access hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed - Designate a qualified individual(s) at the critical access hospital with expertise in infection prevention and control and in antibiotic stewardship as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to critical access hospital staff Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meet all of the requirements at 42 CFR 485.640(g).
§485.641	§485.641 Condition of Participation: Quality Assessment and Performance Improvement Program The CAH must develop,	**LD.03.02.01, EP 1** Leaders set expectations for using data and information, including patient care data and other relevant data, for the following:	**LD.12.01.01, EP 1** The critical access hospital develops, implements, maintains, and documents an effective, ongoing, data-driven, hospitalwide quality assessment and

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	implement, and maintain an effective, ongoing, CAH-wide, data-driven quality assessment and performance improvement (QAPI) program. The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program.	- Improving the safety and quality of care, treatment, or services in order to achieve the goals of the performance improvement program - Creating a culture of safety and quality - Decision making that supports the safety and quality of care, treatment, and services - Identifying and responding to internal and external changes in the environment **LD.03.05.01, EP 1** The critical access hospital has a systematic approach to change and performance improvement. **LD.03.05.01, EP 2** Structures for managing change and performance improvement do the following: - Foster the safety of the patient and the quality of care, treatment, and services - Support a culture of safety and quality - Adapt to changes in the environment **LD.03.05.01, EP 3** Leaders evaluate the effectiveness of processes for the management of change and performance improvement. **LD.03.07.01, EP 1** The critical access hospital has an effective, ongoing, data-driven performance improvement program that occurs organizationwide. **LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following:	performance improvement program. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital maintains and demonstrates evidence of its QAPI program for review by CMS.

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		- Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment **PI.03.01.01, EP 4** The critical access hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. **PI.03.01.01, EP 8** The critical access hospital uses the results of data analysis to identify improvement opportunities.	
§485.641(a)	(a) Definitions. For the purposes of this section— Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof. Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems; and Medical error means an error that occurs in the delivery of healthcare services.		

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§485.641(b)	(b) Standard: QAPI Program Design and scope. The CAH's QAPI program must:		
§485.641(b)(1)	(1) Be appropriate for the complexity of the CAH's organization and services provided.	**LD.01.03.01, EP 21** The governing body is responsible for the performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract; and use objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.04.03.09) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital is not required to participate in a quality improvement organization (QIO) cooperative project, but its own projects are required to be of comparable effort.	**LD.11.01.01, EP 8** The governing body or designated individual is responsible and accountable for the quality assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.14.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.
§485.641(b)(2)	(2) Be ongoing and comprehensive.	**LD.01.03.01, EP 21** The governing body is responsible for the performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract; and use objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services,	**LD.11.01.01, EP 8** The governing body or designated individual is responsible and accountable for the quality assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract or arrangement; and focuses on indicators

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		see Standard LD.04.03.09) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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.	related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.14.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.
§485.641(b)(3)	(3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement).	**LD.01.03.01, EP 21** The governing body is responsible for the performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract; and use objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.04.03.09) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital is not required to participate in a quality improvement organization (QIO) cooperative project, but its own projects are required to be of comparable effort.	**LD.11.01.01, EP 8** The governing body or designated individual is responsible and accountable for the quality assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.14.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.
§485.641(b)(4)	(4) Use objective measures to evaluate its organizational processes, functions and services.	**LD.01.03.01, EP 21** The governing body is responsible for the performance improvement program. The governing body makes sure	**LD.11.01.01, EP 8** The governing body or designated individual is responsible and accountable for the quality

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract; and use objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.04.03.09) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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.	assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.14.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.
§485.641(b)(5)	(5) Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.	**LD.03.02.01, EP 5** The performance improvement program addresses outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, sentinel events, critical access hospital–acquired conditions, and transitions of care, including unplanned readmissions.	**PI.11.01.01, EP 1** The performance improvement program addresses outcome indicators related to the following: - Improved health outcomes and the prevention and reduction of medical errors - Adverse events - Sentinel events - Health care–acquired conditions - Transitions of care, including unplanned readmissions
§485.641(c)	(c) Standard: Governance and leadership. The CAH's governing body or responsible individual is ultimately responsible for the CAH's QAPI program and is responsible and accountable for ensuring that the QAPI program	**LD.01.03.01, EP 21** The governing body is responsible for the performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are ongoing and comprehensive; involve all departments and services, including those services	**LD.11.01.01, EP 8** The governing body or designated individual is responsible and accountable for the quality assessment and performance improvement program. The governing body makes sure that performance improvement activities reflect the complexity of the critical access hospital's organization and services; are

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	meets the requirements of paragraph (b) of this section.	provided under contract; and use objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.04.03.09) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access 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.	ongoing and comprehensive; involve all departments and services, including those services provided under contract or arrangement; and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors and objective measures to evaluate its organizational processes, functions, and services. (For more information on contracted services, see Standard LD.14.03.03) Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: If the hospital does not have a governing body, it identifies the leadership structure that is responsible for these activities.
§485.641(d)	(d) Standard: Program activities. For each of the areas listed in paragraph (b) of this section, the CAH must:		
§485.641(d)(1)	(1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment	**LD.12.01.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas - Identify the frequency and detail of data collection for performance improvement activities - Use measures to analyze and track performance
§485.641(d)(2)	(2) Use the measures to analyze and track its performance.	**PI.03.01.01, EP 3** The critical access hospital uses statistical tools and	**LD.12.01.01, EP 2** As part of performance improvement, leaders

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		techniques to analyze and display data. **PI.03.01.01, EP 4** The critical access hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. **PI.03.01.01, EP 8** The critical access hospital uses the results of data analysis to identify improvement opportunities.	(including the governing body) do the following: - Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas - Identify the frequency and detail of data collection for performance improvement activities - Use measures to analyze and track performance
§485.641(d)(3)	(3) Set priorities for performance improvement, considering either high-volume, high-risk services, or problem-prone areas.	**LD.03.07.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities and patient health outcomes - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities - Identify the frequency of data collection for performance improvement activities - Reprioritize performance improvement activities in response to changes in the internal or external environment	**LD.12.01.01, EP 2** As part of performance improvement, leaders (including the governing body) do the following: - Set priorities for performance improvement activities related to improved health outcomes that are shown to be predictive of desired patient outcomes, patient safety, and quality of care - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities and consider the incidence, prevalence, and severity of problems in those areas - Identify the frequency and detail of data collection for performance improvement activities - Use measures to analyze and track performance
§485.641(e)	(e) Standard: Program data collection and analysis. The program must incorporate quality indicator data including patient care data, and other relevant data, in order to achieve the goals of the QAPI program.	**LD.03.02.01, EP 1** Leaders set expectations for using data and information, including patient care data and other relevant data, for the following: - Improving the safety and quality of care, treatment, or services in order to achieve the goals of the performance improvement program	**PI.11.01.01, EP 2** The critical access hospital has an ongoing quality assessment and performance improvement program that shows measurable improvement for indicators that are selected based on evidence that they will improve health outcomes and aid in the identification and reduction of medical errors. The program incorporates

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Creating a culture of safety and quality - Decision making that supports the safety and quality of care, treatment, and services - Identifying and responding to internal and external changes in the environment **PI.03.01.01, EP 4** The critical access hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. **PI.03.01.01, EP 8** The critical access hospital uses the results of data analysis to identify improvement opportunities. **PI.04.01.01, EP 2** The critical access hospital acts on improvement priorities. **PI.04.01.01, EP 5** The critical access hospital acts when it does not achieve or sustain planned improvements.	quality indicator data, including patient care data and other relevant data to achieve the goals of the program. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Relevant data includes data submitted to or received from Medicare quality reporting and quality performance programs including but not limited to data related to hospital readmissions and hospital-acquired conditions. **PI.14.01.01, EP 1** The critical access hospital acts on improvement priorities.
§485.641(f)	(f) Standard: Unified and integrated QAPI program for a CAH in a multifacility system. If a CAH is part of a system consisting of multiple separately certified hospitals, CAHs, and/or REHs using a system governing body that is legally responsible for the conduct of two or more hospitals, CAHs, and/or REHs, the system governing body can elect to have a	**LD.01.03.01, EP 14** If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable	**LD.11.01.01, EP 9** If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision

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	unified and integrated QAPI program for all of its member facilities after determining that such a decision is in accordance with all applicable State and local laws. The system governing body is responsible and accountable for ensuring that each of its separately certified CAHs meets all of the requirements of this section. Each separately certified CAH subject to the system governing body must demonstrate that:	state and local laws. The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered in each critical access 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	is in accordance with all applicable state and local laws. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641.
§485.641(f)(1)	(1) The unified and integrated QAPI program is established in a manner that takes into account each member CAH's unique circumstances and any significant differences in patient populations and services offered in each CAH; and	**LD.01.03.01, EP 14** If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local laws. The system governing body is	**LD.11.01.01, EP 9** If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered in each critical access 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	laws. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641.
§485.641(f)(2)	(2) The unified and integrated QAPI program establishes and implements policies and procedures to ensure that the needs and concerns of each of its separately certified CAHs, regardless of practice or location, are given due consideration, and that the unified and integrated QAPI program has mechanisms in place to ensure that issues localized to particular CAHs are duly considered and addressed.	**LD.01.03.01, EP 14** If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local laws. The system governing body is responsible and accountable for making certain that each	**LD.11.01.01, EP 9** If a critical access hospital is part of a system consisting of multiple separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, critical access hospitals, and/or rural emergency hospitals, the system governing body can elect to have a unified and integrated quality assessment and performance improvement program for all of its member facilities after determining that such decision is in accordance with all applicable state and local laws. Each separately certified critical access hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641. Each separately certified critical access hospital subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered in each critical access 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	subject to the system governing body demonstrates that the unified and integrated quality assessment and performance improvement program does the following: - Accounts for each member critical access hospital's unique circumstances and any significant differences in patient populations and services offered - Establishes and implements policies and procedures to make certain that the needs and concerns of each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated program has mechanisms in place to ensure that issues localized to particular critical access hospitals are duly considered and addressed Note: The system governing body is responsible and accountable for making certain that each of its separately certified critical access hospitals meets the requirements for quality assessment and performance improvement at 42 CFR 485.641.
§485.642	§ 485.642 Condition of participation: Discharge planning. A Critical Access Hospital (CAH) must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals	**PC.04.01.03, EP 7** The critical access hospital has an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and the patient's caregiver or support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process is consistent with the patient's goals for care and their treatment preferences, makes certain that there is an effective transition of the patient from the hospital to post-discharge care, and reduces the factors leading to preventable critical access hospital readmissions.	**PC.14.01.01, EP 1** The critical access hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the critical access hospital to postdischarge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The critical access hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes.

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	for care and his or her treatment preferences, ensure an effective transition of the patient from the CAH to post-discharge care, and reduce the factors leading to preventable CAH and hospital readmissions.		**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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include but are not limited to participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The critical access hospital sends a copy of the notice to a

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			representative of the office of the state's long-term care ombudsman.
§485.642(a)	(a) Standard: Discharge planning process. The CAH's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.	**PC.04.01.03, EP 2** The critical access hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. **PC.04.01.03, EP 4** Prior to discharge, the critical access 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.	**PC.14.01.01, EP 2** The critical access hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.14.01.01, EP 5** The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.
§485.642(a)(1)	(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-CAH care will be made before discharge and to avoid unnecessary delays in discharge.	**PC.04.01.03, EP 1** The critical access hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.04.01.03, EP 2** The critical access hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer.	**PC.14.01.01, EP 5** The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician.

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		PC.04.01.03, EP 4 Prior to discharge, the critical access 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.	Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.
§485.642(a)(2)	(2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post-CAH extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.	**PC.04.01.03, EP 2** The critical access hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. **PC.04.01.03, EP 4** Prior to discharge, the critical access 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.	**PC.14.01.01, EP 3** As part of the discharge planning evaluation, the critical access hospital evaluates the patient's need for appropriate post–critical access hospital services, including but not limited to hospice care services, extended care services, home health services, and non–health care services and community-based care providers. The critical access hospital also evaluates the availability of the appropriate services and the patient's access to those services as part of the discharge planning evaluation.
§485.642(a)(3)	(3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).	**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	**PC.14.01.01, EP 6** The critical access hospital discusses the results of the discharge planning evaluation with the patient or their representative, including any reevaluations performed and any arrangements made. **RC.12.01.01, EP 2** The medical record contains the following clinical information: - Admitting diagnosis - Any emergency care, treatment, and services provided

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		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 distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses. - Any consultation reports - Any observations relevant to care, treatment, and services - The patient's response to care, treatment, and services - Any emergency care, treatment, and services provided to the patient before their arrival - Any progress notes - All orders - Any medications ordered or prescribed - Any medications administered, including the strength, dose, route, date and time of administration Note 1: When rapid titration of a medication is necessary, the critical access 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	to the patient before their arrival - Any allergies to food and medications - Any findings of assessments and reassessments - Results of all consultative evaluations of the patient and findings by clinical and other staff involved in the care of the patient - Treatment goals, plan of care, and revisions to the plan of care - Documentation of complications, health care–acquired infections, and adverse reactions to drugs and anesthesia - All practitioners' orders - Nursing notes, reports of treatment, laboratory reports, vital signs, and other information necessary to monitor the patient's condition - Medication records, including the strength, dose, route, date and time of administration, access site for medication, administration devices used, and rate of administration Note: When rapid titration of a medication is necessary, the critical access hospital defines in policy the urgent/emergent situations in which block charting would be an acceptable form of documentation. For the definition and a further explanation of block charting, refer to the Glossary. - Administration of each self-administered medication, as reported by the patient (or the patient's caregiver or support person where appropriate) - Records of radiology and nuclear medicine services, including signed interpretation reports - All care, treatment, and services provided to the patient - Patient's response to care, treatment, and services

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		procedures - Any medications dispensed or prescribed on discharge - Discharge diagnosis - Discharge plan and discharge planning evaluation	- Medical history and physical examination, including any conclusions or impressions drawn from the information - Discharge plan and discharge planning evaluation - Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care, including any medications dispensed or prescribed on discharge - Any diagnoses or conditions established during the patient's course of care, treatment, and services Note: Medical records are completed within 30 days following discharge, including final diagnosis.
§485.642(a)(4)	(4) Upon the request of a patient's physician, the CAH must arrange for the development and initial implementation of a discharge plan for the patient.	**PC.04.01.03, EP 1** The critical access hospital begins the discharge planning process early in the patient's episode of care, treatment, and services. **PC.04.01.03, EP 2** The critical access hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer. **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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical	**PC.14.01.01, EP 5** The critical access hospital performs a discharge planning evaluation and creates a discharge plan for those patients it identifies at an early stage of hospitalization are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning or at the request of the patient, patient's representative, or the patient's physician. Note 1: The discharge planning evaluation is completed in a timely manner so that appropriate arrangements for post–hospital care are made before discharge and unnecessary delays in discharge are avoided. Note 2: The discharge planning evaluation is performed and subsequent discharge plan is created by, or under the supervision of, a registered nurse, social worker, or other qualified person.

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		access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move 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 critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **PC.04.01.03, EP 4** Prior to discharge, the critical access 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.	
§485.642(a)(5)	(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42	**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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for

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		CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 3** The critical access hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. **PC.04.01.03, EP 3** The patient, the patient's family, physicians, other 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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing	Medicare & Medicaid Services (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include but are not limited to participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.

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		mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move 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 critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.	
§485.642(a)(6)	(6) The CAH's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.	**PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note 1: 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. Note 2: For rehabilitation distinct part units in critical access hospitals: The Centers for Medicare & Medicaid Services requires that a physician with specialized training and experience in inpatient rehabilitation conducts at least three face-to-face patient visits per week. **PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.	**PC.14.01.01, EP 1** The critical access hospital has an effective discharge planning process that focuses on, and is consistent with, the patient's goals and treatment preferences; makes certain there is an effective transition of the patient from the critical access hospital to postdischarge care; and reduces the factors leading to preventable critical access hospital and hospital readmissions. Note: The critical access hospital's discharge planning process requires regular reevaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan is updated as needed to reflect these changes.

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		PC.01.03.01, EP 22 Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs.	
§485.642(a)(7)	(7) The CAH must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.	**PC.04.01.03, EP 10** The critical access hospital assesses its discharge planning process within its established time frames. The assessment includes ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient post-discharge needs.	**PC.14.01.01, EP 14** The critical access hospital assesses its discharge planning process on a regular basis, as defined by the critical access hospital. The assessment includes an ongoing, periodic review of a representative sample of discharge plans, including plans for patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient postdischarge needs.
§485.642(a)(8)	(8) The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's	**PC.04.01.01, EP 31** The critical access 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 critical access hospital makes certain that the post-acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences.	**PC.14.01.01, EP 7** The critical access hospital assists the patient, their family, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes but is not limited to home health agency, skilled nursing facility, inpatient rehabilitation facility, and long-term care hospital data on quality measures and resource-use measures. The critical access hospital makes certain that the post–acute care data on quality measures and resource-use measures is relevant and applicable to the patient's goals of care and treatment preferences.

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	goals of care and treatment preferences.		
§485.642(b)	(b) Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information. The CAH must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, postdischarge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.	**IM.02.01.01, EP 4** The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **PC.02.02.01, EP 1** The critical access hospital follows a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. **PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

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		- Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals	
§485.643	§485.643 Condition of Participation: Organ, Tissue, and Eye Procurement The CAH must have and implement written protocols that:		
§485.643(a)	§485.643(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;	**TS.01.01.01, EP 1** The critical access hospital has a written agreement with an organ procurement organization (OPO) and follows its rules and regulations. **TS.01.01.01, EP 9** The critical access 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 critical access 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	**TS.11.01.01, EP 1** The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: - A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes - Procedures for informing the family of each potential

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		https://www.aan.com/Guidelines/Home/GuidelineDetail/1085 and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC. **TS.01.01.01, EP 11** The organ procurement organization determines medical suitability of organs for organ donation and, in the absence of alternative arrangements by the critical access hospital, it determines the medical suitability of tissue and eyes for donation.	donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: Note: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used

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			alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.
§485.643(b)	§485.643(b) Incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;	**TS.01.01.01, EP 3** The critical access 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 critical access 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 critical access hospital to have a separate agreement with an eye bank if its OPO provides eye procurement services. The critical access hospital is not required to use the OPO for tissue or eye procurement, and is free to have an agreement with the tissue bank or eye bank of its choice.	**TS.11.01.01, EP 1** The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: - A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or

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			eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: Note: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.
§485.643(c)	§485.643(c) Ensure, in collaboration with the designated OPO, that the family of each	**TS.01.01.01, EP 6** The critical access hospital develops, in collaboration with the designated organ procurement organization,	**TS.11.01.01, EP 1** The critical access hospital develops and implements written policies and procedures for organ procurement

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	potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;	written procedures for notifying the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes. **TS.01.01.01, EP 7** The individual designated by the critical access 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. **TS.01.01.01, EP 8** The individual designated by the critical access hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor. **TS.01.01.01, EP 12** The critical access 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.	responsibilities that include the following: - A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO

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			that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: Note: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC. **TS.11.01.01, EP 3** The individual designated by the critical access hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.
§485.643(d)	§485.643(d) Encourage discretion and sensitivity with respect to the	**TS.01.01.01, EP 5** Staff education includes training in the use of discretion	**TS.11.01.01, EP 1** The critical access hospital develops and implements written policies and procedures for organ procurement

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	circumstances, views, and beliefs of the family of potential donors;	and sensitivity to the circumstances, beliefs, and desires of the families of potential organ, tissue, or eye donors.	responsibilities that include the following: - A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO

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			that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: Note: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.
§485.643(e)	§485.643(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement	**TS.01.01.01, EP 4** The critical access 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	**TS.11.01.01, EP 2** The critical access hospital develops and implements policies and procedures for working with the organ procurement organization (OPO) and tissue and eye banks to do the following: - Review death records in order to improve identification of potential donors - Maintain potential donors while the necessary testing and placement of potential donated organs, tissues,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	of potential donated organs, tissues, and eyes takes place.	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 critical access hospital, its medical staff, and the designated OPO. When the critical access hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the critical access hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the critical access hospital's justification for not providing for asystolic recovery.	and eyes takes place in order to maximize the viability of donor organs for transplant - Educate staff about issues surrounding donation
§485.643(f)	§485.643(f) For purpose of these standards, the term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).		**TS.11.01.01, EP 1** The critical access hospital develops and implements written policies and procedures for organ procurement responsibilities that include the following: - A written agreement with an organ procurement organization (OPO) that requires the critical access hospital to notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the critical access hospital, and that includes the OPO's responsibility to determine medical suitability for organ donation - A written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes to make certain that all usable tissues and eyes are obtained from potential donors, to the extent that the agreement does not interfere with organ procurement - Designation of an individual, who is an organ procurement representative, an organizational

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			representative of a tissue or eye bank, or a designated requestor, to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes - Procedures for informing the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes, in collaboration with the designated OPO - Education and training of staff in the use of discretion and sensitivity to the circumstances, views, and beliefs of the family when discussing potential organ, tissue, or eye donations Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486. Note 2: The requirements for a written agreement with at least one tissue bank and at least one eye bank may be satisfied through a single agreement with an OPO that provides services for organ, tissue, and eye, or by a separate agreement with another tissue and/or eye bank outside the OPO, chosen by the critical access hospital. Note 3: A designated requestor is an individual who has completed a course offered or approved by the OPO. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation. Note 4: The term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). Note 5: Note: For additional information about criteria for the determination of brain death, see the American Academy of Neurology guidelines available at https://n.neurology.org/content/early/2023/09/13/WNL.

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			0000000000207740, the American Academy of Pediatrics guidelines available at https://www.aan.com/Guidelines/Home/GuidelineDetail/1085, and the interactive tool that can be used alongside the new guidance to help walk clinicians through the BD/DNC evaluation process at https://www.aan.com/Guidelines/BDDNC.
§485.645	§485.645 Special Requirements for CAH Providers of Long-Term Care Services (“Swing-Beds”) A CAH must meet the following requirements in order to be granted an approval from CMS to provide post-CAH SNF care, as specified in §409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.		
§485.645(a)	§485.645(a) Eligibility A CAH must meet the following eligibility requirements:		
§485.645(a)(1)	(1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and		
§485.645(a)(2)	(2) The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.	**LD.04.01.01, EP 6** Except as permitted for critical access hospitals having distinct part units under 42 CFR 485.647, the critical access hospital maintains no more than 25 inpatient beds that can be used for either inpatient or swing bed services. Note: Any bed in a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility	**LD.13.01.01, EP 3** Except as permitted for critical access hospitals having distinct part units under 42 CFR 485.647, the critical access hospital maintains no more than 25 inpatient beds that can be used for either inpatient or swing bed services. Note: Any bed in a unit of the facility that is licensed as a distinct part skilled nursing facility at the time the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		applies to the state for designation as a critical access hospital is not counted in this 25-bed count.	facility applies to the state for designation as a critical access hospital is not counted in this 25-bed count.
§485.645(b)	§485.645(b) Facilities Participating as Rural Primary Care Hospitals (RPCHs) on September 30, 1997 These facilities must meet the following requirements:		
§485.645(b)(1)	(1) Notwithstanding paragraph (a) of this section, a hospital that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and limitations that were applicable at the time these approvals were granted.		
§485.645(b)(2)	(2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this section and may not request reinstatement		

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	under paragraph (b)(1) of this section.		
§485.645(c)	§485.645(c) Payment Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with §413.70 of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in §413.114 of this chapter.		
§485.645(d)	§485.645(d) SNF Services The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:		
§485.645(d)(1)	(1) Resident rights (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, and (h) of this chapter).	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The critical access hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **IM.02.01.01, EP 4** The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.	**IM.12.01.01, EP 1** The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records. **IM.12.01.01, EP 2** The critical access hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For swing beds in critical access hospitals: The critical access hospital allows representatives of the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.04.02.03, EP 13 For swing beds in critical access hospitals: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - The items and services included in the state plan for which the resident may not be charged - Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services **LD.04.02.03, EP 14** For swing beds in critical access hospitals: Residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13. **LD.04.02.03, EP 16** For swing beds in critical access hospitals: Residents are informed before or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services not covered under Medicare or by the facility's per diem rate. **MS.06.01.03, EP 6** The credentialing process requires that the critical access 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	Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law. **LD.13.02.01, EP 2** For swing beds in critical access hospitals: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the critical access hospital offers, those for which the resident may be charged, and the amount of charges for those services Note: The critical access hospital informs the resident when changes are made to the items and services. **LD.13.02.01, EP 3** For swing beds in critical access hospitals: The critical access hospital informs residents before or at the time of admission, and periodically during the resident's stay, of services available in the critical access hospital and of charges for those services not covered under Medicare, Medicaid, or by the critical access hospital's per diem rate. **PC.11.03.01, EP 2** The critical access hospital involves the patient in the development and implementation of their plan of care. Note: For swing beds in critical access hospitals: The resident has the right to be informed, in advance, of changes to their plan of care.

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		- The applicant's relevant training - The applicant's current competence **RI.01.01.01, EP 1** The critical access hospital has written policies on patient rights. Note: The critical access hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.01.01, EP 2** The critical access hospital informs the patient of the patient's rights. Note 1: The critical access 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: The critical access hospital informs each patient (or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.01.01, EP 5** The critical access hospital respects the patient's right to and need for effective communication. **RI.01.01.01, EP 6** The critical access hospital respects the patient's cultural	**RI.11.01.01, EP 5** The critical access hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For swing beds in critical access hospitals: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. **RI.11.01.01, EP 8** For swing beds in critical access hospitals: The critical access hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The critical access hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent. **RI.11.02.01, EP 1** The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

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		and personal values, beliefs, and preferences. **RI.01.01.01, EP 7** The critical access hospital respects the patient's right to privacy. Note: 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.02.01.01. **RI.01.01.03, EP 1** The critical access hospital provides information in a manner tailored to the patient's age, language, and ability to understand. **RI.01.01.03, EP 3** The critical access 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 critical access 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 critical access hospital. Note 1: 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 critical access	**RI.12.01.01, EP 1** The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate. **RI.12.01.01, EP 3** For swing beds in critical access hospitals: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

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		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 swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the critical access hospital involves a surrogate decision-maker in making these decisions. Note: For swing beds in critical access hospitals: The selection of the surrogate decision-maker is in accordance with state law. **RI.01.02.01, EP 3** The critical access hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. **RI.01.02.01, EP 4** The critical access hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. **RI.01.03.05, EP 3** The critical access hospital informs the patient that	**RI.12.01.01, EP 4** For swing beds in critical access hospitals: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive. **RI.12.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital supports the residents right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the critical access hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options. **RI.13.01.03, EP 1** For swing beds in critical access hospitals: The critical access hospital allows the resident to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service. **RI.13.01.03, EP 2** For swing beds in critical access hospitals: The critical

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		refusing to participate in research, investigation or clinical trials, or discontinuing participation at any time will not jeopardize the patient's access to care, treatment, and services unrelated to the research. **RI.01.05.01, EP 1** The critical access 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. - For outpatient settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Providing the patient upon admission with information on the extent to which the critical access hospital is able, unable, or unwilling to honor advance directives. - Whether the critical access hospital will honor advance directives in its outpatient settings. - That the critical access 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: 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.	access hospital allows the resident to share a room with their spouse when married residents are living in the same critical access hospital and when both individuals consent to the arrangement. **RI.13.01.03, EP 3** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to send and promptly receive unopened mail and to receive letters, packages, and other materials delivered to the critical access hospital for the resident through a means other than a postal service. The critical access hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.

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		RI.01.06.05, EP 1 For swing beds in critical access hospitals: The critical access hospital's environment of care supports the resident's positive self-image and dignity. **RI.01.06.05, EP 4** For swing beds in critical access hospitals: The critical access hospital allows the resident to keep and use personal clothing and possessions, unless this infringes on others' rights or is medically or therapeutically contraindicated, based on the setting or service. **RI.01.06.05, EP 8** For swing beds in critical access hospitals: The resident has a right to share a room with their spouse when married residents are living in the same facility and when both individuals consent to the arrangement. **RI.01.06.05, EP 14** For swing beds in critical access hospitals: The resident has the right to have access to stationery, postage, and writing implements at the resident's own expense. **RI.01.06.05, EP 15** The critical access hospital offers patients telephone and mail service, based on the setting and population. **RI.01.06.05, EP 16** The critical access hospital provides access to telephones for patients who desire private telephone conversations in a private space, based on the setting and population.	

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		RI.01.06.09, EP 1 For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options. **RI.01.06.11, EP 1** For swing beds in critical access hospitals: The critical access hospital provides the resident and the resident's family with the name, specialty, and telephone number of the physician or other licensed practitioner primarily responsible for the resident's care. **RI.01.07.05, EP 1** For swing beds in critical access hospitals: The critical access hospital establishes liberal visiting hours that are limited only by the resident's personal preferences. **RI.01.07.05, EP 3** For swing beds in critical access hospitals: The critical access hospital provides space for the resident to receive visitors in comfort and privacy. **RI.01.07.05, EP 5** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose with whom the resident communicates.	

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		RI.01.07.05, EP 6 For swing beds in critical access hospitals: The critical access hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident.	
§485.645(d)(2)	(2) Admission, transfer, and discharge rights (§483.5, §483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), and (c)(9) of this chapter).	**PC.04.01.01, EP 14** The critical access hospital transfers a patient upon order of their attending physician. **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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move 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.	**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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include but are not limited to participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **PC.04.01.03, EP 5** For swing beds in critical access hospitals: 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 critical access hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.03, EP 6** For swing beds in critical access hospitals: 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	provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **PC.14.01.01, EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days. **PC.14.01.01, EP 13** For swing beds in critical access hospitals: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests;

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		find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act **PC.04.01.05, EP 1** When the critical access hospital determines the patient's discharge or transfer needs, it promptly shares this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care. **PC.04.01.05, EP 2** Before the patient is discharged, the critical access 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. **PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical	information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act **PC.14.01.03, EP 1** For swing beds in critical access hospitals: The critical access hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the critical access hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access 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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose. **PC.14.01.03, EP 2** For critical access hospitals with swing beds: In the case of critical access hospital closure, the administrator of the critical access hospital provides written notification prior to the impending closure to the state survey agency, the office of the state's long-term care ombudsman, residents of the critical access hospital, and the residents' representatives, as well as the plan for the transfer and adequate relocation of the residents.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.04.01.07, EP 2 For critical access hospitals with swing beds: In the case of critical access hospital closure, the individual who is the administrator of the critical access hospital must provide written notification prior to the impending closure to the state survey agency, the office of the state's long-term care ombudsman, residents of the critical access hospital, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents. **PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care,	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care **RC.11.01.01, EP 2** The medical record includes the following: - Information needed to justify the patient's admission and continued care, treatment, and services

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		when appropriate - Comprehensive care plan goals **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 critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.02.04.01, EP 1** For swing beds in critical access hospitals: 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 critical access 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.	- Information needed to support the patient's diagnosis and condition - Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers Note: For critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RC.12.03.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician document in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the critical access hospital's swing bed. **RC.12.03.01, EP 2** For swing beds in critical access hospitals: The resident's discharge information includes the following: - Reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		RC.02.04.01, EP 2 For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs **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 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	the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge - Attempts to meet the resident's needs **RC.12.03.01, EP 3** For swing beds in critical access hospitals: When the resident is transferred or discharged because the critical access hospital cannot meet their needs, the critical access hospital documents which needs could not be met, the critical access hospital's attempts to meet the resident's needs, and the services available at the receiving organization that will meet the resident's needs. **RC.12.03.01, EP 4** For swing beds in critical access hospitals: The critical access hospital records the reasons for the transfer or discharge in the resident's medical record in accordance with 42 CFR 483.15(c)(2).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Information provided to the patient and family - Provisions for follow-up care - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access 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. **RI.01.01.01, EP 5** The critical access hospital respects the patient's right to and need for effective communication. **RI.01.01.03, EP 1** The critical access hospital provides information in a manner tailored to the patient's age, language, and ability to understand. **RI.01.06.05, EP 19** For swing beds in critical access hospitals: Room changes in an organization that is a composite distinct part (a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in 42 CFR 413.65(a)(2)) are limited to moves within the particular building in which	**RI.11.02.01, EP 1** The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs. **RI.13.01.03, EP 4** For swing beds in critical access hospitals: Room changes in an organization that is a composite distinct part (a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in 42 CFR 413.65(a)(2)) are limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.	
§485.645(d)(3)	(3) Freedom from abuse, neglect and exploitation (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) of this chapter).	**HR.01.01.01, EP 18** For swing beds in critical access hospitals: The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property. **PC.01.02.09, EP 7** The critical access hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. **PC.01.02.09, EP 8** For swing beds in critical access hospitals: The critical access hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **PC.03.05.01, EP 1** The critical access hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. **PC.03.05.01, EP 2** The critical access hospital does not use restraint or	**HR.11.02.01, EP 4** For swing beds in critical access hospitals: The critical access hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property. **PC.13.02.01, EP 1** The critical access hospital does not use restraint or seclusion of any form as a means of coercion, discipline, convenience, or staff retaliation. Restraint or seclusion is only used to protect the immediate physical safety of the patient, staff, or others when less restrictive interventions have been ineffective and is discontinued at the earliest possible time, regardless of the length of time specified in the order. **PC.13.02.01, EP 2** The critical access hospital uses the least restrictive form of restraint or seclusion that will be effective to protect the patient, a staff member, or others from harm. **RI.13.01.01, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		seclusion as a means of coercion, discipline, convenience, or staff retaliation. **PC.03.05.01, EP 3** The critical access hospital uses restraint or seclusion only when less restrictive interventions are ineffective. **PC.03.05.01, EP 4** The critical access hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others. **PC.03.05.01, EP 5** The critical access hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order. **RI.01.06.01, EP 1** For swing beds in critical access hospitals: The critical access hospital has policies and procedures that support the resident's right to be free from chemical and physical restraint. Note: The critical access hospital's use of restraint is consistent with the requirements in the "Provision of Care, Treatment, and Services" (PC) chapter. **RI.01.06.03, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For critical access hospitals with swing beds: The critical access hospital protects residents from	sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property. **RI.13.01.01, EP 2** For swing beds in critical access hospitals: The critical access hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **RI.13.01.01, EP 3** For critical access hospitals with swing beds: The critical access hospital develops and implements written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues. **RI.13.01.01, EP 4** The critical access hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events or as required by law. Note: For swing beds in critical access hospitals: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		For critical access hospitals with swing beds: The critical access 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 actions is taken.	
§485.645(d)(4)	(4) Social services (§483.40(d) of this chapter).	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **HR.01.01.01, EP 3** The critical access hospital verifies and documents that the applicant has the education and experience required by the job responsibilities.	**PC.14.02.01, EP 2** For swing beds in critical access hospitals: The critical access hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		LD.03.06.01, EP 2 Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge.	
§485.645(d)(5)	(5) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical	**PC.11.02.01, EP 6** For swing beds in critical access hospitals: The critical access hospital completes the resident's comprehensive assessment within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. Note: For this element of performance, the term "readmission'' means a return to the critical access hospital following a temporary absence for hospitalization or for therapeutic leave. **PC.11.02.01, EP 7** For swing beds in critical access hospitals: The critical access hospital conducts a comprehensive

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access 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 B for 409.17 requirements. **HR.01.01.01, EP 3** The critical access hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **LD.03.08.01, EP 1** The critical access 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"	assessment within 14 calendar days after it determines that there has been a significant change in the resident's physical or mental condition. Note: For this element of performance, the term "significant change'' means a major decline or improvement in the resident's status that will not resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires interdisciplinary review or revision of the care plan, or both. **PC.11.02.01, EP 8** For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months. **PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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. **PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning **PC.01.02.01, EP 27** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes documentation of summary information about the additional assessment(s) performed through the resident assessment protocols.	- Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise. **PC.11.02.01, EP 12** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes documentation of summary information about the additional assessment(s) performed through the resident assessment protocols. **PC.11.02.01, EP 13** For swing beds in critical access hospitals: The comprehensive assessment includes direct observation and communication with the resident and communication with staff members on all shifts. **PC.11.03.01, EP 1** The critical access hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.01.02.01, EP 28 For swing beds in critical access hospitals: The comprehensive assessment of the resident includes documentation of the resident's participation in the assessment. **PC.01.02.03, EP 14** For swing beds in critical access hospitals: The critical access hospital specifies that each resident's comprehensive assessment is completed within 14 calendar days after admission. **PC.01.02.03, EP 15** For swing beds in critical access hospitals: A comprehensive assessment is conducted within 14 calendar days after the critical access hospital determines that there has been a significant change in the resident's physical or mental condition. **PC.01.02.03, EP 16** For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months. **PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary	services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress. Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as needed by a physician in consultation with other professional staff who provide services to the patient. **PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff. **PC.01.03.01, EP 4** For swing beds in critical access hospitals: The critical access hospital develops the resident's written plan of care as soon as possible after admission, but no later than seven calendar days after the resident's comprehensive assessments are completed. **PC.01.03.01, EP 22** Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The critical access hospital revises plans and goals for care, treatment, and services based on the patient's needs. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.04.06, EP 1** For critical access hospitals with swing beds: The interdisciplinary team works in partnership with the resident to achieve planned outcomes.	psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is included in the resident's medical record. **PC.11.03.01, EP 8** For swing beds in critical access hospitals: The critical access hospital develops the resident's written comprehensive plan of care as soon as possible after admission, but no later than seven calendar days after the resident's comprehensive assessments are completed. **PC.11.03.01, EP 9** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment. **RC.12.03.01, EP 5** For swing beds in critical access hospitals: When the critical access hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		PC.02.04.06, EP 2 For critical access hospitals with swing beds: The interdisciplinary team involves the resident and the resident's representative in the development of the treatment plan. Note: The treatment plan includes the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations. Disagreement with PASARR recommendations is documented in the resident's record. - The resident's goals for admission and desired outcomes. - The resident's preferences and potential for future discharge. - Discharge plans. - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs. **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access hospital's swing bed. There is documentation in the	- 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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs **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 discharge summary that includes the following: - The reason for hospitalization	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access 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.	
§485.645(d)(6)	(6) Specialized rehabilitative services (§483.65 of this chapter).	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **LD.04.03.01, EP 8** The critical access hospital furnishes services that include medical history, physical examination, specimen	**PC.11.03.01, EP 1** The critical access hospital develops, implements, and revises a written individualized plan of care based on the following: - Needs identified by the patient's assessment, reassessment, and results of diagnostic testing - The patient's goals and the time frames, settings, and services required to meet those goals Note 1: Nursing staff develops and keeps current a nursing plan of care, which may be a part of an interdisciplinary plan of care, for each inpatient. Note 2: The hospital evaluates the patient's progress and revises the plan of care based on the patient's progress.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		collection, assessment of health status, and treatment for a variety of medical conditions. **PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital provides residents with specialized rehabilitation services as indicated by the written order of a physician. **PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 3** The critical access hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. **PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical	Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as needed by a physician in consultation with other professional staff who provide services to the patient. **PC.12.01.01, EP 1** Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care. **PC.14.02.01, EP 8** For swing beds in critical access hospitals: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. **PC.02.02.01, EP 10** When the critical access hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.	occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the critical access hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act.
§485.645(d)(7)	(7) Dental services (§483.55(a)(2), (3), (4), and (5) and (b) of this chapter).	**PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. **PC.02.02.01, EP 10** When the critical access hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **PC.02.02.01, EP 12** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services. **PC.02.02.01, EP 29** For critical access hospitals with swing beds: The critical access hospital follows its policy identifying	**PC.14.02.01, EP 3** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services. **PC.14.02.01, EP 4** For swing beds in critical access hospitals: The critical access hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility, and it may not charge a resident for the loss or damage of dentures. **PC.14.02.01, EP 5** For swing beds in critical access hospitals: If necessary or requested, the critical access hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility and it may not charge a resident for the loss or damage of dentures. **PC.02.02.01, EP 30** For critical access hospitals with swing beds: The critical access hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the critical access hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay. **RI.01.06.11, EP 3** For swing beds in critical access hospitals: The critical access hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1** For swing beds in critical access hospitals: The critical access hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	**PC.14.02.01, EP 6** For critical access hospitals with swing beds: The critical access hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the critical access hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay. **PC.14.02.01, EP 7** For swing beds in critical access hospitals: The critical access hospital provides or obtains from an outside resource routine (to the extent covered under the state plan) and emergency dental services.
§485.645(d)(8)	(8) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning **PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note 1: 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. Note 2: For rehabilitation distinct part units in critical access hospitals: The Centers for Medicare & Medicaid Services requires that a physician with specialized training and experience in inpatient rehabilitation conducts at least three face-to-face patient visits per week. **PC.01.02.03, EP 15** For swing beds in critical access hospitals: A comprehensive assessment is conducted within 14 calendar days after the critical access hospital determines that there has been a significant change in	- Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise. **PC.12.01.09, EP 3** For swing beds in critical access hospitals: The critical access hospital offers the resident sufficient fluid intake to maintain proper hydration and health.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the resident's physical or mental condition. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.02.03, EP 7** Food and nutrition products are consistent with each patient's care, treatment, and services. Note 1: The nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the physician or other licensed practitioner responsible for the care of inpatients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to inpatients receiving posthospital skilled nursing facility care.	
§483.5	§483.5 Definitions. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.		
§483.10	§483.10 Resident rights.		
§483.10(b)(7)	(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights	**RI.01.01.01, EP 1** The critical access hospital has written policies on patient rights. Note: The critical access hospital's written policies	**RI.12.01.01, EP 3** For swing beds in critical access hospitals: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.	address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.02.01, EP 1** The critical access 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 critical access hospital. Note 1: 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 critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the critical access hospital involves a surrogate decision-maker in making these decisions.	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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: For swing beds in critical access hospitals: The selection of the surrogate decision-maker is in accordance with state law.	
§483.10(b)(7)(i)	(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.	**RI.01.01.01, EP 1** The critical access hospital has written policies on patient rights. Note: The critical access hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.02.01, EP 1** The critical access 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 critical access hospital. Note 1: 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 critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of	**RI.12.01.01, EP 3** For swing beds in critical access hospitals: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		changes to their plan of care. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the critical access hospital involves a surrogate decision-maker in making these decisions. Note: For swing beds in critical access hospitals: The selection of the surrogate decision-maker is in accordance with state law.	
§483.10(b)(7)(ii)	(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.	**RI.01.01.01, EP 1** The critical access hospital has written policies on patient rights. Note: The critical access hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations. **RI.01.01.01, EP 6** The critical access hospital respects the patient's cultural and personal values, beliefs, and preferences. **RI.01.02.01, EP 1** The critical access 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 critical access hospital. Note 1: 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	**RI.12.01.01, EP 3** For swing beds in critical access hospitals: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		group/entity, as well as all applicable post–acute care services providers and suppliers. The critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care. **RI.01.02.01, EP 2** When a patient is unable to make decisions about their care, treatment, and services, the critical access hospital involves a surrogate decision-maker in making these decisions. Note: For swing beds in critical access hospitals: The selection of the surrogate decision-maker is in accordance with state law.	
§483.10(b)(7)(iii)	(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.	**RI.01.02.01, EP 1** The critical access 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 critical access hospital. Note 1: 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	**RI.12.01.01, EP 3** For swing beds in critical access hospitals: If a resident is adjudged incompetent under state law by a court of proper jurisdiction, the rights of the resident automatically transfer to and are exercised by a resident representative appointed by the court under state law to act on the resident's behalf. The resident representative exercises the resident's rights to the extent allowed by the court in accordance with state law. Note 1: If a resident representative's decision-making authority is limited by state law or court appointment,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		services providers and suppliers. The critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care.	the resident retains the right to make those decisions outside the representative's authority. Note 2: The resident's wishes and preferences are considered by the representative when exercising the patient's rights. Note 3: To the extent practicable, the resident is provided with opportunities to participate in the care planning process.
§483.10(c)	(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including:		**RI.12.01.01, EP 1** The patient or their representative (as allowed, in accordance with state law) has the right to make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This does not mean the patient has the right to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
§483.10(c)(1)	(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	**RI.01.01.01, EP 2** The critical access hospital informs the patient of the patient's rights. Note 1: The critical access 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: The critical access hospital informs each patient	**RI.11.02.01, EP 1** The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.

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		(or support person, where appropriate) of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. **RI.01.01.01, EP 5** The critical access hospital respects the patient's right to and need for effective communication. **RI.01.01.03, EP 1** The critical access hospital provides information in a manner tailored to the patient's age, language, and ability to understand. **RI.01.01.03, EP 3** The critical access 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 critical access 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 critical access hospital. Note 1: 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 critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care.	
§483.10(c)(2)	(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:		
§483.10(c)(2)(iii)	(iii) The right to be informed, in advance, of changes to the plan of care.	**RI.01.02.01, EP 1** The critical access 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 critical access hospital. Note 1: 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 critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations.	**PC.11.03.01, EP 2** The critical access hospital involves the patient in the development and implementation of their plan of care. Note: For swing beds in critical access hospitals: The resident has the right to be informed, in advance, of changes to their plan of care.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care.	
§483.10(c)(6)	(6) The right to request, refuse, and/ or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	**RI.01.02.01, EP 1** The critical access 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 critical access hospital. Note 1: 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 critical access hospital has a process for documenting a patient's refusal to permit notification of registration to the emergency department, admission to an inpatient unit, or discharge or transfer from the emergency department or inpatient unit. Notifications with primary care practitioners and entities are in accordance with all applicable federal and state laws and regulations. Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of changes to their plan of care. **RI.01.02.01, EP 3** The critical access hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. **RI.01.02.01, EP 4**	**RI.12.01.01, EP 4** For swing beds in critical access hospitals: The resident has the right to request, refuse, and/or discontinue treatment; to participate in or refuse to participate in experimental research; and to formulate an advance directive.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access hospital respects the right of the patient or surrogate decision-maker to refuse care, treatment, and services in accordance with law and regulation. **RI.01.03.05, EP 3** The critical access hospital informs the patient that refusing to participate in research, investigation or clinical trials, or discontinuing participation at any time will not jeopardize the patient's access to care, treatment, and services unrelated to the research. **RI.01.05.01, EP 1** The critical access 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. - For outpatient settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided. - Providing the patient upon admission with information on the extent to which the critical access hospital is able, unable, or unwilling to honor advance directives. - Whether the critical access hospital will honor advance directives in its outpatient settings. - That the critical access 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,	

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		treatment, and services whether or not the patient has an advance directive. Note: The patient's right to formulate advance directives and have staff and licensed practitioners comply with these directives is in accordance with 42 CFR 489.100, 489.102, and 489.104.	
§483.10(d)	(d) Choice of attending physician. The resident has the right to choose his or her attending physician.	**RI.01.06.09, EP 1** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	**RI.12.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital supports the residents right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the critical access hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(1)	(1) The physician must be licensed to practice, and	**MS.06.01.03, EP 6** The credentialing process requires that the critical access hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information: - The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration - The applicant's relevant training - The applicant's current competence	**RI.12.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital supports the residents right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the critical access hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The critical access hospital informs the resident if it determines that the physician chosen by

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			the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(2)	(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.	**RI.01.06.09, EP 1** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	**RI.12.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital supports the residents right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the critical access hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(3)	(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.	**RI.01.06.11, EP 1** For swing beds in critical access hospitals: The critical access 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.	
§483.10(d)(4)	(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks	**RI.01.06.09, EP 1** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The critical access hospital informs the resident if it determines that the physician chosen by the resident is	**RI.12.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital supports the residents right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending

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	alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.	unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	physicians at 42 CFR 483, the critical access hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(d)(5)	(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.	**RI.01.06.09, EP 1** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose an attending physician, dentist, and other care providers. Note: The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.	**RI.12.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital supports the residents right to choose a licensed attending physician. Note: If the physician chosen by the resident refuses to or does not meet the requirements for attending physicians at 42 CFR 483, the critical access hospital may seek alternative physician participation to assure provision of appropriate and adequate care and treatment. The critical access hospital informs the resident if it determines that the physician chosen by the resident is unlicensed or unable to serve as the attending physician. The critical access hospital also discusses alternative physician participation with the resident and honors the resident's preferences, if any, among the options.
§483.10(e)	(e) Respect and dignity. The resident has a right to be treated with respect and dignity, including:		
§483.10(e)(2)	(2) The right to retain and use personal possession, including furnishings, and clothing, as space permits, unless to do so would	**RI.01.06.05, EP 4** For swing beds in critical access hospitals: The critical access hospital allows the resident to keep and use personal clothing and possessions, unless this infringes	**RI.13.01.03, EP 1** For swing beds in critical access hospitals: The critical access hospital allows the resident to keep and use personal clothing and possessions, unless this infringes

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	infringe upon the rights or health and safety of other residents.	on others' rights or is medically or therapeutically contraindicated, based on the setting or service.	on others' rights or is medically or therapeutically contraindicated, based on the setting or service.
§483.10(e)(4)	(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.	**RI.01.06.05, EP 8** For swing beds in critical access hospitals: The resident has a right to share a room with their spouse when married residents are living in the same facility and when both individuals consent to the arrangement.	**RI.13.01.03, EP 2** For swing beds in critical access hospitals: The critical access hospital allows the resident to share a room with their spouse when married residents are living in the same critical access hospital and when both individuals consent to the arrangement.
§483.10(f)(4)(ii)	(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;	**RI.01.07.05, EP 1** For swing beds in critical access hospitals: The critical access hospital establishes liberal visiting hours that are limited only by the resident's personal preferences. **RI.01.07.05, EP 5** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose with whom the resident communicates. **RI.01.07.05, EP 6** For swing beds in critical access hospitals: The critical access hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident.	**RI.11.01.01, EP 8** For swing beds in critical access hospitals: The critical access hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The critical access hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent.
§483.10(f)(4)(iii)	(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;	**RI.01.07.05, EP 1** For swing beds in critical access hospitals: The critical access hospital establishes liberal visiting hours that are limited only by the resident's personal preferences. **RI.01.07.05, EP 5** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to choose with whom the resident communicates.	**RI.11.01.01, EP 8** For swing beds in critical access hospitals: The critical access hospital provides immediate family and other relatives immediate access to the resident, except when the resident denies or withdraws consent. The critical access hospital provides others who are visiting immediate access to the resident, except when reasonable clinical or safety restrictions apply or when the resident denies or withdraws consent.

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		RI.01.07.05, EP 6 For swing beds in critical access hospitals: The critical access hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident.	
§483.10(g)(8)	(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:	**RI.01.06.05, EP 15** The critical access hospital offers patients telephone and mail service, based on the setting and population.	**RI.13.01.03, EP 3** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to send and promptly receive unopened mail and to receive letters, packages, and other materials delivered to the critical access hospital for the resident through a means other than a postal service. The critical access hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(g)(8)(i)	(i) Privacy of such communications consistent with this section; and	**RI.01.01.01, EP 7** The critical access hospital respects the patient's right to privacy. Note: 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.02.01.01.	**RI.13.01.03, EP 3** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to send and promptly receive unopened mail and to receive letters, packages, and other materials delivered to the critical access hospital for the resident through a means other than a postal service. The critical access hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(g)(8)(ii)	(ii) Access to stationery, postage, and writing implements at the resident's own expense.	**RI.01.06.05, EP 14** For swing beds in critical access hospitals: The resident has the right to have access to stationery, postage, and writing implements at the resident's own expense.	**RI.13.01.03, EP 3** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to send and promptly receive unopened mail and to receive

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			letters, packages, and other materials delivered to the critical access hospital for the resident through a means other than a postal service. The critical access hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(g)(17)	(17) The facility must—		
§483.10(g)(17)(i)	(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—		
§483.10(g)(17)(i)(A)	(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;	**LD.04.02.03, EP 13** For swing beds in critical access hospitals: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - The items and services included in the state plan for which the resident may not be charged - Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services	**LD.13.02.01, EP 2** For swing beds in critical access hospitals: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the critical access hospital offers, those for which the resident may be charged, and the amount of charges for those services Note: The critical access hospital informs the resident when changes are made to the items and services.
§483.10(g)(17)(i)(B)	(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	**LD.04.02.03, EP 13** For swing beds in critical access hospitals: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - The items and services included in the state plan for which the resident may not be charged - Those items and services that the facility offers and for	**LD.13.02.01, EP 2** For swing beds in critical access hospitals: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the critical access hospital

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		which the resident may be charged, and the amount of charges for those services	offers, those for which the resident may be charged, and the amount of charges for those services Note: The critical access hospital informs the resident when changes are made to the items and services.
§483.10(g)(17)(ii)	(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	**LD.04.02.03, EP 14** For swing beds in critical access hospitals: Residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13.	**LD.13.02.01, EP 2** For swing beds in critical access hospitals: Each Medicaid-eligible resident is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following: - Items and services included in the state plan for which the resident may not be charged - Items and services that the critical access hospital offers, those for which the resident may be charged, and the amount of charges for those services Note: The critical access hospital informs the resident when changes are made to the items and services.
§483.10(g)(18)	(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	**LD.04.02.03, EP 16** For swing beds in critical access hospitals: 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.	**LD.13.02.01, EP 3** For swing beds in critical access hospitals: The critical access hospital informs residents before or at the time of admission, and periodically during the resident's stay, of services available in the critical access hospital and of charges for those services not covered under Medicare, Medicaid, or by the critical access hospital's per diem rate.
§483.10(h)	(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The critical access hospital uses health information only	**IM.12.01.01, EP 1** The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.

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		for purposes permitted by law and regulation or as further limited by its policy on privacy. **IM.02.01.01, EP 4** The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **RI.01.01.01, EP 7** The critical access hospital respects the patient's right to privacy. Note: 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.02.01.01. **RI.01.06.05, EP 16** The critical access hospital provides access to telephones for patients who desire private telephone conversations in a private space, based on the setting and population.	
§483.10(h)(1)	(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The critical access hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy.	**RI.11.01.01, EP 5** The critical access hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For swing beds in critical access hospitals: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and

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		IM.02.01.01, EP 4 The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **RI.01.01.01, EP 7** The critical access hospital respects the patient's right to privacy. Note: 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.02.01.01. **RI.01.06.05, EP 1** For swing beds in critical access hospitals: The critical access hospital's environment of care supports the resident's positive self-image and dignity. **RI.01.06.05, EP 16** The critical access hospital provides access to telephones for patients who desire private telephone conversations in a private space, based on the setting and population. **RI.01.07.05, EP 3** For swing beds in critical access hospitals: The critical access hospital provides space for the resident to receive visitors in comfort and privacy.	resident groups, but this does not require the facility to provide a private room for each resident.
§483.10(h)(2)	(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic	**RI.01.01.01, EP 7** The critical access hospital respects the patient's right to privacy. Note: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy	**RI.11.01.01, EP 5** The critical access hospital respects the patient's right to personal privacy. Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the

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	communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	of a patient's health information, refer to Standard IM.02.01.01. **RI.01.06.05, EP 15** The critical access hospital offers patients telephone and mail service, based on the setting and population.	privacy of a patient's health information, refer to Standard IM.12.01.01. Note 2: For swing beds in critical access hospitals: Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. **RI.13.01.03, EP 3** For swing beds in critical access hospitals: The critical access hospital supports the resident's right to send and promptly receive unopened mail and to receive letters, packages, and other materials delivered to the critical access hospital for the resident through a means other than a postal service. The critical access hospital respects the resident's right to privacy of such communications and allows access to stationery, postage, and writing implements at the resident's expense.
§483.10(h)(3)	(3) The resident has a right to secure and confidential personal and medical records.	**IM.02.01.01, EP 1** The critical access hospital follows a written policy addressing the privacy and confidentiality of health information. **IM.02.01.01, EP 3** The critical access hospital uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. **RI.01.01.01, EP 1** The critical access hospital has written policies on	**IM.12.01.01, EP 1** The critical access hospital develops and implements policies and procedures addressing the privacy and confidentiality of health information. Note: For swing beds in critical access hospitals: Policies and procedures also address the resident's personal records.

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		patient rights. Note: The critical access hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.	
§483.10(h)(3)(i)	(i) The resident has the right to refuse the release of personal and medical records except as provided at § 483.70(i)(2) or other applicable federal or state laws.	**IM.02.01.01, EP 4** The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. **RI.01.01.01, EP 1** The critical access hospital has written policies on patient rights. Note: The critical access hospital's written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.	**IM.12.01.01, EP 2** The critical access hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For swing beds in critical access hospitals: The critical access hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.
§483.10(h)(3)(ii)	(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.	**IM.02.01.01, EP 4** The critical access hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation.	**IM.12.01.01, EP 2** The critical access hospital discloses health information only as authorized by the patient with the patient's written consent or as otherwise required by law and regulation. Note: For swing beds in critical access hospitals: The critical access hospital allows representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with state law.
§483.12	§483.12 Freedom from abuse, neglect, and exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as		

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	defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.		
§483.12(a)	(a) The facility must—		
§483.12(a)(1)	(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	**RI.01.06.03, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For critical access hospitals with swing beds: The critical access hospital protects residents from involuntary seclusion.	**RI.13.01.01, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental, sexual, or physical abuse that could occur while the patient is receiving care, treatment, and services. For swing beds in critical access hospitals: The critical access hospital also protects the resident from misappropriation of property.
§483.12(a)(2)	(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.	**PC.03.05.01, EP 1** The critical access hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. **PC.03.05.01, EP 2** The critical access hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation. **PC.03.05.01, EP 3** The critical access hospital uses restraint or seclusion only when less restrictive interventions are ineffective. **PC.03.05.01, EP 4** The critical access hospital uses the least restrictive form	**PC.13.02.01, EP 3** For swing beds in critical access hospitals: The critical access hospital does not use physical or chemical restraints that are imposed for purposes of discipline or convenience and are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the critical access hospital uses the least restrictive alternative for the least amount of time and documents ongoing reevaluation of the need for restraints.

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		of restraint or seclusion that protects the physical safety of the patient, staff, or others. **PC.03.05.01, EP 5** The critical access hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order. **RI.01.06.01, EP 1** For swing beds in critical access hospitals: The critical access hospital has policies and procedures that support the resident's right to be free from chemical and physical restraint. Note: The critical access hospital's use of restraint is consistent with the requirements in the "Provision of Care, Treatment, and Services" (PC) chapter.	
§483.12(a)(3)	(3) Not employ or otherwise engage individuals who—		
§483.12(a)(3)(i)	(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;	**HR.01.01.01, EP 18** For swing beds in critical access hospitals: The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.	**HR.11.02.01, EP 4** For swing beds in critical access hospitals: The critical access hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.
§483.12(a)(3)(ii)	(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	**HR.01.01.01, EP 18** For swing beds in critical access hospitals: 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	**HR.11.02.01, EP 4** For swing beds in critical access hospitals: The critical access hospital does not employ individuals who have been found guilty by a court of law of abusing, neglecting, exploiting, misappropriating property, or mistreating residents or who have had a finding entered

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		registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.	into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of residents' property.
§483.12(a)(4)	(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.	**PC.01.02.09, EP 8** For swing beds in critical access hospitals: The critical access hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff.	**RI.13.01.01, EP 2** For swing beds in critical access hospitals: The critical access hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff.
§483.12(b)	(b) The facility must develop and implement written policies and procedures that:		
§483.12(b)(1)	(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	**RI.01.06.03, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For critical access hospitals with swing beds: The critical access hospital protects residents from involuntary seclusion. **RI.01.06.03, EP 4** For critical access hospitals with swing beds: The critical access hospital develops and implements written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues.	**RI.13.01.01, EP 3** For critical access hospitals with swing beds: The critical access hospital develops and implements written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues.
§483.12(b)(2)	(2) Establish policies and procedures to investigate any such allegations, and	**RI.01.06.03, EP 4** For critical access hospitals with swing beds: The critical access hospital develops and implements written	**RI.13.01.01, EP 3** For critical access hospitals with swing beds: The critical access hospital develops and implements

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		policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues. **RI.01.06.03, EP 5** For critical access hospitals with swing beds: The critical access 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 actions is taken.	written policies and procedures that prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures also address investigation of allegations related to these issues.
§483.12(c)	(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:		
§483.12(c)(1)	(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious	**PC.01.02.09, EP 7** The critical access hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. **PC.01.02.09, EP 8** For swing beds in critical access hospitals: The critical access hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **RI.01.06.03, EP 1**	**RI.13.01.01, EP 2** For swing beds in critical access hospitals: The critical access hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff. **RI.13.01.01, EP 4** The critical access hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events or as required by law.

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	bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For critical access hospitals with swing beds: The critical access hospital protects residents from involuntary seclusion. **RI.01.06.03, EP 3** The critical access hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. Note: For swing beds in critical access hospitals: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury	Note: For swing beds in critical access hospitals: Alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law and established procedures. The alleged violations are reported in the following time frames: - No later than 2 hours after the allegation is made if the allegation involves abuse or serious bodily injury - No later than 24 hours after the allegation is made if the allegation does not involve abuse or serious bodily injury
§483.12(c)(2)	(2) Have evidence that all alleged violations are thoroughly investigated.	**RI.01.06.03, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services.	**RI.13.01.01, EP 5** For critical access hospitals with swing beds: The critical access hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it

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

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§483.12(c)(4)	(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	**RI.01.06.03, EP 1** The critical access hospital protects the patient from harassment, neglect, exploitation, corporal punishment, and abuse that could occur while the patient is receiving care, treatment, and services. Note: For critical access hospitals with swing beds: The critical access hospital protects residents from involuntary seclusion. **RI.01.06.03, EP 5** For critical access hospitals with swing beds: The critical access 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 actions is taken.	**RI.13.01.01, EP 5** For critical access hospitals with swing beds: The critical access hospital has evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment are thoroughly investigated and that it prevents further abuse, neglect, exploitation, or mistreatment while the investigation is in progress. The results of all investigations are reported to the administrator or their designated representative and to other officials in accordance with state law, including the state survey agency, within five working days of the incident. If the alleged violation is verified, appropriate corrective actions is taken.
§483.15(c)	(c) Transfer and discharge—		
§483.15(c)(1)	(1) Facility requirements—		
§483.15(c)(1)(i)	(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—	**PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access 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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral	

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

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

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

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		- The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	- The transfer or discharge is necessary for the resident's welfare, and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.
§483.15(c)(1)(i)(D)	(D) The health of individuals in the facility would otherwise be endangered;	**PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access hospital transfers or discharges residents only when at least one of the following conditions is met: - The resident's health has improved to the point where	**PC.14.01.03, EP 1** For swing beds in critical access hospitals: The critical access hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where

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

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	under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.

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

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		hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	documents the danger that failure to transfer or discharge would pose.
§483.15(c)(1)(ii)	(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	**PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access 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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the	**PC.14.01.03, EP 1** For swing beds in critical access hospitals: The critical access hospital transfers or discharges residents only under at least one of the following conditions: - The resident's health has improved to the point where they no longer need the critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare, and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the resident's clinical or behavioral status. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- Instructions given to the resident before discharge - Attempts to meet the resident's needs
§483.15(c)(2)(i)(B)	(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).	**RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs	**RC.12.03.01, EP 3** For swing beds in critical access hospitals: When the resident is transferred or discharged because the critical access hospital cannot meet their needs, the critical access hospital documents which needs could not be met, the critical access hospital's attempts to meet the resident's needs, and the services available at the receiving organization that will meet the resident's needs.
§483.15(c)(2)(ii)	(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—		
§483.15(c)(2)(ii)(A)	(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and	**PC.04.01.01, EP 14** The critical access hospital transfers a patient upon order of their attending physician. **RC.02.04.01, EP 1** For swing beds in critical access hospitals:	**RC.12.03.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician document in the resident's medical record when the resident is being

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 critical access 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.	transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the critical access hospital's swing bed.
§483.15(c)(2)(ii)(B)	(B) A physician when transfer or discharge is necessary under paragraph (b)(1)(i)(C) or (D) of this section.	**PC.04.01.01, EP 14** The critical access hospital transfers a patient upon order of their attending physician. **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered.	**RC.12.03.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. A physician document in the resident's medical record when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. The resident's physician documents in the medical record when the transfer is due to the resident improving and no longer needing long term care services or when the transfer is due to the resident's welfare and resident's needs cannot be met in the critical access hospital's swing bed.
§483.15(c)(2)(iii)	(iii) Information provided to the receiving provider must include a minimum of the following:		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.15(c)(2)(iii)(A)	(A) Contact information of the practitioner responsible for the care of the resident	**PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		longer needing long term care services or when the resident's needs cannot be met in the critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs	
§483.15(c)(2)(iii)(B)	(B) Resident representative information including contact information.	**PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access hospital informs other service providers who will provide care, treatment, and services to the	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the	service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs	
§483.15(c)(2)(iii)(C)	(C) Advance Directive information.	**PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		to the patient - The patient's progress toward goals - A list of community resources or referrals made or provided to the patient Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2**	at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs	
§483.15(c)(2)(iii)(D)	(D) All special instructions or precautions for ongoing care, as appropriate.	**PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: The resident's discharge information includes the following: - The reason for transfer, discharge, or referral - Treatment provided, diet, medication orders, and orders	Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		for the resident's immediate care - Referrals provided to the resident, the referring physician's or other licensed practitioner's name, and the name of the physician or other licensed practitioner who has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge - Attempts to meet the resident's needs	
§483.15(c)(2)(iii)(E)	(E) Comprehensive care plan goals,	**PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following:	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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	practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		has agreed to be responsible for the resident's medical care and treatment, if this person is someone other than the referring physician or other licensed practitioner - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge - Attempts to meet the resident's needs	
§483.15(c)(2)(iii)(F)	(F) All other necessary information, including a copy of the residents discharge summary, consistent with § 483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	**PC.04.02.01, EP 1** At the time of the patient's discharge or transfer, the critical access 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: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information	**PC.14.02.03, EP 1** The critical access hospital provides or transmits necessary medical information when discharging, transferring, or referring the patient to post–acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners who are responsible for the patient's follow-up or ancillary care. Necessary medical information includes, at a minimum, the following: - Current course of illness and treatment - Postdischarge goals of care - Treatment preferences at the time of discharge Note: For swing beds in critical access hospitals: The information sent to the receiving provider also includes the following: - Contact information of the physician or other licensed practitioner responsible for the care of the resident - Resident representative information, including contact information - Advance directive information

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Advance directive information - All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals **RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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,	- All special instructions or precautions for ongoing care, when appropriate - Comprehensive care plan goals - All other necessary information, including a copy of the residents discharge summary, consistent with 42 CFR 483.21(c)(2), and any other documentation, as applicable, to support a safe and effective transition of care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		treatment, and services provided; and progress reached toward goals - Information about the resident's behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation - Nursing information that is useful in the resident's care - Any advance directives - Instructions given to the resident before discharge - Attempts to meet the resident's needs **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 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 - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access hospital, and caregivers change, a transfer summary may be substituted for the	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		discharge summary. If the caregivers do not change, a progress note may be used.	
§483.15(c)(3)	(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—		
§483.15(c)(3)(i)	(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move 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 critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **RI.01.01.01, EP 5**	**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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include but are not limited to participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also provides sufficient preparation and orientation to

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		The critical access hospital respects the patient's right to and need for effective communication. **RI.01.01.03, EP 1** The critical access hospital provides information in a manner tailored to the patient's age, language, and ability to understand.	residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **RI.11.02.01, EP 1** The critical access hospital provides information, including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.
§483.15(c)(3)(ii)	(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	**RC.01.01.01, EP 5** The medical record includes the following: - Information needed to support the patient's diagnosis and condition - Information needed to justify the patient's care, treatment, and services - Information that documents the course and result of the patient's care, treatment, and services - Information about the patient's care, treatment, and services that promotes continuity of care among staff and providers Note: For critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.	**RC.12.03.01, EP 4** For swing beds in critical access hospitals: The critical access hospital records the reasons for the transfer or discharge in the resident's medical record in accordance with 42 CFR 483.15(c)(2).
§483.15(c)(3)(iii)	(iii) Include in the notice the items described in paragraph (b)(5) of this section.	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff	**PC.14.01.01, EP 4** The patient, the patient's caregiver(s) or support person(s), physicians, other licensed practitioners,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move 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 critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **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	clinical psychologists, and staff who are involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. The patient and their caregiver(s) or support person(s) are included as active partners when planning for postdischarge care. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include but are not limited to participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **RI.11.02.01, EP 1** The critical access hospital provides information,

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		services that promotes continuity of care among staff and providers Note: For critical access hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers. **RI.01.01.01, EP 5** The critical access hospital respects the patient's right to and need for effective communication. **RI.01.01.03, EP 1** The critical access hospital provides information in a manner tailored to the patient's age, language, and ability to understand.	including but not limited to the patient's total health status, in a manner tailored to the patient's age, language, and ability to understand. Note: The critical access hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs.
§483.15(c)(4)	(4) Timing of the notice.		
§483.15(c)(4)(i)	(i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	**PC.04.01.03, EP 5** For swing beds in critical access hospitals: 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 critical access hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days.	**PC.14.01.01, EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

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§483.15(c)(4)(ii)	(ii) Notice must be made as soon as practicable before transfer or discharge when—		
§483.15(c)(4)(ii)(A)	(A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section;	**PC.04.01.03, EP 5** For swing beds in critical access hospitals: 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 critical access hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access 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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident.	**PC.14.01.01, EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(B)	(B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section;	**PC.04.01.03, EP 5** For swing beds in critical access hospitals: 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 critical access 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	**PC.14.01.01, EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access 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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or	resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(C)	(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;	**PC.04.01.03, EP 5** For swing beds in critical access hospitals: 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 critical access hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access 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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs.	**PC.14.01.01, EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(D)	(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or	**PC.04.01.03, EP 5** For swing beds in critical access hospitals: 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 critical access 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	**PC.14.01.01, EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access 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 critical access hospital's services. - The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable	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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(4)(ii)(E)	(E) A resident has not resided in the facility for 30 days.	**PC.04.01.03, EP 5** For swing beds in critical access hospitals: 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 critical access hospital at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident's urgent medical needs; or a resident has not resided in the facility for 30 days. **PC.04.01.07, EP 1** For swing beds in critical access hospitals: The critical access 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 critical access hospital's services.	**PC.14.01.01, EP 12** For swing beds in critical access hospitals: The critical access hospital provides the written notice of transfer or discharge at least 30 days before the resident is transferred or discharged. Note: Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered, the health of the individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The transfer or discharge is necessary for the resident's welfare and the critical access hospital cannot meet the resident's needs. - The safety of the individuals in the critical access hospital is endangered due to the clinical or behavioral status of the resident. - The health of individuals in the critical access hospital would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the critical access hospital. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. For a resident who becomes eligible for Medicaid after admission to a critical access hospital, the critical access hospital may charge a resident only the allowable charges under Medicaid. - The critical access hospital ceases operation. Note: The critical access hospital cannot transfer or discharge a resident while an appeal is pending pursuant to 42 CFR 431.230, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the critical access hospital. The critical access hospital documents the danger that failure to transfer or discharge would pose.	
§483.15(c)(5)	(5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following:		
§483.15(c)(5)(i)	(i) The reason for transfer or discharge;	**PC.04.01.03, EP 6** For swing beds in critical access hospitals: The written	**PC.14.01.01, EP 13** For swing beds in critical access hospitals: The written

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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
§483.15(c)(5)(vi)	(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106–402, codified at 42 U.S.C. 15001 et seq.); and	**PC.04.01.03, EP 6** For swing beds in critical access hospitals: 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	**PC.14.01.01, EP 13** For swing beds in critical access hospitals: The written notice before transfer or discharge specified in 42 CFR 483.15(c)(3) includes the following: - Reason for transfer or discharge - Effective date of transfer or discharge - Location to which the resident is transferred or discharged - Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act
§483.15(c)(7)	(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.	**PC.04.01.03, EP 3** The patient, the patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services participate in planning the patient's discharge or transfer. Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move 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 critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman. **PC.04.01.05, EP 1** When the critical access hospital determines the patient's discharge or transfer needs, it promptly shares	**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: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (refer to the Glossary). Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include but are not limited to participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital. Note 3: For swing beds in critical access hospitals: The critical access hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move. The notice is in writing, in a language and manner they understand, and includes the items described in 42 CFR 483.15(c)(5). The critical access hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the critical access hospital is safe and orderly. The

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		this information with the patient, and also with the patient's family when it is involved in decision making or ongoing care. **PC.04.01.05, EP 2** Before the patient is discharged, the critical access 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.	critical access hospital sends a copy of the notice to a representative of the office of the state's long-term care ombudsman.
§483.15(c)(8)	(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	**PC.04.01.07, EP 2** For critical access hospitals with swing beds: In the case of critical access hospital closure, the individual who is the administrator of the critical access hospital must provide written notification prior to the impending closure to the state survey agency, the office of the state's long-term care ombudsman, residents of the critical access hospital, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents.	**PC.14.01.03, EP 2** For critical access hospitals with swing beds: In the case of critical access hospital closure, the administrator of the critical access hospital provides written notification prior to the impending closure to the state survey agency, the office of the state's long-term care ombudsman, residents of the critical access hospital, and the residents' representatives, as well as the plan for the transfer and adequate relocation of the residents.
§483.15(c)(9)	(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in §483.5) are subject to the requirements of §483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident	**RI.01.06.05, EP 19** For swing beds in critical access hospitals: Room changes in an organization that is a composite distinct part (a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in 42 CFR 413.65(a)(2)) are limited to moves within the particular building in which the resident resides, unless the resident voluntarily	**RI.13.01.03, EP 4** For swing beds in critical access hospitals: Room changes in an organization that is a composite distinct part (a distinct part consisting of two or more noncontiguous components that are not located within the same campus, as defined in 42 CFR 413.65(a)(2)) are limited to moves within the particular building in which the resident resides, unless the resident

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	voluntarily agrees to move to another of the composite distinct part's locations.	agrees to move to another of the composite distinct part's locations.	voluntarily agrees to move to another of the composite distinct part's locations.
§483.20	§483.20 Resident assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.		
§483.20(b)	(b) Comprehensive assessments –		
§483.20(b)(1)	(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(i)	(i) Identification and demographic information.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(ii)	(ii) Customary routine.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(iii)	(iii) Cognitive patterns.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	- Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(iv)	(iv) Communication.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	- Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(v)	(v) Vision.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(vi)	(vi) Mood and behavior patterns.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(vii)	(vii) Psychosocial well-being.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(viii)	(viii) Physical functioning and structural problems.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following:	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	- Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(ix)	(ix) Continence.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	- Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(x)	(x) Disease diagnoses and health conditions.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(xi)	(xi) Dental and nutritional status.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(xii)	(xii) Skin condition.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.20(b)(1)(xiii)	(xiii) Activity pursuit.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(xiv)	(xiv) Medications.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	- Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(xv)	(xv) Special treatments and procedures.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning	- Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(xvi)	(xvi) Discharge planning.	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Need for special treatment(s) and procedure(s) - Discharge planning	- Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise.
§483.20(b)(1)(xvii)	(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).	**PC.01.02.01, EP 27** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes documentation of summary information about the additional assessment(s) performed through the resident assessment protocols.	**PC.11.02.01, EP 12** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes documentation of summary information about the additional assessment(s) performed through the resident assessment protocols.
§483.20(b)(1)(xviii)	(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.	**PC.01.02.01, EP 28** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes documentation of the resident's participation in the assessment.	**PC.11.02.01, EP 13** For swing beds in critical access hospitals: The comprehensive assessment includes direct observation and communication with the resident and communication with staff members on all shifts.
§483.20(b)(2)	(2) When required. Subject to the timeframes prescribed in § 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes	**PC.01.02.03, EP 14** For swing beds in critical access hospitals: The critical access hospital specifies that each resident's comprehensive assessment is completed within 14 calendar days after admission. **PC.01.02.03, EP 15** For swing beds in critical access hospitals: A comprehensive assessment is conducted within 14 calendar days after the critical access hospital	**PC.11.02.01, EP 6** For swing beds in critical access hospitals: The critical access hospital completes the resident's comprehensive assessment within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. Note: For this element of performance, the term "readmission'' means a return to the critical access hospital following a temporary absence for

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	prescribed in § 413.343(b) of this chapter do not apply to CAHs.	determines that there has been a significant change in the resident's physical or mental condition. **PC.01.02.03, EP 16** For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months.	hospitalization or for therapeutic leave. **PC.11.02.01, EP 7** For swing beds in critical access hospitals: The critical access hospital conducts a comprehensive assessment within 14 calendar days after it determines that there has been a significant change in the resident's physical or mental condition. Note: For this element of performance, the term "significant change'' means a major decline or improvement in the resident's status that will not resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires interdisciplinary review or revision of the care plan, or both. **PC.11.02.01, EP 8** For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months.
§483.20(b)(2)(i)	(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission'' means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)	**PC.01.02.03, EP 14** For swing beds in critical access hospitals: The critical access hospital specifies that each resident's comprehensive assessment is completed within 14 calendar days after admission.	**PC.11.02.01, EP 6** For swing beds in critical access hospitals: The critical access hospital completes the resident's comprehensive assessment within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. Note: For this element of performance, the term "readmission'' means a return to the critical access hospital following a temporary absence for hospitalization or for therapeutic leave.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.20(b)(2)(ii)	(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change'' means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	**PC.01.02.03, EP 15** For swing beds in critical access hospitals: A comprehensive assessment is conducted within 14 calendar days after the critical access hospital determines that there has been a significant change in the resident's physical or mental condition.	**PC.11.02.01, EP 7** For swing beds in critical access hospitals: The critical access hospital conducts a comprehensive assessment within 14 calendar days after it determines that there has been a significant change in the resident's physical or mental condition. Note: For this element of performance, the term "significant change'' means a major decline or improvement in the resident's status that will not resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and that requires interdisciplinary review or revision of the care plan, or both.
§483.20(b)(2)(iii)	(iii) Not less often than once every 12 months.	**PC.01.02.03, EP 16** For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months.	**PC.11.02.01, EP 8** For swing beds in critical access hospitals: Each resident receives a comprehensive assessment no less often than every 12 months.
§483.21	§483.21 Comprehensive person-centered care planning.		
§483.21(b)	(b) Comprehensive care plans.		
§483.21(b)(1)	(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at § 483.10(c)(2) and § 483.10(c)(3), that includes measurable	**PC.02.04.06, EP 1** For critical access hospitals with swing beds: The interdisciplinary team works in partnership with the resident to achieve planned outcomes. **PC.02.04.06, EP 2** For critical access hospitals with swing beds: The	**PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:	interdisciplinary team involves the resident and the resident's representative in the development of the treatment plan. Note: The treatment plan includes the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations. Disagreement with PASARR recommendations is documented in the resident's record. - The resident's goals for admission and desired outcomes. - The resident's preferences and potential for future discharge. - Discharge plans. - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.	- Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is included in the resident's medical record.
§483.21(b)(1)(i)	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under § 483.24, § 483.25, or § 483.40; and	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing.	**PC.11.03.01, EP 7** For swing beds in critical access hospitals: The resident's comprehensive treatment plan includes the services to be provided to attain or maintain the resident's optimal physical, mental, and psychosocial well-being. Note: The comprehensive treatment plan includes any services that would otherwise be required under 42 CFR 483.24, 483.25, or 483.40 but are not provided due to the resident's exercise of rights, including the right to refuse treatment.
§483.21(b)(1)(ii)	(ii) Any services that would otherwise be required under § 483.24, § 483.25, or § 483.40 but	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the	**PC.11.03.01, EP 7** For swing beds in critical access hospitals: The resident's comprehensive treatment plan includes the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	are not provided due to the resident's exercise of rights under § 483.10, including the right to refuse treatment under § 483.10(c)(6).	patient's assessment, reassessment, and results of diagnostic testing.	services to be provided to attain or maintain the resident's optimal physical, mental, and psychosocial well-being. Note: The comprehensive treatment plan includes any services that would otherwise be required under 42 CFR 483.24, 483.25, or 483.40 but are not provided due to the resident's exercise of rights, including the right to refuse treatment.
§483.21(b)(1)(iii)	(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	**PC.02.04.06, EP 2** For critical access hospitals with swing beds: The interdisciplinary team involves the resident and the resident's representative in the development of the treatment plan. Note: The treatment plan includes the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations. Disagreement with PASARR recommendations is documented in the resident's record. - The resident's goals for admission and desired outcomes. - The resident's preferences and potential for future discharge. - Discharge plans. - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.	**PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			treatment plan, an explanation is included in the resident's medical record.
§483.21(b)(1)(iv)	(iv) In consultation with the resident and the resident's representative(s)—		**PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is included in the resident's medical record.
§483.21(b)(1)(iv)(A)	(A) The resident's goals for admission and desired outcomes.	**PC.02.04.06, EP 2** For critical access hospitals with swing beds: The interdisciplinary team involves the resident and the resident's representative in the development of the treatment plan.	**PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: The treatment plan includes the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations. Disagreement with PASARR recommendations is documented in the resident's record. - The resident's goals for admission and desired outcomes. - The resident's preferences and potential for future discharge. - Discharge plans. - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.	Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is included in the resident's medical record.
§483.21(b)(1)(iv)(B)	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	**PC.02.04.06, EP 2** For critical access hospitals with swing beds: The interdisciplinary team involves the resident and the resident's representative in the development of the treatment plan. Note: The treatment plan includes the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations. Disagreement with PASARR recommendations is documented in the resident's record.	**PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The resident's goals for admission and desired outcomes. - The resident's preferences and potential for future discharge. - Discharge plans. - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.	- Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is included in the resident's medical record.
§483.21(b)(1)(iv)(C)	(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	**PC.02.04.06, EP 2** For critical access hospitals with swing beds: The interdisciplinary team involves the resident and the resident's representative in the development of the treatment plan. Note: The treatment plan includes the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations. Disagreement with PASARR recommendations is documented in the resident's record. - The resident's goals for admission and desired outcomes. - The resident's preferences and potential for future discharge. - Discharge plans. - Measurable objectives and time frames to meet a	**PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		resident's medical, nursing, and mental and psychosocial needs.	- Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is included in the resident's medical record.
§483.21(b)(2)	(2) A comprehensive care plan must be—		
§483.21(b)(2)(i)	(i) Developed within 7 days after completion of the comprehensive assessment.	**PC.01.03.01, EP 4** For swing beds in critical access hospitals: The critical access hospital develops the resident's written plan of care as soon as possible after admission, but no later than seven calendar days after the resident's comprehensive assessments are completed.	**PC.11.03.01, EP 8** For swing beds in critical access hospitals: The critical access hospital develops the resident's written comprehensive plan of care as soon as possible after admission, but no later than seven calendar days after the resident's comprehensive assessments are completed.
§483.21(b)(2)(ii)	(ii) Prepared by an interdisciplinary team, that includes but is not limited to—	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.21(b)(2)(ii)(A)	(A) The attending physician.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff.	**PC.11.03.01, EP 9** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment.
§483.21(b)(2)(ii)(B)	(B) A registered nurse with responsibility for the resident.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff.	**PC.11.03.01, EP 9** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.21(b)(2)(ii)(C)	(C) A nurse aide with responsibility for the resident.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff.	**PC.11.03.01, EP 9** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment.
§483.21(b)(2)(ii)(D)	(D) A member of food and nutrition services staff.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff.	**PC.11.03.01, EP 9** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.21(b)(2)(ii)(E)	(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	**PC.02.04.06, EP 1** For critical access hospitals with swing beds: The interdisciplinary team works in partnership with the resident to achieve planned outcomes. **PC.02.04.06, EP 2** For critical access hospitals with swing beds: The interdisciplinary team involves the resident and the resident's representative in the development of the treatment plan. Note: The treatment plan includes the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations. Disagreement with PASARR recommendations is documented in the resident's record. - The resident's goals for admission and desired outcomes. - The resident's preferences and potential for future discharge. - Discharge plans. - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs.	**PC.11.03.01, EP 6** For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the resident's representative in developing the person-centered, comprehensive treatment plan. Note 1: The treatment plan includes documentation of the following: - Any specialized or rehabilitation services the critical access hospital will provide as a result of preadmission screening and resident review (PASARR) recommendations and any disagreement with PASARR recommendations - Resident's goals for admission and desired outcomes - Resident's preferences and potential for future discharge, including whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities for this purpose - Discharge plans - Measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs Note 2: If not feasible for the resident and the resident's representative to participate in the development of the treatment plan, an explanation is included in the resident's medical record.
§483.21(b)(2)(ii)(F)	(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2**	**PC.11.03.01, EP 9** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff.	for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment.
§483.21(b)(2)(iii)	(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	**PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.01.03.01, EP 2** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the following individuals: the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food and nutrition services staff. **PC.01.03.01, EP 22** Based on the goals established in the patient's plan of care, staff evaluate the patient's progress. **PC.01.03.01, EP 23** The critical access hospital revises plans and goals for	**PC.11.03.01, EP 9** For swing beds in critical access hospitals: The resident's written plan of care is developed by an interdisciplinary team comprised of health care professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the attending physician, registered nurse with responsibility for the resident, nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and other appropriate staff as determined by the resident's needs or as requested by the resident. Note: The plan of care is reviewed and revised by the interdisciplinary team after each assessment.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		care, treatment, and services based on the patient's needs.	
§483.21(b)(3)	(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—		
§483.21(b)(3)(i)	(i) Meet professional standards of quality.	**LD.03.08.01, EP 1** The critical access hospital's design of new or modified services or processes incorporates the following: - The needs of patients, staff, and others - The results of performance improvement activities - Information about potential risks to patients - Evidence-based information in the decision-making process - Information about sentinel events Note 1: A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the "Proactive Risk Assessment" section at the beginning of this chapter. Note 2: Evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.	**LD.13.03.01, EP 19** For swing beds in critical access hospitals: The critical access hospital provides or arranges for culturally competent and trauma-informed services, as outlined by the comprehensive care plan, that meet professional standards of quality and are provided by qualified staff in accordance with each resident's written plan of care.
§483.21(b)(3)(ii)	(ii) Be provided by qualified persons in accordance with each resident's written plan of care.	**HR.01.01.01, EP 1** The critical access hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-	**LD.13.03.01, EP 19** For swing beds in critical access hospitals: The critical access hospital provides or arranges for culturally competent and trauma-informed services, as outlined by the comprehensive care plan, that meet professional standards of quality and are provided by qualified staff in accordance with each resident's written plan of care.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access 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 B for 409.17 requirements. **HR.01.01.01, EP 3** The critical access hospital verifies and documents that the applicant has the education and experience required by the job responsibilities. **LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care.	
§483.21(b)(3)(iii)	(iii) Be culturally-competent and trauma-informed.	**HR.01.04.01, EP 3** The critical access hospital orients staff on the following: - Relevant critical access hospitalwide and unit-specific policies and procedures	**LD.13.03.01, EP 19** For swing beds in critical access hospitals: The critical access hospital provides or arranges for culturally competent and trauma-informed services, as outlined

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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. **RI.01.01.01, EP 6** The critical access hospital respects the patient's cultural and personal values, beliefs, and preferences. **RI.01.01.01, EP 29** The critical access hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. Note: This includes prohibiting discrimination through restricting, limiting, or otherwise denying visitation privileges.	by the comprehensive care plan, that meet professional standards of quality and are provided by qualified staff in accordance with each resident's written plan of care.
§483.21(c)	(c) Discharge planning—		
§483.21(c)(2)	(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:		
§483.21(c)(2)(i)	(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and	**RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the	**RC.12.03.01, EP 5** For swing beds in critical access hospitals: When the critical access hospital anticipates the discharge of a resident, the discharge summary includes but is not

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	pertinent lab, radiology, and consultation results.	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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 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 - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access 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.	
§483.21(c)(2)(ii)	(ii) A final summary of the resident's status to include items in paragraph (b)(1) of § 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the	**RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident's medical record by the resident's physician when the resident is transferred or discharged, either	**RC.12.03.01, EP 5** For swing beds in critical access hospitals: When the critical access hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following: - A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	consent of the resident or resident's representative.	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 critical access hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs **RC.02.04.01, EP 3** In order to provide information to other caregivers and	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		facilitate the patient's continuity of care, the medical record contains a 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 - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access 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.	
§483.21(c)(2)(iii)	(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	**RC.02.04.01, EP 1** For swing beds in critical access hospitals: 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 critical access	**RC.12.03.01, EP 5** For swing beds in critical access hospitals: When the critical access hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following: - A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of illness/treatment or therapy, and pertinent laboratory, radiology, and consultation results - A final summary of the resident's status to include

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospital's swing bed. There is documentation in the resident's medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs **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 discharge summary that includes the following:	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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 - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access 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.	
§483.21(c)(2)(iv)	(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any	**RC.02.04.01, EP 1** For swing beds in critical access hospitals: Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. 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 critical access 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	**RC.12.03.01, EP 5** For swing beds in critical access hospitals: When the critical access hospital anticipates the discharge of a resident, the discharge summary includes but is not limited to the following: - A summary of the resident's stay that includes at a minimum the resident's diagnosis, course of illness/treatment or therapy, and pertinent laboratory, radiology, and consultation results - A final summary of the resident's status to include items in 42 CFR 483.20 (b)(1) at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	post-discharge medical and non-medical services.	safety of other residents would otherwise be endangered. **RC.02.04.01, EP 2** For swing beds in critical access hospitals: 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 - Attempts to meet the resident's needs **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 discharge summary that includes the following: - The reason for hospitalization - The procedures performed - The care, treatment, and services provided	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The patient's condition and disposition at discharge - Information provided to the patient and family - Provisions for follow-up care - For critical access hospitals with swing beds: Where the resident plans to reside 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 critical access 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.	
§483.25	§483.25 Quality of care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices, including but not limited to the following:		
§483.25(g)	(g) Assisted nutrition and hydration. (Includes naso-gastric		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident—		
§483.25(g)(1)	(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning **PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note 1: Reassessments may also be based on the	**PC.11.02.01, EP 11** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental status - Nutritional status (such as usual body weight or desirable body weight range, electrolyte balance) - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning Note: The critical access hospital maintains the resident's acceptable nutritional status parameters unless the resident's clinical condition demonstrates

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		patient's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; discharge planning needs; and/or their setting requirements. Note 2: For rehabilitation distinct part units in critical access hospitals: The Centers for Medicare & Medicaid Services requires that a physician with specialized training and experience in inpatient rehabilitation conducts at least three face-to-face patient visits per week. **PC.01.02.03, EP 15** For swing beds in critical access hospitals: A comprehensive assessment is conducted within 14 calendar days after the critical access hospital determines that there has been a significant change in the resident's physical or mental condition. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.02.03, EP 7** Food and nutrition products are consistent with each patient's care, treatment, and services. Note 1: The nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the physician or other licensed practitioner responsible for the care of inpatients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to	that this is not possible or the resident's preferences indicate otherwise.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		inpatients receiving posthospital skilled nursing facility care.	
§483.25(g)(2)	(2) Is offered sufficient fluid intake to maintain proper hydration and health; and	**PC.01.02.01, EP 26** For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following: - Identifying and demographic information - Customary routines - Cognitive patterns - Communication needs - Vision needs - Psychosocial well-being - Mood and behavior patterns - Physical functioning and structural problems - Continence - Disease(s), diagnoses, and health conditions - Dental and nutritional status - Skin - Pursuit of activity - Medications - Need for special treatment(s) and procedure(s) - Discharge planning **PC.01.02.03, EP 3** Each patient is reassessed as necessary based on their plan for care or changes in their condition. Note 1: 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. Note 2: For rehabilitation distinct part units in critical access hospitals: The Centers for Medicare &	**PC.12.01.09, EP 3** For swing beds in critical access hospitals: The critical access hospital offers the resident sufficient fluid intake to maintain proper hydration and health.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Medicaid Services requires that a physician with specialized training and experience in inpatient rehabilitation conducts at least three face-to-face patient visits per week. **PC.01.02.03, EP 15** For swing beds in critical access hospitals: A comprehensive assessment is conducted within 14 calendar days after the critical access hospital determines that there has been a significant change in the resident's physical or mental condition. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.02.03, EP 7** Food and nutrition products are consistent with each patient's care, treatment, and services. Note 1: The nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the physician or other licensed practitioner responsible for the care of inpatients. Note 2: For swing beds in critical access hospitals: The critical access hospital meets the assisted nutrition and hydration requirement at 42 CFR 483.25(g) with respect to inpatients receiving posthospital skilled nursing facility care.	
§483.40	§483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.		
§483.40(d)	(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	**PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge.	**PC.14.02.01, EP 2** For swing beds in critical access hospitals: The critical access hospital provides medically related social services to attain or maintain the optimal physical, mental, and psychosocial well-being of each resident.
§483.55	§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.	**PC.02.02.01, EP 12** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	
§483.55(a)	(a) Skilled nursing facilities. A facility		
§483.55(a)(2)	(2) May charge a Medicare resident an additional amount for routine and emergency dental services;	**PC.02.02.01, EP 12** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an	**PC.14.02.01, EP 3** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.
§483.55(a)(3)	(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;	**PC.02.02.01, EP 29** For critical access hospitals with swing beds: The critical access hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility and it may not charge a resident for the loss or damage of dentures.	**PC.14.02.01, EP 4** For swing beds in critical access hospitals: The critical access hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility, and it may not charge a resident for the loss or damage of dentures.
§483.55(a)(4)	(4) Must if necessary or if requested, assist the resident—		
§483.55(a)(4)(i)	(i) In making appointments; and	**PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. **PC.02.02.01, EP 10** When the critical access hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **RI.01.06.11, EP 3** For swing beds in critical access hospitals: The critical access hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1**	**PC.14.02.01, EP 5** For swing beds in critical access hospitals: If necessary or requested, the critical access hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		For swing beds in critical access hospitals: The critical access hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	
§483.55(a)(4)(ii)	(ii) By arranging for transportation to and from the dental services location; and	**PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. **PC.02.02.01, EP 10** When the critical access hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services. **RI.01.06.11, EP 3** For swing beds in critical access hospitals: The critical access hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1** For swing beds in critical access hospitals: The critical access hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	**PC.14.02.01, EP 5** For swing beds in critical access hospitals: If necessary or requested, the critical access hospital assists residents in making dental appointments and arranging for transportation to and from the dental services location.
§483.55(a)(5)	(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of	**PC.02.02.01, EP 30** For critical access hospitals with swing beds: The critical access hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the critical access hospital documents what was done to make sure that the	**PC.14.02.01, EP 6** For critical access hospitals with swing beds: The critical access hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the critical access hospital documents what was done to

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.	resident could adequately eat and drink and any extenuating circumstances that led to the delay.	make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.
§483.55(b)	(b) Nursing facilities. The facility		
§483.55(b)(1)	(1) Must provide or obtain from an outside resource, in accordance with § 483.70(g) of this part, the following dental services to meet the needs of each resident:		
§483.55(b)(1)(i)	(i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	**PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge. **PC.02.02.01, EP 12** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	**PC.14.02.01, EP 7** For swing beds in critical access hospitals: The critical access hospital provides or obtains from an outside resource routine (to the extent covered under the state plan) and emergency dental services.
§483.55(b)(2)	(2) Must, if necessary or if requested, assist the resident—		
§483.55(b)(2)(i)	(i) In making appointments; and	**PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through referral) to facilitate family support, social work, nursing	**PC.14.02.01, EP 5** For swing beds in critical access hospitals: If necessary or requested, the critical access hospital assists residents in making dental appointments and arranging

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

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		access hospital helps the resident make and keep appointments with medical, dental, and other care providers. **RI.01.07.13, EP 1** For swing beds in critical access hospitals: The critical access hospital arranges transportation for the resident to and from medical or dental appointments and other activities identified in the resident's care or service plan.	
§483.55(b)(3)	(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	**PC.02.02.01, EP 30** For critical access hospitals with swing beds: The critical access hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the critical access hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.	**PC.14.02.01, EP 6** For critical access hospitals with swing beds: The critical access hospital refers residents with lost or damaged dentures for dental services within three days. If referral does not occur within three days, the critical access hospital documents what was done to make sure that the resident could adequately eat and drink and any extenuating circumstances that led to the delay.
§483.55(b)(4)	(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	**PC.02.02.01, EP 29** For critical access hospitals with swing beds: The critical access hospital follows its policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility and it may not charge a resident for the loss or damage of dentures.	**PC.14.02.01, EP 4** For swing beds in critical access hospitals: The critical access hospital develops and implements a policy identifying circumstances when loss of or damage to a resident's dentures is the critical access hospital's responsibility, and it may not charge a resident for the loss or damage of dentures.
§483.55(b)(5)	(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental	**PC.02.02.01, EP 12** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and	**PC.14.02.01, EP 3** For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and

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	services as an incurred medical expense under the State plan.	wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.	wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.
§483.65	§483.65 Specialized rehabilitative services.		
§483.65(a)	(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at § 483.120(c), are required in the resident's comprehensive plan of care, the facility must—		
§483.65(a)(1)	(1) Provide the required services; or	**LD.04.03.01, EP 8** The critical access hospital furnishes services that include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.02.01, EP 3** The critical access hospital coordinates the patient's	**PC.14.02.01, EP 8** For swing beds in critical access hospitals: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the critical access hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care

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		care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. **PC.02.02.01, EP 10** When the critical access hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.	programs pursuant to section 1128 and 1156 of the Social Security Act.
§483.65(a)(2)	(2) In accordance with § 483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.	**LD.04.03.01, EP 8** The critical access hospital furnishes services that include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.02.01, EP 3** The critical access hospital coordinates the patient's care, treatment, and services within a time frame that meets the patient's needs. Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services. **PC.02.02.01, EP 10** When the critical access hospital uses external resources to meet the patient's needs, it coordinates the patient's care, treatment, and services.	**PC.14.02.01, EP 8** For swing beds in critical access hospitals: If a resident's comprehensive plan of care requires specialized rehabilitative services, including but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity, the critical access hospital provides or obtains the required services from a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Social Security Act.
§483.65(b)	(b) Qualifications. Specialized rehabilitative services must be	**LD.03.06.01, EP 2** Leaders provide for a sufficient number and mix of	**PC.12.01.01, EP 1** Prior to providing care, treatment, and services, the

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	provided under the written order of a physician by qualified personnel.	individuals to support safe, quality care, treatment, and services. Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered. **LD.03.06.01, EP 3** Those who work in the critical access hospital are competent to complete their assigned responsibilities. **PC.01.03.01, EP 1** The critical access hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. **PC.02.01.01, EP 1** The critical access hospital provides the patient with care, treatment, and services according to the patient's individualized plan of care. **PC.02.01.01, EP 6** For swing beds in critical access hospitals: The critical access hospital provides residents with specialized rehabilitation services as indicated by the written order of a physician. **PC.02.01.05, EP 1** Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner. **PC.02.02.01, EP 9** For swing beds in critical access hospitals: The critical access hospital provides services (directly or through	critical access hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. Note 1: This includes but is not limited to respiratory services, radiology services, rehabilitation services, nuclear medicine services, and dietetic services, if provided. Note 2: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals. The requirement of 42 CFR 483.25(i) is met for inpatients receiving care at a skilled nursing facility subsequent to critical access hospital care.

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		referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge.	
§485.647	§485.647 Condition of Participation: Psychiatric and Rehabilitation Distinct Part Units.		
§485.647(a)	(a) Conditions.		
§485.647(a)(1)	(1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of Part 412 of this chapter for excluded psychiatric units.		
§485.647(a)(2)	(2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in Subparts A, B, C, and D of Part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of Part 412 of this chapter for hospital units excluded from the prospective		

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	payments systems, and the additional requirements of §§ 412.29 and § 412.30 of Part 412 of this chapter related specifically to rehabilitation units.		
§485.647(b)	(b) Eligibility requirements.		
§485.647(b)(1)	(1) To be eligible to receive Medicare payments for psychiatric or rehabilitation services as a distinct part unit, the facility provides no more than 10 beds in the distinct part unit.	**LD.04.01.01, EP 12** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in the CoP from 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under the CoP from 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in the CoP from 42 CFR 485.620.	**LD.13.01.01, EP 4** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.
§485.647(b)(2)	(2) The beds in the distinct part are excluded from the 25 inpatient-bed count limit specified in § 485.620(a).	**LD.04.01.01, EP 12** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in the CoP from 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under the CoP from 42 CFR 485.620(b) does not apply to the 10 beds in the distinct	**LD.13.01.01, EP 4** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay

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		part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in the CoP from 42 CFR 485.620.	requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.
§485.647(b)(3)	(3) The average annual 96-hour length of stay requirement specified under § 485.620(b) does not apply to the 10 beds in the distinct part units specified in paragraph (b)(1) of this section, and admissions and days of inpatient care in the distinct part units are not taken into account in determining the CAH's compliance with the limits on the number of beds and length of stay in § 485.620.	**LD.04.01.01, EP 12** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in the CoP from 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under the CoP from 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in the CoP from 42 CFR 485.620.	**LD.13.01.01, EP 4** For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital provides no more than 10 beds in a distinct part unit. The beds are physically separate from the critical access hospital's other beds. Note 1: Beds in the rehabilitation and psychiatric distinct part units are excluded from the 25 inpatient-bed count limits specified in 42 CFR 485.620(a). Note 2: The average annual 96-hour length of stay requirement specified under 42 CFR 485.620(b) does not apply to the 10 beds in the distinct part units specified in 42 CFR 485.647(b)(1). Admissions and days of inpatient care in the distinct part units are not taken into account in determining the critical access hospital's compliance with the limits on the number of beds and length of stay in 42 CFR 485.620.