

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§412.25(a)(2)	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. (2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare	PC.01.01.01, EP 2 The critical access hospital follows a written process for accepting a patient that addresses the following:	PC.11.01.01, EP 1 The critical access hospital develops and implements a written process for accepting a patient that addresses
	patients.	- 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.	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	and support patient care, treatment, and services.	the patient is referred to internal providers of care,
	transferred to the unit.		treatment, and services.
		PC.02.02.01, EP 1	Note: For rehabilitation distinct part units in critical
		The critical access hospital follows a process to receive	access hospitals: The process includes how it will
		or share patient information when the patient is referred	transmit necessary clinical patient information to the
		to other internal or external providers of care, treatment,	distinct part unit when a critical access hospital patient
		and services.	is transferred to the unit.
		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.	
§412.25(a)(5)	(5) Meet applicable State licensure	LD.04.01.01, EP 1	LD.13.01.01, EP 2
	laws.	The critical access hospital is licensed, is certified, or has	The critical access hospital is licensed in accordance
		a permit, in accordance with law and regulation, to	with law and regulation to provide the care, treatment,
		provide the care, treatment, or services for which the	or services for which the critical access hospital is
		critical access hospital is seeking accreditation from The	seeking accreditation from The Joint Commission.
		Joint Commission.	Note: For rehabilitation or psychiatric distinct part units
		Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical	in critical access hospitals: The critical access hospital is licensed or approved as meeting the standards for
		Laboratory Improvement Amendments of 1988 (CLIA '88)	licensing established by the state or responsible
		certificate as specified by the federal CLIA regulations (42	, ,
		Certificate as specified by the federal OLIA regulations (42)	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_C ertificate_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.	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	LD.01.03.01, EP 2	NPG.12.01.01, EP 1
	cost reporting period for which all	For rehabilitation and psychiatric distinct part units in	Leaders provide for an adequate number and mix of
	other exclusion requirements are	critical access hospitals: The governing body provides for	qualified individuals to support safe, quality care,
	met, the unit is fully equipped and	organization management and planning.	treatment, and services.
	staffed and is capable of providing		Note 1: The number and mix of individuals is
	hospital inpatient psychiatric or	LD.03.03.01, EP 2	appropriate to the scope and complexity of the services
	rehabilitation care regardless of	Planning is hospitalwide, systematic, and involves	offered. Services may include but are not limited to the
	whether there are any inpatients in	designated individuals and information sources.	following:
	the unit on that date.		- Rehabilitation services
		LD.03.06.01, EP 2	- Emergency services
		Leaders provide for a sufficient number and mix of	- Outpatient services
		individuals to support safe, quality care, treatment, and	- Respiratory services
		services.	- Pharmaceutical services, including emergency
		Note: The number and mix of individuals is appropriate to	pharmaceutical services
		the scope and complexity of the services offered.	- Diagnostic and therapeutic radiology services
			Note 2: Emergency services staff are qualified in
		LD.04.01.11, EP 2	emergency care.
		The arrangement and allocation of space supports safe,	Note 3: For rehabilitation and psychiatric distinct part
		efficient, and effective care, treatment, and services.	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	exclusion requirements are met, the unit is fully
		The leaders provide for equipment, information systems,	equipped and staffed and is capable of providing
		supplies, and other resources.	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	PC.01.01.01, EP 33	PC.11.01.01, EP 3
	admission to the unit is required	For psychiatric distinct part units in critical access	For psychiatric distinct part units in critical access

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	for active treatment, of an intensity	hospitals: Patients with a psychiatric principal diagnosis	hospitals: Patients with a psychiatric principal
	that can be provided appropriately	(listed in the American Psychiatric Association Diagnostic	diagnosis (listed in the American Psychiatric
	only in an inpatient hospital	and Statistical Manual of Mental Disorders, 4th Edition,	Association Diagnostic and Statistical Manual of Mental
	setting, of a psychiatric principal	Text Revision (DSM-IV-TR) or in Chapter 5 of the	Disorders, 4th Edition, Text Revision (DSM-IV-TR) or in
	diagnosis that is listed in the	International Classification of Diseases, 9th Revision	Chapter 5 of the International Classification of
	Fourth Edition, Text Revision of the	(ICD-9-CM)) are admitted only when the intensity of the	Diseases, 9th Revision (ICD-9-CM)) are admitted only
	American Psychiatric	active treatment can be provided only in an inpatient	when the intensity of the active treatment can be
	Association's Diagnostic and	hospital setting.	provided only in an inpatient hospital setting.
	Statistical Manual, or in Chapter		
	Five ("Mental Disorders") of the		
	International Classification of		
	Diseases, Ninth Revision, Clinical		
	Modification.		
§412.27(b)	(b) Furnish, through the use of	LD.04.03.01, EP 14	LD.13.03.01, EP 18
	qualified personnel, psychological	For psychiatric distinct part units in critical access	For psychiatric distinct part units in critical access
	services, social work services,	hospitals: The critical access hospital provides	hospitals: The critical access hospital provides
	psychiatric nursing, and	psychological services, social work services, psychiatric	psychological services, social work services,
	therapeutic activities.	nursing, and therapeutic activities.	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		RC.11.01.01, EP 6
	permit determination of the degree		For psychiatric distinct part units in critical access
	and intensity of the treatment		hospitals: The medical record reflects the degree and
	provided to individuals who are		intensity of treatment and contains the following
	furnished services in the unit, and		information:
			- History of findings and treatment provided for the

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	that meet the following		psychiatric condition for which the patient is
	requirements:		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
0.440.07(.)(4)	(4) 5		discharge
§412.27(c)(1)	(1) Development of	PC.01.02.13, EP 1	RC.11.01.01, EP 6
	assessment/diagnostic data.	For psychiatric distinct part units in critical access	For psychiatric distinct part units in critical access
	Medical records must stress the	hospitals: Patients who receive treatment for emotional	hospitals: The medical record reflects the degree and
	psychiatric components of the	and behavioral disorders receive an assessment that	intensity of treatment and contains the following
	record, including history of	includes a history of mental, emotional, behavioral, and	information:
	findings and treatment provided for the psychiatric condition for	substance use problems, their co-occurrence, and their	- History of findings and treatment provided for the
		treatment.	psychiatric condition for which the patient is hospitalized
	which the inpatient is treated in	DC 01 02 12 ED 2	· .
	the unit.	PC.01.02.13, EP 2	- Identification data, including the patient's legal status

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		For psychiatric distinct part units in critical access	- Provisional or admitting diagnosis for the patient at the
		hospitals: Patients who receive treatment for emotional	time of admission that includes the diagnoses of
		and behavioral disorders receive an assessment that	intercurrent diseases as well as the psychiatric
		includes the following:	diagnoses
		- Current mental, emotional, and behavioral functioning	- Reasons for admission, as stated by the patient and/or
		- Maladaptive or other behaviors that create a risk to the	others significantly involved
		patient or others	- Social service records, including reports of interviews
		- Mental status examination	with patients, family members, and others; an
		- Reason for admission as stated by the patient and/or	assessment of home plans, family attitudes, and
		others significantly involved in the patient's care.	community resource contacts; and a social history
			- When indicated, record of a complete neurological
		RC.02.01.01, EP 2	examination, recorded at the time of the admission
		The medical record contains the following clinical	physical examination
		information:	- Documentation of treatment received, including all
		- The reason(s) for admission for care, treatment, and	active therapeutic efforts
		services	- Discharge summary of the patient's hospitalization
		- The patient's initial diagnosis, diagnostic impression(s),	that includes a recapitulation of the patient's
		or condition(s)	hospitalization in the unit, recommendations from
		- Any findings of assessments and reassessments	appropriate services concerning follow-up or aftercare,
		- Any allergies to food	and a brief summary of the patient's condition on
		- Any allergies to medications	discharge
		- 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	

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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	RC.02.01.01, EP 1	RC.11.01.01, EP 6
	include the inpatient's legal status.	The medical record contains the following demographic	For psychiatric distinct part units in critical access
		information:	hospitals: The medical record reflects the degree and
		- The patient's name, address, and date of birth, and the	intensity of treatment and contains the following
		name of any legally authorized representative	information:
		- The patient's sex	- History of findings and treatment provided for the
		- The legal status of any patient receiving behavioral	psychiatric condition for which the patient is

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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, 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

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

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	
§412.27(c)(1)(iii)	(iii) The reasons for admission	PC.01.02.13, EP 2	RC.11.01.01, EP 6
	must be clearly documented as	For psychiatric distinct part units in critical access	For psychiatric distinct part units in critical access
	stated by the inpatient or others	hospitals: Patients who receive treatment for emotional	hospitals: The medical record reflects the degree and
	significantly involved, or both.	and behavioral disorders receive an assessment that	intensity of treatment and contains the following
		includes the following:	information:
		- Current mental, emotional, and behavioral functioning	- History of findings and treatment provided for the
		- Maladaptive or other behaviors that create a risk to the	psychiatric condition for which the patient is
		patient or others	hospitalized
		- Mental status examination	- Identification data, including the patient's legal status
		- Reason for admission as stated by the patient and/or	- Provisional or admitting diagnosis for the patient at the
		others significantly involved in the patient's 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,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			and a brief summary of the patient's condition on
			discharge
§412.27(c)(1)(iv)	(iv) The social service records,	PC.01.02.13, EP 3	RC.11.01.01, EP 6
	including reports of interviews with	For psychiatric distinct part units in critical access	For psychiatric distinct part units in critical access
	inpatients, family members, and	hospitals: Based on the patient's age and needs, the	hospitals: The medical record reflects the degree and
	others must provide an	assessment for patients who receive treatment for	intensity of treatment and contains the following
	assessment of home plans and	emotional and behavioral disorders includes the	information:
	family attitudes, and community	following:	- History of findings and treatment provided for the
	resource contacts as well as a	- The patient's religion and spiritual beliefs, values, and	psychiatric condition for which the patient is
	social history.	preferences	hospitalized
		- Living situation	- Identification data, including the patient's legal status
		- Leisure and recreational activities	- Provisional or admitting diagnosis for the patient at the
		- Military service history	time of admission that includes the diagnoses of
		- Peer group	intercurrent diseases as well as the psychiatric
		- Social factors	diagnoses
		- Ethnic and cultural factors	- Reasons for admission, as stated by the patient and/or
		- Financial status	others significantly involved
		- Vocational or educational background	- Social service records, including reports of interviews
		- Legal history	with patients, family members, and others; an
		- Communication skills	assessment of home plans, family attitudes, and
			community resource contacts; and a social history
		PC.01.02.13, EP 4	- When indicated, record of a complete neurological
		For psychiatric distinct part units in critical access	examination, recorded at the time of the admission
		hospitals: Based on the patient's age and needs, the	physical examination
		assessment for patients who receive treatment for	- Documentation of treatment received, including all
		emotional and behavioral disorders includes the	active therapeutic efforts
		following:	- Discharge summary of the patient's hospitalization
		- Any history of physical or sexual abuse as either the	that includes a recapitulation of the patient's
		abuser or abused	hospitalization in the unit, recommendations from
		- The patient's sexual history	appropriate services concerning follow-up or aftercare,
		- Childhood history	and a brief summary of the patient's condition on
		- Emotional and health care issues	discharge
		- Visual-motor functioning	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
S412.27(c)(1)(v)	(v) When indicated, a complete neurological examination must be	- 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 PC.01.02.13, EP 6 For psychiatric distinct part units in critical access	PC.11.02.03, EP 1 For psychiatric distinct part units in critical access
	recorded at the time of the admission physical examination.	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	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	PC.11.02.03, EP 2
		The patient receives a medical history and physical	For psychiatric distinct part units in critical access
		examination no more than 30 days prior to, or within 24	hospitals: Each patient receives a psychiatric
		hours after, registration or inpatient admission, but prior	evaluation completed within 60 hours of admission. The
		to surgery or a procedure requiring anesthesia services.	psychiatric evaluation includes the following:
		Note 1: For rehabilitation and psychiatric distinct part	- Medical history
		units in critical access hospitals: Medical histories and	- Record of mental status
		physical examinations are performed as required in this	- Description of the onset of illness and the
		element of performance, except any specific outpatient	circumstances leading to admission
		surgical or procedural services for which an assessment	- Description of attitudes and behavior
		is performed instead.	- Estimation of intellectual functioning, memory
		Note 2: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR	functioning, and orientation - Inventory of the patient's assets in descriptive, not
		482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A:	interpretative, fashion
		Medicare Requirements for Hospitals" (AXA) for full text.	interpretative, rasmon
		Tredicate negationents for Prospitate (AVA) for fatt 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	

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	PC.01.02.13, EP 2	PC.11.02.03, EP 2
	status;	For psychiatric distinct part units in critical access	For psychiatric distinct part units in critical access
		hospitals: Patients who receive treatment for emotional	hospitals: Each patient receives a psychiatric
		and behavioral disorders receive an assessment that	evaluation completed within 60 hours of admission. The
		includes the following:	psychiatric evaluation includes the following:
		- Current mental, emotional, and behavioral functioning	- Medical history
		- Maladaptive or other behaviors that create a risk to the	- Record of mental status
		patient or others	- Description of the onset of illness and the
		- Mental status examination	circumstances leading to admission
		- Reason for admission as stated by the patient and/or	- Description of attitudes and behavior
		others significantly involved in the patient's care.	- 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	PC.01.02.13, EP 1	PC.11.02.03, EP 2
3412.27(0)(2)(10)	the circumstances leading to	For psychiatric distinct part units in critical access	For psychiatric distinct part units in critical access
	admission;	hospitals: Patients who receive treatment for emotional	hospitals: Each patient receives a psychiatric
	adimesisin,	and behavioral disorders receive an assessment that	evaluation completed within 60 hours of admission. The
		includes a history of mental, emotional, behavioral, and	psychiatric evaluation includes the following:
		substance use problems, their co-occurrence, and their	- Medical history
		treatment.	- Record of mental status
			- Description of the onset of illness and the
		PC.01.02.13, EP 2	circumstances leading to admission
		For psychiatric distinct part units in critical access	- Description of attitudes and behavior
		hospitals: Patients who receive treatment for emotional	- Estimation of intellectual functioning, memory
		and behavioral disorders receive an assessment that	functioning, and orientation
		includes the following:	- Inventory of the patient's assets in descriptive, not
		- Current mental, emotional, and behavioral functioning	interpretative, fashion
		- Maladaptive or other behaviors that create a risk to the	
		patient or others	
		- Mental status examination	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
\$412.27(c)(2)(vii)	(vii) Include an inventory of the	- 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 3	- 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 PC.11.02.03, EP 2
	inpatient's assets in descriptive, not interpretative fashion.	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	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-	PC.01.03.01, EP 5	- Substantiated diagnosis
	term and long-term goals; the	The written plan of care is based on the patient's goals	- Short-term and long-term goals
	specific treatment modalities	and the time frames, settings, and services required to	- Specific treatment modalities utilized
	utilized; the responsibilities of	meet those goals.	- Responsibilities of each member of the treatment
	each member of the treatment	Note: For psychiatric distinct part units in critical access	team
	team; and adequate	hospitals: The patient's goals include both short- and	- Adequate documentation to justify the diagnosis and
	documentation to justify the	long-term goals.	the treatment and rehabilitation activities carried out
	diagnosis and the treatment and		
	rehabilitation activities carried	PC.01.03.01, EP 43	
	out; and	For psychiatric distinct part units in critical access	
		hospitals: The plan of care includes the responsibilities of	
		each member of the treatment team.	
§412.27(c)(3)(ii)	(ii) The treatment received by the	RC.01.01.01, EP 5	RC.11.01.01, EP 6
	inpatient must be documented in	The medical record includes the following:	For psychiatric distinct part units in critical access
	such a way as to assure that all	- Information needed to support the patient's diagnosis	hospitals: The medical record reflects the degree and
	active therapeutic efforts are	and condition	intensity of treatment and contains the following
	included.	- Information needed to justify the patient's care,	information:
		treatment, and services	- History of findings and treatment provided for the
		- Information that documents the course and result of the	psychiatric condition for which the patient is
		patient's care, treatment, and services	hospitalized
		- Information about the patient's care, treatment, and	- Identification data, including the patient's legal status
		services that promotes continuity of care among staff and	- Provisional or admitting diagnosis for the patient at the
		providers	time of admission that includes the diagnoses of
		Note: For critical access hospitals that elect The Joint	intercurrent diseases as well as the psychiatric
		Commission Primary Care Medical Home option: This	diagnoses
		requirement refers to care provided by both internal and	- Reasons for admission, as stated by the patient and/or
		external providers.	others significantly involved
		DC 00 04 04 FD 0	- Social service records, including reports of interviews
		RC.02.01.01, EP 2	with patients, family members, and others; an
		The medical record contains the following clinical information:	assessment of home plans, family attitudes, and
			community resource contacts; and a social history
		- The reason(s) for admission for care, treatment, and	- When indicated, record of a complete neurological
		services	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),	physical examination
		or condition(s)	- Documentation of treatment received, including all
		- Any findings of assessments and reassessments	active therapeutic efforts
		- Any allergies to food	- Discharge summary of the patient's hospitalization
		- Any allergies to medications	that includes a recapitulation of the patient's
		- Any conclusions or impressions drawn from the	hospitalization in the unit, recommendations from
		patient's medical history and physical examination	appropriate services concerning follow-up or aftercare,
		- Any diagnoses or conditions established during the	and a brief summary of the patient's condition on
		patient's course of care, treatment, and services	discharge
		(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.	

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	PC.01.03.01, EP 1	RC.12.01.01, EP 4
	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	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.	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.
	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.	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	

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	
§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	least monthly thereafter. 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	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
	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.	 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 	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	diagnoses
		Note 1: A discharge summary is not required when a	- Reasons for admission, as stated by the patient and/or
		patient is seen for minor problems or interventions, as	others significantly involved
		defined by the medical staff. In this instance, a final	- Social service records, including reports of interviews
		progress note may be substituted for the discharge	with patients, family members, and others; an
		summary provided the note contains the outcome of	assessment of home plans, family attitudes, and
		hospitalization, disposition of the case, and provisions for	community resource contacts; and a social history
		follow-up care. Note 2: When a patient is transferred to a different level of	- When indicated, record of a complete neurological examination, recorded at the time of the admission
		care within the critical access hospital, and caregivers	physical examination
		change, a transfer summary may be substituted for the	- Documentation of treatment received, including all
		discharge summary. If the caregivers do not change, a	active therapeutic efforts
		progress note may be used.	- Discharge summary of the patient's hospitalization
		progress made made account	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	LD.03.06.01, EP 2	NPG.12.03.01, EP 4
	in that the unit must have	Leaders provide for a sufficient number and mix of	For psychiatric distinct part units in critical access
	adequate numbers of qualified	individuals to support safe, quality care, treatment, and	hospitals: There is an adequate number of qualified
	professional and supportive staff	services.	professional, technical, and consultative staff
	to evaluate inpatients, formulate	Note: The number and mix of individuals is appropriate to	(including but not limited to doctors of medicine and/or
	written, individualized,	the scope and complexity of the services offered.	osteopathy, registered nurses, licensed practical
	comprehensive treatment plans,	I D 00 00 04 5D 0	nurses, and mental health workers) to do the following:
	provide active treatment measures	LD.03.06.01, EP 3	- Evaluate patients
	and engage in discharge planning,	Those who work in the critical access hospital are	- Formulate written individualized, comprehensive
	as follows:	competent to complete their assigned responsibilities.	treatment plans - Provide active treatment measures
			- Provide active treatment measures - Engage in discharge planning
			- Provide the nursing care necessary under each
			patient's active treatment program
			patient 3 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
			osteopathy, registered nurses, licensed practical
		PC.01.03.01, EP 5	nurses, and mental health workers) to do the following:
		The written plan of care is based on the patient's goals	- Evaluate patients
		and the time frames, settings, and services required to	- Formulate written individualized, comprehensive
		meet those goals.	treatment plans
		Note: For psychiatric distinct part units in critical access	- Provide active treatment measures
		hospitals: The patient's goals include both short- and	- Engage in discharge planning
		long-term goals.	- Provide the nursing care necessary under each
			patient's active treatment program
		PC.01.03.01, EP 22	- Maintain progress notes on each patient
		Based on the goals established in the patient's plan of	- Provide essential psychiatric services
		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.	
§412.27(d)(1)(iii)	(iii) Provide active treatment	PC.01.03.01, EP 1	NPG.12.03.01, EP 4
	measures; and	The critical access hospital plans the patient's care,	For psychiatric distinct part units in critical access
		treatment, and services based on needs identified by the	hospitals: There is an adequate number of qualified
		patient's assessment, reassessment, and results of	professional, technical, and consultative staff
		diagnostic testing.	(including but not limited to doctors of medicine and/or
			osteopathy, registered nurses, licensed practical
		PC.01.03.01, EP 5	nurses, and mental health workers) to do the following:
		The written plan of care is based on the patient's goals	- Evaluate patients
		and the time frames, settings, and services required to	- Formulate written individualized, comprehensive
		meet those goals.	treatment plans
		Note: For psychiatric distinct part units in critical access	- Provide active treatment measures

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospitals: The patient's goals include both short- and	- Engage in discharge planning
		long-term goals.	- Provide the nursing care necessary under each
			patient's active treatment program
		PC.01.03.01, EP 22	- Maintain progress notes on each patient
		Based on the goals established in the patient's plan of	- Provide essential psychiatric services
		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.	
§412.27(d)(1)(iv)	(iv) Engage in discharge planning.	PC.04.01.03, EP 1	NPG.12.03.01, EP 4
		The critical access hospital begins the discharge planning	For psychiatric distinct part units in critical access
		process early in the patient's episode of care, treatment,	hospitals: There is an adequate number of qualified
		and services.	professional, technical, and consultative staff
			(including but not limited to doctors of medicine and/or
		PC.04.01.03, EP 2	osteopathy, registered nurses, licensed practical
		The critical access hospital identifies any needs the	nurses, and mental health workers) to do the following:
		patient may have for psychosocial or physical care,	- Evaluate patients
		treatment, and services after discharge or transfer.	- Formulate written individualized, comprehensive treatment plans
		PC.04.01.03, EP 3	- Provide active treatment measures
		The patient, the patient's family, physicians, other	- Engage in discharge planning
		licensed practitioners, clinical psychologists, and staff	- Provide the nursing care necessary under each
		involved in the patient's care, treatment, and services	patient's active treatment program
		participate in planning the patient's discharge or transfer.	- Maintain progress notes on each patient
		Note 1: For rehabilitation and psychiatric distinct part	- Provide essential psychiatric services
		units in critical access hospitals: The definition of	

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	LD.04.01.05, EP 1	MS.17.01.03, EP 6
	services: Medical staff. Inpatient	Leaders of the program, service, site, or department	For psychiatric distinct part units in critical access
	psychiatric services must be under	oversee operations.	hospitals: Inpatient psychiatric services are under the
	the supervision of a clinical		direction and supervision of a clinical director, service
	director, service chief, or	LD.04.01.05, EP 2	chief, or equivalent who is qualified to provide the
	equivalent who is qualified to	For rehabilitation and psychiatric distinct part units in	leadership required for an intensive treatment program
	provide the leadership required for	critical access hospitals: Programs, services, sites, or	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	departments providing patient care are directed by one or more qualified professionals or by a qualified licensed practitioner with clinical privileges.	requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
	provide essential psychiatric services.	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 & Emp; Medicaid Services (CMS) (refer to the Glossary).	
§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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
CoP Requirement	CoPText	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
§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.	provided is evaluated by one of the entities listed in this element of performance. 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.

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.	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.

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

		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.	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
		LD.04.03.01, EP 14 For psychiatric distinct part units in critical access	procedures.
		hospitals: The critical access hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities.	
a dire monit and a service must with a practice and p staff rebut are in discontinuous for followers.	Social services. There must be rector of social services who nitors and evaluates the quality appropriateness of social vices furnished. The services at be furnished in accordance accepted standards of ctice and established policies procedures. Social service of responsibilities must include, are not limited to, participating ischarge planning, arranging follow-up care, and developing chanisms for exchange of propriate information with reces 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, speechlanguage 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	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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		requires of its staff who provide patient care, treatment,	
		or services.	
		LD 04 04 05 ED 4	
		LD.04.01.05, EP 1	
		Leaders of the program, service, site, or department oversee operations.	
		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	
		LD.VT.VO.VI, LF 17	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
		DC 04 04 02 ED 2	
		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.	
		treatment, and services after discharge of 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 & Dedicaid 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§412.27(d)(6)	(6) Therapeutic activities. The unit must provide a therapeutic activities program.	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. 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
§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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		For psychiatric distinct part units in critical access	accordance with accepted standards of practice,
		hospitals: The critical access hospital provides	service objectives, and established policies and
		psychological services, social work services, psychiatric	procedures.
		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.	
§412.27(d)(6)(ii)	(ii) The number of qualified	HR.01.01, EP 1	NPG.12.01.01, EP 1
	therapists, support personnel, and	The critical access hospital defines staff qualifications	Leaders provide for an adequate number and mix of
	consultants must be adequate to	specific to their job responsibilities.	qualified individuals to support safe, quality care,
	provide comprehensive	Note 1: Qualifications for infection control may be met	treatment, and services.
	therapeutic activities consistent	through ongoing education, training, experience, and/or	Note 1: The number and mix of individuals is
	with each inpatient's active	certification (such as that offered by the Certification	appropriate to the scope and complexity of the services
	treatment program.	Board for Infection Control).	offered. Services may include but are not limited to the
		Note 2: For rehabilitation and psychiatric distinct part	following:
		units in critical access hospitals: Qualified physical	- Rehabilitation services
		therapists, physical therapist assistants, occupational	- Emergency services
		therapists, occupational therapy assistants, speech-	- Outpatient services
		language pathologists, or audiologists (as defined in 42	- Respiratory services
		CFR 484.4) provide physical therapy, occupational	- Pharmaceutical services, including emergency
		therapy, speech-language pathology, or audiology	pharmaceutical services
		services, if these services are provided by the critical	- Diagnostic and therapeutic radiology services
		access hospital. The provision of care and staff	Note 2: Emergency services staff are qualified in
		qualifications are in accordance with national acceptable	emergency care.
		standards of practice and also meet the requirements of	Note 3: For rehabilitation and psychiatric distinct part
		409.17. See Appendix B for 409.17 requirements.	units in critical access hospitals: As of the first day of
		LD 00 00 01 FD 0	the first cost reporting period for which all other
		LD.03.06.01, EP 2	exclusion requirements are met, the unit is fully

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Leaders provide for a sufficient number and mix of	equipped and staffed and is capable of providing
		individuals to support safe, quality care, treatment, and	hospital inpatient psychiatric or rehabilitation care
		services.	regardless of whether there are any inpatients in the
		Note: The number and mix of individuals is appropriate to	unit on that date.
		the scope and complexity of the services offered.	
			NPG.12.03.01, EP 3
		LD.03.06.01, EP 3	For psychiatric distinct part units in critical access
		Those who work in the critical access hospital are	hospitals: The number of qualified therapists, support
		competent to complete their assigned responsibilities.	personnel, and consultants is adequate to provide
			therapeutic activities consistent with each patient's
§412.29	\$412.29 Classification criteria for		active treatment program.
9412.29	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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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:		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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.		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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).		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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	MS.03.01.03, EP 1	PC.11.01.01, EP 2
	screening procedure under which	Physicians and other licensed practitioners with	For rehabilitation and psychiatric distinct part units in
	each prospective patient's	appropriate privileges manage and coordinate the	critical access hospitals: The critical access hospital
	condition and medical history are	patient's care, treatment, and services. For rehabilitation	has a preadmission screening procedure under which
	reviewed to determine whether the	and psychiatric distinct part units in critical access	each prospective patient's condition and medical

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	patient is likely to benefit	hospitals: Physicians and clinical psychologists with	history are reviewed to determine whether the patient is
	significantly from an intensive	appropriate privileges manage and coordinate the	likely to benefit significantly from an intensive inpatient
	inpatient hospital program. This	patient's care, treatment, and services.	hospital program.
	procedure must ensure that the	Note: For rehabilitation and psychiatric distinct part units	Note: This procedure makes certain that the
	preadmission screening for each	in critical access hospitals: The definition of "physician"	preadmission screening for each Medicare Part A fee-
	Medicare Part A Fee-for-Service	is the same as that used by the Centers for Medicare	for-service patient is reviewed and approved by a
	patient is reviewed and approved	& Medicaid Services (CMS) (refer to the Glossary).	rehabilitation physician prior to the patient's admission
	by a rehabilitation physician prior	MC 00 04 00 ED 5	to the inpatient rehabilitation facility.
	to the patient's admission to the IRF.	MS.03.01.03, EP 5	
	IKF.	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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	MS.03.01.03, EP 1	PC.11.02.01, EP 5
	ensure that patients receive close	Physicians and other licensed practitioners with	For rehabilitation distinct part units in critical access
	medical supervision, as evidenced	appropriate privileges manage and coordinate the	hospitals: The critical access hospital develops and
	by at least 3 face-to-face visits per	patient's care, treatment, and services. For rehabilitation	implements a process to make certain that patients
	week by a licensed physician with	and psychiatric distinct part units in critical access	receive close medical supervision, as evidenced by at
	specialized training and	hospitals: Physicians and clinical psychologists with	least three face-to-face visits per week by a licensed
	experience in inpatient	appropriate privileges manage and coordinate the	physician with specialized training and experience in
	rehabilitation to assess the patient	patient's care, treatment, and services.	inpatient rehabilitation, to assess the patient both
	both medically and functionally, as	Note: For rehabilitation and psychiatric distinct part units	medically and functionally and to modify the course of
	well as to modify the course of	in critical access hospitals: The definition of "physician"	treatment as needed to maximize the patient's capacity
	treatment as needed to maximize	is the same as that used by the Centers for Medicare	to benefit from the rehabilitation process.
	the patient's capacity to benefit	& Medicaid Services (CMS) (refer to the Glossary).	Note: Beginning with the second week, as defined in 42
	from the rehabilitation process.		CFR 412.622, after admission to the inpatient
		MS.06.01.05, EP 2	rehabilitation unit, a non-physician practitioner who is
		The critical access hospital, based on recommendations	determined by the inpatient rehabilitation unit to have
		by the organized medical staff and approval by the	specialized training and experience in inpatient
		governing body, establishes criteria that determine a	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	face-to-face patient visits per week, provided that such
		provide patient care, treatment, and services within the	duties are within the nonphysician practitioner's scope
		scope of the privilege(s) requested. Evaluation of all of the	of practice under applicable state law.
		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	

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.	
		112K.	
		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 & Description (1997)	
		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	HR.01.01.01, EP 1	PC.12.01.01, EP 4
	qualified personnel, rehabilitation	The critical access hospital defines staff qualifications	If the critical access hospital provides rehabilitation,
	nursing, physical therapy, and	specific to their job responsibilities.	physical therapy, occupational therapy, speech-

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
CoP Requirement	cop Text 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, speechlanguage 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	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, speechlanguage pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services by qualified staff in accordance with national accepted standards of practice.
		<u> </u>	
		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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: Rehabilitation therapy services include physical	
		therapy, occupational therapy, and speech-language	
\$440.00(~)	(a)	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	
	WIIO—	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	LD.04.01.05, EP 2	MS.17.01.03, EP 7
	hospital and its inpatients on a	For rehabilitation and psychiatric distinct part units in	For rehabilitation distinct part units in critical access
	full-time basis or, in the case of a	critical access hospitals: Programs, services, sites, or	hospitals: The critical access hospital has a director of
	rehabilitation unit, at least 20	departments providing patient care are directed by one or	the rehabilitation unit who fulfills all of the following
	hours per week;	more qualified professionals or by a qualified licensed	requirements:
		practitioner with clinical privileges.	- Provides services to the unit and to its inpatients for at least 20 hours per week
		LD.04.01.05, EP 3	- Is a doctor of medicine or osteopathy
		For rehabilitation and psychiatric distinct part units in	- Is licensed under state law to practice medicine or
		critical access hospitals: The critical access hospital	surgery
		defines, in writing, the responsibility of those with	- Has had, after completing a one-year hospital
		administrative and clinical direction of its programs,	internship, at least two years of training or experience in
		services, sites, or departments. Note: This includes the full-time employee who directs	the medical management of inpatients requiring rehabilitation services
		and manages dietary services.	Terrapidiation 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.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
		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	

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 medicalmanagement 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	PC.01.03.01, EP 1	PC.11.03.01, EP 1
	each inpatient that is established,	The critical access hospital plans the patient's care,	The critical access hospital develops, implements, and
	reviewed, and revised as needed	treatment, and services based on needs identified by the	revises a written individualized plan of care based on
	by a physician in consultation with	patient's assessment, reassessment, and results of	the following:
	other professional personnel who	diagnostic testing.	- Needs identified by the patient's assessment,
	provide services to the patient.	DO 04 00 04 ED 5	reassessment, and results of diagnostic testing
		PC.01.03.01, EP 5	- The patient's goals and the time frames, settings, and
		The written plan of care is based on the patient's goals and the time frames, settings, and services required to	services required to meet those goals Note 1: Nursing staff develops and keeps current a
		meet those goals.	nursing plan of care, which may be a part of an
		Note: For psychiatric distinct part units in critical access	interdisciplinary plan of care, for each inpatient.
		hospitals: The patient's goals include both short- and	Note 2: The hospital evaluates the patient's progress
		long-term goals.	and revises the plan of care based on the patient's
			progress.
		PC.01.03.01, EP 22	Note 3: For rehabilitation distinct part units in critical
		Based on the goals established in the patient's plan of	access hospitals: The plan is reviewed and revised as
		care, staff evaluate the patient's progress.	needed by a physician in consultation with other
			professional staff who provide services to the patient.
		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.	
§412.29(i)	(i) Use a coordinated	PC.02.01.05, EP 1	PC.12.01.03, EP 1
	interdisciplinary team approach in	Care, treatment, and services are provided to the patient	The critical access hospital provides care, treatment,
	the rehabilitation of each	in an interdisciplinary, collaborative manner.	and services to the patient in an interdisciplinary,
I	inpatient, as documented by the		collaborative manner.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	periodic clinical entries made in	PC.02.01.05, EP 2	Note: For rehabilitation distinct part units in critical
	the patient's medical record to	For rehabilitation distinct part units in critical access	access hospitals: The critical access hospital uses a
	note the patient's status in	hospitals: The critical access hospital conducts team	coordinated interdisciplinary team approach in the
	relationship to goal attainment	conferences at least once per week to determine the	rehabilitation of each inpatient, as documented by the
	and discharge plans, and that	appropriateness of the patient's treatment.	periodic clinical entries made in the patient's medical
	team conferences are held at least		record to note the patient's status related to goal
	once per week to determine the	PC.02.02.01, EP 3	attainment and discharge plans, and team conferences
	appropriateness of treatment.	The critical access hospital coordinates the patient's	that are held at least once per week to determine the
		care, treatment, and services within a time frame that	appropriateness of treatment.
		meets the patient's needs.	
		Note: Coordination involves resolving scheduling	
		conflicts and duplication of care, treatment, and services.	
§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		
§485.601	\$412.130.		
	\$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	LD.04.01.01, EP 25	LD.13.01.01, EP 6
	rural health network is an	If the critical access hospital is a member of a rural health	If the critical access hospital is a member of a rural
	organization that meets the	network, the network meets the criteria required by the	health network, the network meets the criteria required
	following specifications:	Centers for Medicare & Description (CMS)	by the Centers for Medicare & Dedicaid Services'
		regulations at 42 CFR 485.603.	(CMS) regulations at 42 CFR 485.603.
		Note: See the Glossary for a definition of rural health	Note: See the Glossary for a definition of rural health
		network.	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 & Dedicard 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		LD.13.01.01, EP 6
	State has designated or plans to		If the critical access hospital is a member of a rural
	designate as a CAH; and		health network, the network meets the criteria required
			by the Centers for Medicare & Described Services'
			(CMS) regulations at 42 CFR 485.603.
			Note: See the Glossary for a definition of rural health
0.100	(2) (1)		network.
§485.603(a)(2)	(2) At least one hospital that		LD.13.01.01, EP 6
	furnishes acute care services.		If the critical access hospital is a member of a rural
			health network, the network meets the criteria required
			by the Centers for Medicare & Described 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		LD.13.01.01, EP 6
	organization have entered into		If the critical access hospital is a member of a rural
	agreements regarding—		health network, the network meets the criteria required
			by the Centers for Medicare & Described 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 & Dedicare & 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		LD.13.01.01, EP 6
	communications systems,		If the critical access hospital is a member of a rural
	including, where feasible,		health network, the network meets the criteria required
	telemetry systems and systems for		by the Centers for Medicare & mp; Medicaid Services'
	electronic sharing of patient data;		(CMS) regulations at 42 CFR 485.603.
	and		Note: See the Glossary for a definition of rural health
			network.
§485.603(b)(3)	(3) The provision of emergency and		LD.13.01.01, EP 6
	nonemergency transportation		If the critical access hospital is a member of a rural
	among members.		health network, the network meets the criteria required
			by the Centers for Medicare & Dedicard 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		LD.13.01.01, EP 6
	with respect to credentialing and		If the critical access hospital is a member of a rural
	quality assurance with at least—		health network, the network meets the criteria required
			by the Centers for Medicare & Dedicard 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		LD.13.01.01, EP 6
	of the network when applicable;		If the critical access hospital is a member of a rural
			health network, the network meets the criteria required
			by the Centers for Medicare & mp; 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 & Dedicard 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		LD.13.01.01, EP 6
	qualified entity identified in the		If the critical access hospital is a member of a rural
	State rural health care plan.		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
0.405.00.4	0.405.004.5		network.
§485.604	\$485.604 Personnel qualifications.	HR.01.02.05, EP 43	NPG.12.01.01, EP 2
	Staff that furnish services in a CAH	Staff that provide care, treatment, and services meet the	Staff that provide care, treatment, and services meet
	must meet the applicable	personnel qualifications required by the Centers for	the personnel qualifications required by the Centers for
	requirements of this section.	Medicare & Medicaid Services' (CMS) regulations at	Medicare & Definition of the Action of the A
		42 CFR 485.604.	at 42 CFR 485.604.
		Note: The following terms are defined in the Glossary:	Note: The following terms are defined in the Glossary:
		clinical nurse specialist, nurse practitioner, physician	clinical nurse specialist, nurse practitioner, physician
		assistant.	assistant.

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.604(b)(1)	(1) Is currently certified as a		NPG.12.01.01, EP 2
	primary care nurse practitioner by		Staff that provide care, treatment, and services meet
	the American Nurses' Association		the personnel qualifications required by the Centers for
	or by the National Board of		Medicare & Medicaid Services' (CMS) regulations
	Pediatric Nurse Practitioners and		at 42 CFR 485.604.
	Associates.		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		NPG.12.01.01, EP 2
	1 academic year program that—		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
0.40=.00.4(.)(0)(")			assistant.
§485.604(b)(2)(i)	(i) Prepares registered nurses to		NPG.12.01.01, EP 2
	perform an expanded role in the		Staff that provide care, treatment, and services meet
	delivery of primary care;		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		NPG.12.01.01, EP 2
5 .55.55 ·(\&)(\Z)(\\)	the aggregate) of classroom		Staff that provide care, treatment, and services meet
	instruction and a component of		the personnel qualifications required by the Centers for
	supervised clinical practice; and		Medicare & Described 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 & Medicare & 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 & Medicare & 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 & Medicare & Services' (CMS) regulations

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	Assistants to assist primary care		at 42 CFR 485.604.
	physicians.		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		NPG.12.01.01, EP 2
	program for preparing physician		Staff that provide care, treatment, and services meet
	assistants that—		the personnel qualifications required by the Centers for
			Medicare & Amp; 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		NPG.12.01.01, EP 2
	in length;		Staff that provide care, treatment, and services meet
			the personnel qualifications required by the Centers for
			Medicare & Dedicaid 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		NPG.12.01.01, EP 2
	clinical practice and at least 4		Staff that provide care, treatment, and services meet
	months (in the aggregate) of		the personnel qualifications required by the Centers for
	classroom instruction directed		Medicare & Description (CMS) regulations
	toward preparing students to		at 42 CFR 485.604.
	deliver health care; and		Note: The following terms are defined in the Glossary:
			clinical nurse specialist, nurse practitioner, physician
\$40F CO 4/=\/O\/:::\	(iii) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		assistant.
§485.604(c)(2)(iii)	(iii) Was accredited by the		NPG.12.01.01, EP 2
	American Medical Association's		Staff that provide care, treatment, and services meet
	Committee on Allied Health		the personnel qualifications required by the Centers for
	Education and Accreditation.		Medicare & Description Medicard 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		NPG.12.01.01, EP 2
	formal educational program (for		Staff that provide care, treatment, and services meet
	preparing physician assistants)		the personnel qualifications required by the Centers for
	that does not meet the		Medicare & mp; Medicaid Services' (CMS) regulations
	requirements of paragraph (c)(2) of		at 42 CFR 485.604.
	this section and has been		Note: The following terms are defined in the Glossary:
	assisting primary care physicians		clinical nurse specialist, nurse practitioner, physician
	for a total of 12 months during the		assistant.
	18-month period immediately		
	preceding June 25, 1993.		
§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	LD.04.01.01, EP 1	LD.13.01.01, EP 1
	Participation: Compliance With	The critical access hospital is licensed, is certified, or has	The critical access hospital provides care, treatment,
	Federal, State, and Local Laws and	a permit, in accordance with law and regulation, to	and services in accordance with licensure
	Regulations The CAH and its staff	provide the care, treatment, or services for which the	requirements and federal, state, and local laws, rules,
	are in compliance with applicable	critical access hospital is seeking accreditation from The	and regulations.
	Federal, State and local laws and	Joint Commission.	
	regulations.	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-	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_C	
		ertificate_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:	LD.04.01.01, EP 2	LD.13.01.01, EP 1
	Compliance With Federal Laws	The critical access hospital provides care, treatment, and	The critical access hospital provides care, treatment,
	and Regulations The CAH is in	services in accordance with licensure requirements, laws	and services in accordance with licensure
	compliance with applicable	(including state law), and rules and regulations.	requirements and federal, state, and local laws, rules,
	Federal laws and regulations		and regulations.
	related to the health and safety of	LD.04.01.01, EP 3	
	patients.	Leaders act on or comply with reports or	
		recommendations from external authorized agencies,	
		such as accreditation, certification, or regulatory bodies.	
§485.608(b)	§485.608(b) Standard:	LD.04.01.01, EP 2	LD.13.01.01, EP 1
	Compliance With State and Local	The critical access hospital provides care, treatment, and	The critical access hospital provides care, treatment,
	Laws and Regulations All patient	services in accordance with licensure requirements, laws	and services in accordance with licensure
	care services are furnished in	(including state law), and rules and regulations.	requirements and federal, state, and local laws, rules,
	accordance with applicable State		and regulations.
2425 2224)	and local laws and regulations.	10040404504	ID 40 04 04 ED 0
§485.608(c)	§485.608(c) Standard: Licensure	LD.04.01.01, EP 1	LD.13.01.01, EP 2
	of CAH The CAH is licensed in	The critical access hospital is licensed, is certified, or has	The critical access hospital is licensed in accordance
	accordance with applicable	a permit, in accordance with law and regulation, to	with law and regulation to provide the care, treatment,
	Federal, State and local laws and	provide the care, treatment, or services for which the critical access hospital is seeking accreditation from The	or services for which the critical access hospital is seeking accreditation from The Joint Commission.
	regulations.	Joint Commission.	Note: For rehabilitation or psychiatric distinct part units
		יוווער פיווווווווים ווווווים וווווים וווווים וווווים ווווים ווווים ווווים ווווים ווווים ווווים ווווים ווווים ו	Note. For renabilitation of 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_C ertificate_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,		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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,		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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 colocation 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	
§485.614(a)	(a) Standard: Notice of rights.	patient's dignity.	
§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.01.03, 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	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.
		complaint and informs the patient and the patient's family about it. Note: The governing body is responsible for the effective	RI.14.01.01, EP 2 The 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) \$485.614(b)(1)	(b) Standard: Exercise of rights (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	Note: For swing beds in critical access hospitals: The	being involved in care planning and treatment, and
	status, being involved in care	selection of the surrogate decision-maker is in	being able to request or refuse treatment. This does not
	planning and treatment, and being	accordance with state law.	mean the patient has the right to demand the provision
	able to request or refuse		of treatment or services deemed medically
	treatment. This right must not be	RI.01.02.01, EP 3	unnecessary or inappropriate.
	construed as a mechanism to	The critical access hospital provides the patient or	
	demand the provision of treatment	surrogate decision-maker with written information about	
	or services deemed medically unnecessary or inappropriate.	the right to refuse care, treatment, and services.	
	unnecessary of mappropriate.	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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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,	
\$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).	treatment, and services. 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 lifesustaining 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	RI.01.02.01, EP 1	RI.12.01.01, EP 2
	a family member or representative	The critical access hospital involves the patient in making	The critical access hospital asks the patient whether
	of their choice and their own	decisions about their care, treatment, and services,	they want a family member, representative, or physician
	physician notified promptly of their	including the right to have the patient's family and	or other licensed practitioner notified of their admission
	admission to the hospital.	physician or other licensed practitioner promptly notified	to the critical access hospital. The critical access
		of their admission to or discharge or transfer from the	hospital promptly notifies the identified individual(s).
		critical access hospital.	Note: The patient is informed, prior to the notification
		Note 1: The patient is informed, prior to the notification	occurring, of any process to automatically notify the
		occurring, of any process to automatically notify the	patient's established primary care practitioner, primary
		patient's established primary care practitioner, primary	care practice group/entity, or other practitioner
		care practice group/entity, or other practitioner group/entity, as well as all applicable post–acute care	group/entity, as well as all applicable post–acute care service providers and suppliers. The critical access
		services providers and suppliers. The critical access	hospital has a process for documenting a patient's
		hospital has a process for documenting a patient's refusal	refusal to permit notification of registration to the
		to permit notification of registration to the emergency	emergency department, admission to an inpatient unit,
		department, admission to an inpatient unit, or discharge	or discharge or transfer from the emergency
		or transfer from the emergency department or inpatient	department or inpatient unit. Notifications with primary
		unit. Notifications with primary care practitioners and	care practitioners and entities are in accordance with
		entities are in accordance with all applicable federal and	all applicable federal and state laws and regulations.
		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.	
§485.614(c)	(c) Standard: Privacy and safety.		
§485.614(c)(1)	(1) The patient has the right to	RI.01.01.01, EP 7	RI.11.01.01, EP 5
	personal privacy.	The critical access hospital respects the patient's right to	The critical access hospital respects the patient's right
		privacy.	to personal privacy.
		Note: This element of performance (EP) addresses a	Note 1: This element of performance (EP) addresses a
		patient's personal privacy. For EPs addressing the privacy	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	Standard IM.12.01.01.
		IM.02.01.01.	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	EC.01.01.01, EP 4	PE.01.01.01, EP 1
	receive care in a safe setting.	The critical access hospital has a written plan for	The critical access hospital's building is constructed,
		managing the following: The environmental safety of	arranged, and maintained to allow safe access and to
		patients and everyone else who enters the critical access	protect the safety and well-being of patients.
		hospital's facilities.	Note 1: Diagnostic and therapeutic facilities are located
			in areas appropriate for the services provided.
		EC.01.01.01, EP 5	Note 2: When planning for new, altered, or renovated
		The critical access hospital has a written plan for	space, the critical access hospital uses state rules and
		managing the following: The security of everyone who	regulations or the current Guidelines for Design and
		enters the critical access hospital's facilities.	Construction of Hospitals published by the Facility
			Guidelines Institute. If the state rules and regulations or
		EC.02.01.01, EP 3	the Guidelines do not address the design needs of the
		The critical access hospital takes action to minimize or	critical access hospital, then it uses other reputable
		eliminate identified safety and security risks in the	standards and guidelines that provide equivalent design
		physical environment.	criteria.
		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.	
§485.614(c)(3)	(3) The patient has the right to be	RI.01.06.03, EP 1	RI.13.01.01, EP 1
. , , ,	free from all forms of abuse or	The critical access hospital protects the patient from	The critical access hospital protects the patient from
	harassment.	harassment, neglect, exploitation, corporal punishment,	harassment, neglect, exploitation, corporal
		and abuse that could occur while the patient is receiving	punishment, involuntary seclusion, and verbal, mental,
		care, treatment, and services.	sexual, or physical abuse that could occur while the
		Note: For critical access hospitals with swing beds: The	patient is receiving care, treatment, and services.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		critical access hospital protects residents from	For swing beds in critical access hospitals: The critical
		involuntary seclusion.	access hospital also protects the resident from
			misappropriation of property.
		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	
S40F C14(d)	(d) Chandards Carefidentiality of	allegation does not involve abuse or serious bodily injury	
§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:
§485.614(d)(2)	(2) The patient has the right to	RI.01.01.01, EP 10	Policies and procedures also address the resident's personal records. RI.11.01.01, EP 6
	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.	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).	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	PC.03.05.01, EP 1	PC.13.02.01, EP 1
	seclusion. All patients have the right to be free from physical or mental abuse, and corporal	The critical access hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others.	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
Cor nequirement	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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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.	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. 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)(ii)(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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	that are consistent with current	policies and procedures also include the following:	
	standards of practice.	- Restraint and seclusion may only be used when less	For rehabilitation and psychiatric distinct part units in
		restrictive interventions have been determined to be	critical access hospitals: The policies and procedures
		ineffective to protect the patient, a staff member, or	include the following:
		others from harm.	- Definitions for restraint and seclusion that are
		- A definition of restraint in accordance with 42 CFR	consistent with state and federal law and regulation
		485.614 (e)(1)(i)(A-C).	- Physician and other licensed practitioner training
		- A definition of seclusion in accordance with 42 CFR	requirements
		485.614 (e)(1)(ii).	- Staff training requirements
		Note 1: The definition of restraint per 42 CFR 485.614	- Who has authority to order restraint or seclusion
		(e)(1)(i)(A–C) is as follows:	- Who has authority to discontinue the use of restraint
		42 CFR 485.614 (e)(1) Definitions. (i) A restraint is— (A)	or seclusion
		Any manual method, physical or mechanical device,	- Who can initiate the use of restraint or seclusion
		material, or equipment that immobilizes or reduces the	- Circumstances under which restraint or seclusion is
		ability of a patient to move his or her arms, legs, body, or	discontinued
		head freely; or 42 CFR 485.614 (e)(1)(i)(B) (A restraint is—	- Requirement that restraint or seclusion is
) A drug or medication when it is used as a restriction to	discontinued as soon as is safely possible
		manage the patient's behavior or restrict the patient's	- Who can assess and monitor patients in restraint or
		freedom of movement and is not a standard treatment or	seclusion
		dosage for the patient's condition.	- Time frames for assessing and monitoring patients in
		42 CFR 485.614 (e)(1)(i)(C) A restraint does not include	restraint or seclusion
		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	

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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	information to the Centers for Medicare & Decical Control of the Centers for Medicare & Decical Office of the Center of t	information to the Centers for Medicare & Description (1975)
	use of seclusion or restraint.	Services (CMS) regarding deaths related to restraint or	Medicaid Services regarding deaths related to restraint
		seclusion (this requirement does not apply to deaths	or seclusion:
		related to the use of soft wrist restraints; for more	- Each death that occurs while a patient is in restraint or
		information, refer to EP 3 in this standard):	seclusion
		- Each death that occurs while a patient is in restraint or	- Each death that occurs within 24 hours after the
		seclusion	patient has been removed from restraint or seclusion
		- Each death that occurs within 24 hours after the patient	- Each death known to the critical access hospital that
		has been removed from restraint or seclusion	occurs within one week after restraint or seclusion was
		- Each death known to the critical access hospital that	used when it is reasonable to assume that the use of
		occurs within one week after restraint or seclusion was	the restraint or seclusion contributed directly or
		used when it is reasonable to assume that the use of the	indirectly to the patient's death
		restraint or seclusion contributed directly or indirectly to	Note 1: This reporting requirement includes all
		the patient's death. The types of restraints included in this	restraints except soft wrist restraints. For more
		reporting requirement are all restraints except soft wrist	information on deaths related to the use of soft wrist
		restraints.	restraints, refer to EP 3 in this standard.
		Note: In this element of performance "reasonable to	Note 2: In this element of performance "reasonable to
		assume" includes, but is not limited to, deaths related to	assume" includes but is not limited to deaths related to
		restrictions of movement for prolonged periods of time or	restrictions of movement for prolonged periods of time
		deaths related to chest compression, restriction of	or deaths related to chest compression, restriction of
		breathing, or asphyxiation.	breathing, or asphyxiation.
§485.614(g)(1)	(1) With the exception of deaths	PC.03.05.19, EP 2	PC.13.02.19, EP 2
	described under paragraph (g)(2)	The deaths addressed in PC.03.05.19, EP 1, are reported	The deaths addressed in PC.13.02.19, EP 1, are
	of this section, the hospital must	to the Centers for Medicare & Dedicard Services	reported to the Centers for Medicare & Dedicaid
	report the following information to	(CMS) by telephone, by facsimile, or electronically no	Services by telephone, by facsimile, or electronically no
	CMS by telephone, facsimile, or	later than the close of the next business day following	later than the close of the next business day following
	electronically, as determined by	knowledge of the patient's death. The date and time that	knowledge of the patient's death. The date and time
	CMS, no later than the close of	the patient's death was reported is documented in the	that the patient's death was reported is documented in
	business on the next business day	patient's medical record.	the patient's medical record.
	following knowledge of the		
	patient's death:		
§485.614(g)(1)(i)	(i) Each death that occurs while a	PC.03.05.19, EP 1	PC.13.02.19, EP 1
	patient is in restraint or seclusion.	The critical access hospital reports the following	The critical access hospital reports the following

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		information to the Centers for Medicare & Decical Control of the Centers for Medicare & Decical Office of the Center of the	information to the Centers for Medicare & Description (1988)
		Services (CMS) regarding deaths related to restraint or	Medicaid Services regarding deaths related to restraint
		seclusion (this requirement does not apply to deaths	or seclusion:
		related to the use of soft wrist restraints; for more	- Each death that occurs while a patient is in restraint or
		information, refer to EP 3 in this standard):	seclusion
		- Each death that occurs while a patient is in restraint or	- Each death that occurs within 24 hours after the
		seclusion	patient has been removed from restraint or seclusion
		- Each death that occurs within 24 hours after the patient	- Each death known to the critical access hospital that
		has been removed from restraint or seclusion	occurs within one week after restraint or seclusion was
		- Each death known to the critical access hospital that	used when it is reasonable to assume that the use of
		occurs within one week after restraint or seclusion was	the restraint or seclusion contributed directly or
		used when it is reasonable to assume that the use of the	indirectly to the patient's death
		restraint or seclusion contributed directly or indirectly to	Note 1: This reporting requirement includes all
		the patient's death. The types of restraints included in this	restraints except soft wrist restraints. For more
		reporting requirement are all restraints except soft wrist	information on deaths related to the use of soft wrist
		restraints.	restraints, refer to EP 3 in this standard.
		Note: In this element of performance "reasonable to	Note 2: In this element of performance "reasonable to
		assume" includes, but is not limited to, deaths related to	assume" includes but is not limited to deaths related to
		restrictions of movement for prolonged periods of time or	restrictions of movement for prolonged periods of time
		deaths related to chest compression, restriction of	or deaths related to chest compression, restriction of
		breathing, or asphyxiation.	breathing, or asphyxiation.
§485.614(g)(1)(ii)	(ii) Each death that occurs within	PC.03.05.19, EP 1	PC.13.02.19, EP 1
	24 hours after the patient has been	The critical access hospital reports the following	The critical access hospital reports the following
	removed from restraint or	information to the Centers for Medicare & Dedicaid	information to the Centers for Medicare & Description (1975)
	seclusion.	Services (CMS) regarding deaths related to restraint or	Medicaid Services regarding deaths related to restraint
		seclusion (this requirement does not apply to deaths	or seclusion:
		related to the use of soft wrist restraints; for more	- Each death that occurs while a patient is in restraint or
		information, refer to EP 3 in this standard):	seclusion
		- Each death that occurs while a patient is in restraint or	- Each death that occurs within 24 hours after the
		seclusion	patient has been removed from restraint or seclusion
		- Each death that occurs within 24 hours after the patient	- Each death known to the critical access hospital that
		has been removed from restraint or seclusion	occurs within one week after restraint or seclusion was
		- Each death known to the critical access hospital that	used when it is reasonable to assume that the use of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		occurs within one week after restraint or seclusion was	the restraint or seclusion contributed directly or
		used when it is reasonable to assume that the use of the	indirectly to the patient's death
		restraint or seclusion contributed directly or indirectly to	Note 1: This reporting requirement includes all
		the patient's death. The types of restraints included in this	restraints except soft wrist restraints. For more
		reporting requirement are all restraints except soft wrist	information on deaths related to the use of soft wrist
		restraints.	restraints, refer to EP 3 in this standard.
		Note: In this element of performance "reasonable to	Note 2: In this element of performance "reasonable to
		assume" includes, but is not limited to, deaths related to	assume" includes but is not limited to deaths related to
		restrictions of movement for prolonged periods of time or	restrictions of movement for prolonged periods of time
		deaths related to chest compression, restriction of	or deaths related to chest compression, restriction of
		breathing, or asphyxiation.	breathing, or asphyxiation.
§485.614(g)(1)(iii)	(iii) Each death known to the	PC.03.05.19, EP 1	PC.13.02.19, EP 1
	hospital that occurs within 1 week	The critical access hospital reports the following	The critical access hospital reports the following
	after restraint or seclusion where it	information to the Centers for Medicare & Dedicaid	information to the Centers for Medicare & Description (1975)
	is reasonable to assume that use	Services (CMS) regarding deaths related to restraint or	Medicaid Services regarding deaths related to restraint
	of restraint or placement in	seclusion (this requirement does not apply to deaths	or seclusion:
	seclusion contributed directly or	related to the use of soft wrist restraints; for more	- Each death that occurs while a patient is in restraint or
	indirectly to a patient's death,	information, refer to EP 3 in this standard):	seclusion
	regardless of the type(s) of	- Each death that occurs while a patient is in restraint or	- Each death that occurs within 24 hours after the
	restraint used on the patient	seclusion	patient has been removed from restraint or seclusion
	during this time. "Reasonable to	- Each death that occurs within 24 hours after the patient	- Each death known to the critical access hospital that
	assume" in this context includes,	has been removed from restraint or seclusion	occurs within one week after restraint or seclusion was
	but is not limited to, deaths related	- Each death known to the critical access hospital that	used when it is reasonable to assume that the use of
	to restrictions of movement for	occurs within one week after restraint or seclusion was	the restraint or seclusion contributed directly or
	prolonged periods of time, or	used when it is reasonable to assume that the use of the	indirectly to the patient's death
	death related to chest	restraint or seclusion contributed directly or indirectly to	Note 1: This reporting requirement includes all
	compression, restriction of	the patient's death. The types of restraints included in this	restraints except soft wrist restraints. For more
	breathing, or asphyxiation.	reporting requirement are all restraints except soft wrist	information on deaths related to the use of soft wrist
		restraints.	restraints, refer to EP 3 in this standard.
		Note: In this element of performance "reasonable to	Note 2: In this element of performance "reasonable to
		assume" includes, but is not limited to, deaths related to	assume" includes but is not limited to deaths related to
		restrictions of movement for prolonged periods of time or	restrictions of movement for prolonged periods of time

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		deaths related to chest compression, restriction of	or deaths related to chest compression, restriction of
		breathing, or asphyxiation.	breathing, or asphyxiation.
§485.614(g)(2)	(2) When no seclusion has been	PC.03.05.19, EP 3	
	used and when the only restraints	When no seclusion has been used and when the only	
	used on the patient are those	restraints used on the patient are wrist restraints	
	applied exclusively to the patient's	composed solely of soft, non-rigid, cloth-like material,	
	wrist(s), and which are composed	the critical access hospital does the following:	
	solely of soft, non-rigid, cloth-like	- Records in a log or other system any death that occurs	
	materials, the hospital staff must	while a patient is in restraint. The information is recorded	
	record in an internal log or other	within seven days of the date of death of the patient.	
	system, the following information:	- 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	PC.03.05.19, EP 3	PC.13.02.19, EP 3
	patient is in such restraints.	When no seclusion has been used and when the only	When no seclusion has been used and when the only
		restraints used on the patient are wrist restraints	restraints used on the patient are wrist restraints
		composed solely of soft, non-rigid, cloth-like material,	composed solely of soft, nonrigid, cloth-like material,
		the critical access hospital does the following:	the critical access hospital does the following:
		- Records in a log or other system any death that occurs	- Records in a log or other system any death that occurs
		while a patient is in restraint. The information is recorded	while a patient is in restraint. The information is
		within seven days of the date of death of the patient.	recorded within seven days of the date of death of the
		- Records in a log or other system any death that occurs	patient.

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 & Dedicard 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).

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 & Dedicare & 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 & Decided 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:

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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, 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
			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	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
		The critical access hospital's agreement for quality assurance includes medical record review for quality and medical necessity of care.	

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	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.	medical necessity of care. 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	LD.04.03.09, EP 2	LD.13.03.03, EP 4
	must ensure that, when	The critical access hospital describes, in writing, the	When telemedicine services are provided to the critical
	telemedicine services are	nature and scope of services provided through	access hospital's patients through an agreement with a
	furnished to the CAH's patients	contractual agreements.	distant-site hospital, the critical access hospital's
	through an agreement with a		governing body makes certain that the written
	distant-site hospital, the	LD.04.03.09, EP 4	agreement specifies that it is the responsibility of the
	agreement is written and specifies	Leaders monitor contracted services by establishing	governing body of the distant-site hospital to do the
	that it is the responsibility of the	expectations for the performance of the contracted	following with regard to its physicians or other licensed
	governing body of the distant-site	services.	practitioners providing telemedicine services:
	hospital to meet the following	Note 1: When the critical access hospital contracts with	- Determine, in accordance with state law, which
	requirements with regard to its	another accredited organization for patient care,	categories of practitioners are eligible candidates for
	physicians or practitioners	treatment, and services to be provided off site, it can do	appointment to the medical staff
	providing telemedicine services:	the following:	- Appoint members of the medical staff after
		- Verify that all physicians and other licensed	considering the recommendations of the existing
		practitioners who will be providing patient care,	members of the medical staff
		treatment, and services have appropriate privileges by	- Assure that the medical staff has bylaws
		obtaining, for example, a copy of the list of privileges.	- Approve medical staff bylaws and other medical staff
		- Specify in the written agreement that the contracted	rules and regulations
		organization will ensure that all contracted services	- Make certain that the medical staff is accountable to
		provided by physicians and other licensed practitioners	the governing body for the quality of care provided to
		will be within the scope of their privileges.	patients
		Note 2: The leaders who monitor the contracted services	- Make certain that the criteria for selection for
		are the governing body.	appointment to the medical staff are individual
			character, competence, training, experience, and
		LD.04.03.09, EP 23	judgment
		When telemedicine services are furnished to the critical	- Make certain that under no circumstances is the
		access hospital's patients, the originating site has a	accordance of staff membership or professional
		written agreement with the distant site that specifies the	privileges in the critical access hospital dependent
		following:	solely upon certification, fellowship or membership in a
		- The distant site is a contractor of services to the critical access hospital.	specialty body or society
		- The distant site furnishes services in a manner that	
		permits the originating site to be in compliance with the	

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	considering the recommendations of the existing
		CFR 485.616(c)(1)(i) through (c)(1)(vii).	members of the medical staff
		Note: For the language of the Medicare Conditions of	- Assure that the medical staff has bylaws
		Participation pertaining to telemedicine, see Appendix A.	- Approve medical staff bylaws and other medical staff
		If the originating site chooses to use the credentialing and	rules and regulations
		privileging decision of the distant-site telemedicine	- Make certain that the medical staff is accountable to
		provider, then the following requirements apply:	the governing body for the quality of care provided to
		- The governing body of the distant site is responsible for	patients
		having a process that is consistent with the credentialing	- Make certain that the criteria for selection for
		and privileging requirements in the "Medical Staff" (MS)	appointment to the medical staff are individual
		chapter (Standards MS.06.01.01 through MS.06.01.13).	character, competence, training, experience, and
		- The governing body of the originating site grants	judgment
		privileges to a distant-site physician or other licensed	- Make certain that under no circumstances is the
		practitioner based on the originating site's medical staff	accordance of staff membership or professional
		recommendations, which rely on information provided by	privileges in the critical access hospital dependent
		the distant site.	solely upon certification, fellowship or membership in a
			specialty body or society
		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.	

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 reappointment 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.	solely upon certification, fellowship or membership in a
			specialty body or society
		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.)	
		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)(1)(iii)	(iii) Assure that the medical staff	LD.04.03.09, EP 23	LD.13.03.03, EP 4
	has bylaws.	When telemedicine services are furnished to the critical	When telemedicine services are provided to the critical
		access hospital's patients, the originating site has a	access hospital's patients through an agreement with a
		written agreement with the distant site that specifies the	distant-site hospital, the critical access hospital's
		following:	governing body makes certain that the written
		- The distant site is a contractor of services to the critical	agreement specifies that it is the responsibility of the
		access hospital.	governing body of the distant-site hospital to do the
		- The distant site furnishes services in a manner that	following with regard to its physicians or other licensed
		permits the originating site to be in compliance with the	practitioners providing telemedicine services:
		Medicare Conditions of Participation	- Determine, in accordance with state law, which
		- The originating site makes certain through the written	categories of practitioners are eligible candidates for
		agreement that all distant-site telemedicine providers'	appointment to the medical staff

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		credentialing and privileging processes meet, at a	- Appoint members of the medical staff after
		minimum, the Medicare Conditions of Participation at 42	considering the recommendations of the existing
		CFR 485.616(c)(1)(i) through (c)(1)(vii).	members of the medical staff
		Note: For the language of the Medicare Conditions of	- Assure that the medical staff has bylaws
		Participation pertaining to telemedicine, see Appendix A.	- Approve medical staff bylaws and other medical staff
		If the originating site chooses to use the credentialing and	rules and regulations
		privileging decision of the distant-site telemedicine	- Make certain that the medical staff is accountable to
		provider, then the following requirements apply:	the governing body for the quality of care provided to
		- The governing body of the distant site is responsible for	patients
		having a process that is consistent with the credentialing	- Make certain that the criteria for selection for
		and privileging requirements in the "Medical Staff" (MS)	appointment to the medical staff are individual
		chapter (Standards MS.06.01.01 through MS.06.01.13).	character, competence, training, experience, and
		- The governing body of the originating site grants	judgment
		privileges to a distant-site physician or other licensed	- Make certain that under no circumstances is the
		practitioner based on the originating site's medical staff	accordance of staff membership or professional
		recommendations, which rely on information provided by	privileges in the critical access hospital dependent
		the distant site.	solely upon certification, fellowship or membership in a
		NO 04 04 04 ED 4	specialty body or society
		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	
	L	and conflict management processes.)	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
S485.616(c)(1)(iv)	CoP Text (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	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	
§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
Con requirement	GOI TEXT	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)	appointment to the medical staff are individual
		chapter (Standards MS.06.01.01 through MS.06.01.13).	character, competence, training, experience, and
		- The governing body of the originating site grants	judgment
		privileges to a distant-site physician or other licensed	- Make certain that under no circumstances is the
		practitioner based on the originating site's medical staff	accordance of staff membership or professional
		recommendations, which rely on information provided by	privileges in the critical access hospital dependent
		the distant site.	solely upon certification, fellowship or membership in a
		MS 04 04 04 ED 40	specialty body or society
		MS.01.01.01, EP 12 The medical staff bylaws include the following	
		requirements: The structure of the medical staff.	
		requirements. The structure of the medical stall.	
		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.	
		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.	
§485.616(c)(1)(vii)	(vii) Ensure that under no	LD.04.03.09, EP 23	LD.13.03.03, EP 4
	circumstances is the accordance	When telemedicine services are furnished to the critical	When telemedicine services are provided to the critical
	of staff membership or	access hospital's patients, the originating site has a	access hospital's patients through an agreement with a
	professional privileges in the	written agreement with the distant site that specifies the	distant-site hospital, the critical access hospital's

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	hospital dependent solely upon	following:	governing body makes certain that the written
	certification, fellowship or	- The distant site is a contractor of services to the critical	agreement specifies that it is the responsibility of the
	membership in a specialty body or	access hospital.	governing body of the distant-site hospital to do the
	society.	- The distant site furnishes services in a manner that	following with regard to its physicians or other licensed
		permits the originating site to be in compliance with the	practitioners providing telemedicine services:
		Medicare Conditions of Participation	- Determine, in accordance with state law, which
		- The originating site makes certain through the written	categories of practitioners are eligible candidates for
		agreement that all distant-site telemedicine providers'	appointment to the medical staff
		credentialing and privileging processes meet, at a	- Appoint members of the medical staff after
		minimum, the Medicare Conditions of Participation at 42	considering the recommendations of the existing
		CFR 485.616(c)(1)(i) through (c)(1)(vii).	members of the medical staff
		Note: For the language of the Medicare Conditions of	- Assure that the medical staff has bylaws
		Participation pertaining to telemedicine, see Appendix A.	- Approve medical staff bylaws and other medical staff
		If the originating site chooses to use the credentialing and	rules and regulations
		privileging decision of the distant-site telemedicine	- Make certain that the medical staff is accountable to
		provider, then the following requirements apply:	the governing body for the quality of care provided to
		- The governing body of the distant site is responsible for	patients
		having a process that is consistent with the credentialing	- Make certain that the criteria for selection for
		and privileging requirements in the "Medical Staff" (MS)	appointment to the medical staff are individual
		chapter (Standards MS.06.01.01 through MS.06.01.13).	character, competence, training, experience, and
		- The governing body of the originating site grants	judgment
		privileges to a distant-site physician or other licensed	- Make certain that under no circumstances is the
		practitioner based on the originating site's medical staff	accordance of staff membership or professional
		recommendations, which rely on information provided by	privileges in the critical access hospital dependent
		the distant site.	solely upon certification, fellowship or membership in a
			specialty body or society
		MS.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	

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	LD.04.03.09, EP 2	MS.20.01.01, EP 1
	are furnished to the CAH's patients	The critical access hospital describes, in writing, the	When telemedicine services are furnished to the critical
	through an agreement with a	nature and scope of services provided through	access hospital's patients through an agreement with a
	distant-site hospital, the CAH's	contractual agreements.	distant-site hospital or telemedicine entity, the
	governing body or responsible		governing body of the originating critical access
	individual may choose to rely upon	LD.04.03.09, EP 4	hospital may choose to rely upon the credentialing and
	the credentialing and privileging	Leaders monitor contracted services by establishing	privileging decisions made by the distant-site hospital
	decisions made by the governing	expectations for the performance of the contracted	or telemedicine entity for the individual distant-site
	body of the distant-site hospital	services.	physicians and other licensed practitioners providing
	regarding individual distant-site	Note 1: When the critical access hospital contracts with	such services if the critical access hospital's governing
	physicians or practitioners. The	another accredited organization for patient care,	body includes all of the following provisions in its
	CAH's governing body or	treatment, and services to be provided off site, it can do	written agreement with the distant-site hospital or
	responsible individual must	the following:	telemedicine entity:
	ensure, through its written	- Verify that all physicians and other licensed	- The distant site telemedicine entity provides services
	agreement with the distant-site	practitioners who will be providing patient care,	in accordance with contract service requirements.
	hospital, that the following	treatment, and services have appropriate privileges by	- The distant-site telemedicine entity's medical staff
	provisions are met:	obtaining, for example, a copy of the list of privileges.	credentialing and privileging process and standards is
		- Specify in the written agreement that the contracted	consistent with the critical access hospital's process
		organization will ensure that all contracted services	and standards, at a minimum.
		provided by physicians and other licensed practitioners	- The distant-site hospital providing the telemedicine
		will be within the scope of their privileges.	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	- The individual distant-site physician or other licensed
		are the governing body.	practitioner is privileged at the distant-site hospital or
			telemedicine entity providing the telemedicine services,
		LD.04.03.09, EP 23	and the distant-site hospital or telemedicine entity
		When telemedicine services are furnished to the critical	provides a current list of the distant-site physician's or
		access hospital's patients, the originating site has a	practitioner's privileges at the distant-site hospital or
		written agreement with the distant site that specifies the	telemedicine entity.
		following:	- The individual distant-site physician or other licensed
		- The distant site is a contractor of services to the critical	practitioner holds a license issued or recognized by the
		access hospital.	state in which the critical access hospital whose
		- The distant site furnishes services in a manner that	patients are receiving the telemedicine services is
		permits the originating site to be in compliance with the	located.
		Medicare Conditions of Participation	- For distant-site physicians or other licensed
		- The originating site makes certain through the written	practitioners privileged by the originating critical access
		agreement that all distant-site telemedicine providers'	hospital, the originating critical access hospital
		credentialing and privileging processes meet, at a	internally reviews services provided by the distant-site
		minimum, the Medicare Conditions of Participation at 42	physician or other licensed practitioner and sends the
		CFR 485.616(c)(1)(i) through (c)(1)(vii).	distant-site hospital or telemedicine entity information
		Note: For the language of the Medicare Conditions of	for use in the periodic evaluation of the practitioner. At a
		Participation pertaining to telemedicine, see Appendix A.	minimum, this information includes adverse events that
		If the originating site chooses to use the credentialing and	result from the telemedicine services provided by the
		privileging decision of the distant-site telemedicine	distant-site physician or other licensed practitioner to
		provider, then the following requirements apply:	the critical access hospital's patients and complaints
		- The governing body of the distant site is responsible for	the critical access hospital has received about the
		having a process that is consistent with the credentialing	distant-site physician or other licensed practitioner.
		and privileging requirements in the "Medical Staff" (MS)	Note 1: In the case of distant-site physicians and
		chapter (Standards MS.06.01.01 through MS.06.01.13).	licensed practitioners providing telemedicine services
		- The governing body of the originating site grants	to the critical access hospital's patients under a written
		privileges to a distant-site physician or other licensed	agreement between the critical access hospital and a
		practitioner based on the originating site's medical staff	distant-site telemedicine entity, the distant-site
		recommendations, which rely on information provided by	telemedicine entity is not required to be a Medicare
		the distant site.	participating
			provider or supplier.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		MS.13.01.01, EP 1	Note 2: For rehabilitation and psychiatric distinct part
		All physicians or other licensed practitioners who are	units in critical access hospitals: The distant-site
		responsible for the patient's care, treatment, and services	telemedicine entity's medical staff credentialing and
		via telemedicine link are credentialed and privileged to do	privileging process and standards at least meet the
		so at the originating site through one of the following	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		mechanisms:	482.22(a)(1) through (a)(2).
		- 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	

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	
§485.616(c)(2)(i)	(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.	A.) 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.	credentialing and privileging process and standards is
		If the originating site chooses to use the credentialing and	consistent with the critical access hospital's process
		privileging decision of the distant-site telemedicine	and standards, at a minimum.
		provider, then the following requirements apply:	- The distant-site hospital providing the telemedicine
		- The governing body of the distant site is responsible for	services is a Medicare-participating hospital.
		having a process that is consistent with the credentialing	- The individual distant-site physician or other licensed
		and privileging requirements in the "Medical Staff" (MS)	practitioner is privileged at the distant-site hospital or
		chapter (Standards MS.06.01.01 through MS.06.01.13).	telemedicine entity providing the telemedicine services,
		- The governing body of the originating site grants	and the distant-site hospital or telemedicine entity
		privileges to a distant-site physician or other licensed	provides a current list of the distant-site physician's or
		practitioner based on the originating site's medical staff	practitioner's privileges at the distant-site hospital or
		recommendations, which rely on information provided by	telemedicine entity.
		the distant site.	- The individual distant-site physician or other licensed
			practitioner holds a license issued or recognized by the
		MS.13.01.01, EP 1	state in which the critical access hospital whose
		All physicians or other licensed practitioners who are	patients are receiving the telemedicine services is
		responsible for the patient's care, treatment, and services	located.
		via telemedicine link are credentialed and privileged to do	- For distant-site physicians or other licensed
		so at the originating site through one of the following	practitioners privileged by the originating critical access
		mechanisms:	hospital, the originating critical access hospital
		- The originating site fully credentials and privileges the	internally reviews services provided by the distant-site
		physician or other licensed practitioner according to	physician or other licensed practitioner and sends the
		Standards MS.06.01.03 through MS.06.01.13.	distant-site hospital or telemedicine entity information
		Or	for use in the periodic evaluation of the practitioner. At a
		- The originating site privileges physicians or other	minimum, this information includes adverse events that
		licensed practitioners using credentialing information	result from the telemedicine services provided by the
		from the distant site if the distant site is a Joint	distant-site physician or other licensed practitioner to
		Commission–accredited or a Medicare-participating	the critical access hospital's patients and complaints
		organization. The distant-site physician or other licensed	the critical access hospital has received about the
		practitioner has a license that is issued or recognized by	distant-site physician or other licensed practitioner.
		the state in which the patient is receiving telemedicine	Note 1: In the case of distant-site physicians and
		services.	licensed practitioners providing telemedicine services
		Or	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	agreement between the critical access hospital and a
		and privileging decision from the distant site to make a	distant-site telemedicine entity, the distant-site
		final privileging decision if all the following requirements	telemedicine entity is not required to be a Medicare
		are met:	participating
		- The distant site is a Joint Commission–accredited or a	provider or supplier.
		Medicare-participating organization.	Note 2: For rehabilitation and psychiatric distinct part
		- The physician or other licensed practitioner is	units in critical access hospitals: The distant-site
		privileged at the distant site for those services to be	telemedicine entity's medical staff credentialing and
		provided at the originating site.	privileging process and standards at least meet the
		- The distant site provides the originating site with a	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		current list of the physician's or other licensed	482.22(a)(1) through (a)(2).
		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.	

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	MS.13.01.01, EP 1	MS.20.01.01, EP 1
	physician or practitioner is	All physicians or other licensed practitioners who are	When telemedicine services are furnished to the critical

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	privileged at the distant-site	responsible for the patient's care, treatment, and services	access hospital's patients through an agreement with a
	hospital providing the	via telemedicine link are credentialed and privileged to do	distant-site hospital or telemedicine entity, the
	telemedicine services, which	so at the originating site through one of the following	governing body of the originating critical access
	provides a current list of the	mechanisms:	hospital may choose to rely upon the credentialing and
	distant-site physician's or	- The originating site fully credentials and privileges the	privileging decisions made by the distant-site hospital
	practitioner's privileges at the	physician or other licensed practitioner according to	or telemedicine entity for the individual distant-site
	distant-site hospital;	Standards MS.06.01.03 through MS.06.01.13.	physicians and other licensed practitioners providing
		Or	such services if the critical access hospital's governing
		- The originating site privileges physicians or other	body includes all of the following provisions in its
		licensed practitioners using credentialing information	written agreement with the distant-site hospital or
		from the distant site if the distant site is a Joint	telemedicine entity:
		Commission–accredited or a Medicare-participating	- The distant site telemedicine entity provides services
		organization. The distant-site physician or other licensed	in accordance with contract service requirements.
		practitioner has a license that is issued or recognized by	- The distant-site telemedicine entity's medical staff
		the state in which the patient is receiving telemedicine	credentialing and privileging process and standards is
		services.	consistent with the critical access hospital's process
		Or	and standards, at a minimum.
		- The originating site may choose to use the credentialing	- The distant-site hospital providing the telemedicine
		and privileging decision from the distant site to make a	services is a Medicare-participating hospital.
		final privileging decision if all the following requirements	- The individual distant-site physician or other licensed
		are met:	practitioner is privileged at the distant-site hospital or
		- The distant site is a Joint Commission–accredited or a	telemedicine entity providing the telemedicine services,
		Medicare-participating organization.	and the distant-site hospital or telemedicine entity
		- The physician or other licensed practitioner is	provides a current list of the distant-site physician's or
		privileged at the distant site for those services to be	practitioner's privileges at the distant-site hospital or
		provided at the originating site.	telemedicine entity.
		- The distant site provides the originating site with a	- The individual distant-site physician or other licensed
		current list of the physician's or other licensed	practitioner holds a license issued or recognized by the
		practitioner's privileges.	state in which the critical access hospital whose
		- The originating site has evidence of an internal review	patients are receiving the telemedicine services is
		of the physician's or other licensed practitioner's	located.
		performance of these privileges and sends to the distant	- For distant-site physicians or other licensed
		site information that is useful to assess the physician's or	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,	hospital, the originating critical access hospital
		and services for use in privileging and performance	internally reviews services provided by the distant-site
		improvement. At a minimum, this information includes all	physician or other licensed practitioner and sends the
		adverse outcomes related to sentinel events considered	distant-site hospital or telemedicine entity information
		reviewable by The Joint Commission that result from the	for use in the periodic evaluation of the practitioner. At a
		telemedicine services provided and complaints about the	minimum, this information includes adverse events that
		distant site physician or other licensed practitioner from	result from the telemedicine services provided by the
		patients, physicians or other licensed practitioners, or	distant-site physician or other licensed practitioner to
		staff at the originating site. This occurs in a way	the critical access hospital's patients and complaints
		consistent with any hospital policies or procedures	the critical access hospital has received about the
		intended to preserve any confidentiality or privilege of	distant-site physician or other licensed practitioner.
		information established by applicable law.	Note 1: In the case of distant-site physicians and
		- When telemedicine services are provided by a distant-	licensed practitioners providing telemedicine services
		site Medicare-participating hospital, the distant-site	to the critical access hospital's patients under a written
		hospital evaluates the quality and appropriateness of the	agreement between the critical access hospital and a
		diagnosis, treatment, and treatment outcomes furnished	distant-site telemedicine entity, the distant-site
		in the critical access hospital.	telemedicine entity is not required to be a Medicare
		- When telemedicine services are provided by a distant-	participating
		site telemedicine entity (a non-Medicare-participating	provider or supplier.
		provider or supplier), the quality and appropriateness of	Note 2: For rehabilitation and psychiatric distinct part
		the diagnosis, treatment, and treatment outcomes	units in critical access hospitals: The distant-site
		furnished in the critical access hospital are evaluated by	telemedicine entity's medical staff credentialing and
		a hospital that is a member of the network, a QIO or	privileging process and standards at least meet the
		equivalent entity, or an appropriate and qualified entity	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		identified in the state rural health plan.	482.22(a)(1) through (a)(2).
		- 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	
		uistant site made its decision using the process	

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	
\$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	and standards, at a minimum.
		- The originating site may choose to use the credentialing	- The distant-site hospital providing the telemedicine
		and privileging decision from the distant site to make a	services is a Medicare-participating hospital.
		final privileging decision if all the following requirements	- The individual distant-site physician or other licensed
		are met:	practitioner is privileged at the distant-site hospital or
		- The distant site is a Joint Commission–accredited or a	telemedicine entity providing the telemedicine services,
		Medicare-participating organization.	and the distant-site hospital or telemedicine entity
		- The physician or other licensed practitioner is	provides a current list of the distant-site physician's or
		privileged at the distant site for those services to be	practitioner's privileges at the distant-site hospital or
		provided at the originating site.	telemedicine entity.
		- The distant site provides the originating site with a	- The individual distant-site physician or other licensed
		current list of the physician's or other licensed	practitioner holds a license issued or recognized by the
		practitioner's privileges.	state in which the critical access hospital whose
		- The originating site has evidence of an internal review	patients are receiving the telemedicine services is
		of the physician's or other licensed practitioner's	located.
		performance of these privileges and sends to the distant	- For distant-site physicians or other licensed
		site information that is useful to assess the physician's or	practitioners privileged by the originating critical access
		other licensed practitioner's quality of care, treatment,	hospital, the originating critical access hospital
		and services for use in privileging and performance	internally reviews services provided by the distant-site
		improvement. At a minimum, this information includes all	physician or other licensed practitioner and sends the
		adverse outcomes related to sentinel events considered	distant-site hospital or telemedicine entity information
		reviewable by The Joint Commission that result from the	for use in the periodic evaluation of the practitioner. At a
		telemedicine services provided and complaints about the	minimum, this information includes adverse events that
		distant site physician or other licensed practitioner from	result from the telemedicine services provided by the
		patients, physicians or other licensed practitioners, or	distant-site physician or other licensed practitioner to
		staff at the originating site. This occurs in a way	the critical access hospital's patients and complaints
		consistent with any hospital policies or procedures	the critical access hospital has received about the
		intended to preserve any confidentiality or privilege of	distant-site physician or other licensed practitioner.
		information established by applicable law.	Note 1: In the case of distant-site physicians and
		- When telemedicine services are provided by a distant-	licensed practitioners providing telemedicine services
		site Medicare-participating hospital, the distant-site	to the critical access hospital's patients under a written
		hospital evaluates the quality and appropriateness of the	agreement between the critical access hospital and a
		diagnosis, treatment, and treatment outcomes furnished	distant-site telemedicine entity, the distant-site

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		in the critical access hospital.	telemedicine entity is not required to be a Medicare
		- When telemedicine services are provided by a distant-	participating
		site telemedicine entity (a non-Medicare-participating	provider or supplier.
		provider or supplier), the quality and appropriateness of	Note 2: For rehabilitation and psychiatric distinct part
		the diagnosis, treatment, and treatment outcomes	units in critical access hospitals: The distant-site
		furnished in the critical access hospital are evaluated by	telemedicine entity's medical staff credentialing and
		a hospital that is a member of the network, a QIO or	privileging process and standards at least meet the
		equivalent entity, or an appropriate and qualified entity	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		identified in the state rural health plan.	482.22(a)(1) through (a)(2).
		- 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.)	
		[n.)	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.616(c)(2)(iv)	(iv) With respect to a distant-site	MS.13.01.01, EP 1	MS.20.01.01, EP 1
	physician or practitioner, who	All physicians or other licensed practitioners who are	When telemedicine services are furnished to the critical
	holds current privileges at the CAH	responsible for the patient's care, treatment, and services	access hospital's patients through an agreement with a
	whose patients are receiving the	via telemedicine link are credentialed and privileged to do	distant-site hospital or telemedicine entity, the
	telemedicine services, the CAH	so at the originating site through one of the following	governing body of the originating critical access
	has evidence of an internal review	mechanisms:	hospital may choose to rely upon the credentialing and
	of the distant-site physician's or	- The originating site fully credentials and privileges the	privileging decisions made by the distant-site hospital
	practitioner's performance of	physician or other licensed practitioner according to	or telemedicine entity for the individual distant-site
	these privileges and sends the	Standards MS.06.01.03 through MS.06.01.13.	physicians and other licensed practitioners providing
	distant-site hospital such	Or	such services if the critical access hospital's governing
	information for use in the periodic	- The originating site privileges physicians or other	body includes all of the following provisions in its
	appraisal of the individual distant-	licensed practitioners using credentialing information	written agreement with the distant-site hospital or
	site physician or practitioner. At a	from the distant site if the distant site is a Joint	telemedicine entity:
	minimum, this information must	Commission–accredited or a Medicare-participating	- The distant site telemedicine entity provides services
	include all adverse events that	organization. The distant-site physician or other licensed	in accordance with contract service requirements.
	result from the telemedicine	practitioner has a license that is issued or recognized by	- The distant-site telemedicine entity's medical staff
	services provided by the distant-	the state in which the patient is receiving telemedicine	credentialing and privileging process and standards is
	site physician or practitioner to the	services.	consistent with the critical access hospital's process
	CAH's patients and all complaints	Or	and standards, at a minimum.
	the CAH has received about the	- The originating site may choose to use the credentialing	- The distant-site hospital providing the telemedicine
	distant-site physician or	and privileging decision from the distant site to make a	services is a Medicare-participating hospital.
	practitioner.	final privileging decision if all the following requirements	- The individual distant-site physician or other licensed
		are met:	practitioner is privileged at the distant-site hospital or
		- The distant site is a Joint Commission–accredited or a	telemedicine entity providing the telemedicine services,
		Medicare-participating organization.	and the distant-site hospital or telemedicine entity
		- The physician or other licensed practitioner is	provides a current list of the distant-site physician's or
		privileged at the distant site for those services to be	practitioner's privileges at the distant-site hospital or
		provided at the originating site.	telemedicine entity.
		- The distant site provides the originating site with a	- The individual distant-site physician or other licensed
		current list of the physician's or other licensed	practitioner holds a license issued or recognized by the
		practitioner's privileges.	state in which the critical access hospital whose
		- The originating site has evidence of an internal review	patients are receiving the telemedicine services is
		of the physician's or other licensed practitioner's	located.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		performance of these privileges and sends to the distant	- For distant-site physicians or other licensed
		site information that is useful to assess the physician's or	practitioners privileged by the originating critical access
		other licensed practitioner's quality of care, treatment,	hospital, the originating critical access hospital
		and services for use in privileging and performance	internally reviews services provided by the distant-site
		improvement. At a minimum, this information includes all	physician or other licensed practitioner and sends the
		adverse outcomes related to sentinel events considered	distant-site hospital or telemedicine entity information
		reviewable by The Joint Commission that result from the	for use in the periodic evaluation of the practitioner. At a
		telemedicine services provided and complaints about the	minimum, this information includes adverse events that
		distant site physician or other licensed practitioner from	result from the telemedicine services provided by the
		patients, physicians or other licensed practitioners, or	distant-site physician or other licensed practitioner to
		staff at the originating site. This occurs in a way	the critical access hospital's patients and complaints
		consistent with any hospital policies or procedures	the critical access hospital has received about the
		intended to preserve any confidentiality or privilege of	distant-site physician or other licensed practitioner.
		information established by applicable law.	Note 1: In the case of distant-site physicians and
		- When telemedicine services are provided by a distant-	licensed practitioners providing telemedicine services
		site Medicare-participating hospital, the distant-site	to the critical access hospital's patients under a written
		hospital evaluates the quality and appropriateness of the	agreement between the critical access hospital and a
		diagnosis, treatment, and treatment outcomes furnished	distant-site telemedicine entity, the distant-site
		in the critical access hospital.	telemedicine entity is not required to be a Medicare
		- When telemedicine services are provided by a distant-	participating
		site telemedicine entity (a non-Medicare-participating	provider or supplier.
		provider or supplier), the quality and appropriateness of	Note 2: For rehabilitation and psychiatric distinct part
		the diagnosis, treatment, and treatment outcomes	units in critical access hospitals: The distant-site
		furnished in the critical access hospital are evaluated by	telemedicine entity's medical staff credentialing and
		a hospital that is a member of the network, a QIO or	privileging process and standards at least meet the
		equivalent entity, or an appropriate and qualified entity	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		identified in the state rural health plan.	482.22(a)(1) through (a)(2).
		- 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	
		Twole 1. III the case of an accidulted 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)(3)	(3) The governing body of the CAH	LD.04.03.09, EP 23	LD.11.01.03, EP 1
	must ensure that when	When telemedicine services are furnished to the critical	The person responsible for the operation of the critical
	telemedicine services are	access hospital's patients, the originating site has a	access hospital under 42 CFR 485.627(b)(2) is also
	furnished to the CAH's patients	written agreement with the distant site that specifies the	responsible for the following:
	through an agreement with a	following:	- Services provided in the critical access hospital
	distant-site telemedicine entity,	- The distant site is a contractor of services to the critical	whether or not they are furnished under arrangements
	the agreement is written and	access hospital.	or agreements
	specifies that the distant-site	- The distant site furnishes services in a manner that	- Ensuring that contractors of services (including
	telemedicine entity is a contractor	permits the originating site to be in compliance with the	contractors for shared services and joint ventures)
	of services to the CAH and as	Medicare Conditions of Participation	provide services that enable the critical access hospital
	such, in accordance with	- The originating site makes certain through the written	to comply with all applicable Centers for Medicare
	§485.635(c)(4)(ii), furnishes the	agreement that all distant-site telemedicine providers'	& Medicaid (CMS) Conditions of Participation and
	contracted services in a manner	credentialing and privileging processes meet, at a	standards for the contracted services
	that enables the CAH to comply	minimum, the Medicare Conditions of Participation at 42	
	with all applicable conditions of	CFR 485.616(c)(1)(i) through (c)(1)(vii).	LD.13.03.03, EP 3
	participation for the contracted	Note: For the language of the Medicare Conditions of	When telemedicine services are furnished to the critical

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	services, including, but not limited	Participation pertaining to telemedicine, see Appendix A.	access hospital's patients, the originating site has a
	to, the requirements in this section	If the originating site chooses to use the credentialing and	written agreement with the distant site that specifies
	with regard to its physicians and	privileging decision of the distant-site telemedicine	the following:
	practitioners providing	provider, then the following requirements apply:	- The distant site is a contractor of services to the
	telemedicine services.	- The governing body of the distant site is responsible for	critical access hospital.
		having a process that is consistent with the credentialing	- The distant site furnishes services in a manner that
		and privileging requirements in the "Medical Staff" (MS)	permits the originating site to be in compliance with all
		chapter (Standards MS.06.01.01 through MS.06.01.13).	applicable Medicare Conditions of Participation for the
		- The governing body of the originating site grants	contracted services, in accordance with 42 CFR
		privileges to a distant-site physician or other licensed	485.635(c)(4)(ii).
		practitioner based on the originating site's medical staff	- The originating site makes certain through the written
		recommendations, which rely on information provided by	agreement that all distant-site telemedicine providers'
		the distant site.	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	LD.04.03.09, EP 2	MS.20.01.01, EP 1
	are furnished to the CAH's patients	The critical access hospital describes, in writing, the	When telemedicine services are furnished to the critical
	through an agreement with a	nature and scope of services provided through	access hospital's patients through an agreement with a
	distant-site telemedicine entity,	contractual agreements.	distant-site hospital or telemedicine entity, the
	the CAH's governing body or		governing body of the originating critical access
	responsible individual may choose	LD.04.03.09, EP 4	hospital may choose to rely upon the credentialing and
	to rely upon the credentialing and	Leaders monitor contracted services by establishing	privileging decisions made by the distant-site hospital
	privileging decisions made by the	expectations for the performance of the contracted	or telemedicine entity for the individual distant-site
	governing body of the distant-site	services.	physicians and other licensed practitioners providing
	telemedicine entity regarding	Note 1: When the critical access hospital contracts with	such services if the critical access hospital's governing
	individual distant-site physicians	another accredited organization for patient care,	body includes all of the following provisions in its
	or practitioners. The CAH's	treatment, and services to be provided off site, it can do	written agreement with the distant-site hospital or
	governing body or responsible	the following:	telemedicine entity:
	individual must ensure, through its	- Verify that all physicians and other licensed	- The distant site telemedicine entity provides services
	written agreement with the	practitioners who will be providing patient care,	in accordance with contract service requirements.
	distant-site telemedicine entity,	treatment, and services have appropriate privileges by	- The distant-site telemedicine entity's medical staff
	that the following provisions are	obtaining, for example, a copy of the list of privileges.	credentialing and privileging process and standards is
	met:	- Specify in the written agreement that the contracted	consistent with the critical access hospital's process
		organization will ensure that all contracted services	and standards, at a minimum.
		provided by physicians and other licensed practitioners	- The distant-site hospital providing the telemedicine
		will be within the scope of their privileges.	services is a Medicare-participating hospital.
		Note 2: The leaders who monitor the contracted services	- The individual distant-site physician or other licensed
		are the governing body.	practitioner is privileged at the distant-site hospital or
		I D 04 00 00 FD 00	telemedicine entity providing the telemedicine services,
		LD.04.03.09, EP 23	and the distant-site hospital or telemedicine entity
		When telemedicine services are furnished to the critical	provides a current list of the distant-site physician's or
		access hospital's patients, the originating site has a	practitioner's privileges at the distant-site hospital or
		written agreement with the distant site that specifies the	telemedicine entity.
		following:	- The individual distant-site physician or other licensed
		- The distant site is a contractor of services to the critical	practitioner holds a license issued or recognized by the
		access hospital.	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	patients are receiving the telemedicine services is
		permits the originating site to be in compliance with the	located.
		Medicare Conditions of Participation	- For distant-site physicians or other licensed
		- The originating site makes certain through the written	practitioners privileged by the originating critical access
		agreement that all distant-site telemedicine providers'	hospital, the originating critical access hospital
		credentialing and privileging processes meet, at a	internally reviews services provided by the distant-site
		minimum, the Medicare Conditions of Participation at 42	physician or other licensed practitioner and sends the
		CFR 485.616(c)(1)(i) through (c)(1)(vii).	distant-site hospital or telemedicine entity information
		Note: For the language of the Medicare Conditions of	for use in the periodic evaluation of the practitioner. At a
		Participation pertaining to telemedicine, see Appendix A.	minimum, this information includes adverse events that
		If the originating site chooses to use the credentialing and	result from the telemedicine services provided by the
		privileging decision of the distant-site telemedicine	distant-site physician or other licensed practitioner to
		provider, then the following requirements apply:	the critical access hospital's patients and complaints
		- The governing body of the distant site is responsible for	the critical access hospital has received about the
		having a process that is consistent with the credentialing	distant-site physician or other licensed practitioner.
		and privileging requirements in the "Medical Staff" (MS)	Note 1: In the case of distant-site physicians and
		chapter (Standards MS.06.01.01 through MS.06.01.13).	licensed practitioners providing telemedicine services
		- The governing body of the originating site grants	to the critical access hospital's patients under a written
		privileges to a distant-site physician or other licensed	agreement between the critical access hospital and a
		practitioner based on the originating site's medical staff	distant-site telemedicine entity, the distant-site
		recommendations, which rely on information provided by	telemedicine entity is not required to be a Medicare
		the distant site.	participating
			provider or supplier.
		MS.13.01.01, EP 1	Note 2: For rehabilitation and psychiatric distinct part
		All physicians or other licensed practitioners who are	units in critical access hospitals: The distant-site
		responsible for the patient's care, treatment, and services	telemedicine entity's medical staff credentialing and
		via telemedicine link are credentialed and privileged to do	privileging process and standards at least meet the
		so at the originating site through one of the following	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		mechanisms:	482.22(a)(1) through (a)(2).
		- 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	

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	LD.04.03.09, EP 2	MS.20.01.01, EP 1
	entity's medical staff credentialing	The critical access hospital describes, in writing, the	When telemedicine services are furnished to the critical
	and privileging process and	nature and scope of services provided through	access hospital's patients through an agreement with a
	standards at least meet the	contractual agreements.	distant-site hospital or telemedicine entity, the
	standards at paragraphs (c)(1)(i)		governing body of the originating critical access
	through (c)(1)(vii) of this section.	LD.04.03.09, EP 4	hospital may choose to rely upon the credentialing and
		Leaders monitor contracted services by establishing	privileging decisions made by the distant-site hospital
		expectations for the performance of the contracted	or telemedicine entity for the individual distant-site
		services.	physicians and other licensed practitioners providing
		Note 1: When the critical access hospital contracts with	such services if the critical access hospital's governing
		another accredited organization for patient care,	body includes all of the following provisions in its
		treatment, and services to be provided off site, it can do	written agreement with the distant-site hospital or
		the following:	telemedicine entity:
		- Verify that all physicians and other licensed	- The distant site telemedicine entity provides services
		practitioners who will be providing patient care,	in accordance with contract service requirements.
		treatment, and services have appropriate privileges by	- The distant-site telemedicine entity's medical staff
		obtaining, for example, a copy of the list of privileges.	credentialing and privileging process and standards is
		- Specify in the written agreement that the contracted	consistent with the critical access hospital's process
		organization will ensure that all contracted services	and standards, at a minimum.
		provided by physicians and other licensed practitioners	- The distant-site hospital providing the telemedicine
		will be within the scope of their privileges.	services is a Medicare-participating hospital.
		Note 2: The leaders who monitor the contracted services	- The individual distant-site physician or other licensed
		are the governing body.	practitioner is privileged at the distant-site hospital or
		LD 04 00 00 ED 00	telemedicine entity providing the telemedicine services,
		LD.04.03.09, EP 23	and the distant-site hospital or telemedicine entity
		When telemedicine services are furnished to the critical	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	practitioner's privileges at the distant-site hospital or
		written agreement with the distant site that specifies the	telemedicine entity.
		following:	- The individual distant-site physician or other licensed
		- The distant site is a contractor of services to the critical	practitioner holds a license issued or recognized by the
		access hospital.	state in which the critical access hospital whose
		- The distant site furnishes services in a manner that	patients are receiving the telemedicine services is
		permits the originating site to be in compliance with the	located.
		Medicare Conditions of Participation	- For distant-site physicians or other licensed
		- The originating site makes certain through the written	practitioners privileged by the originating critical access
		agreement that all distant-site telemedicine providers'	hospital, the originating critical access hospital
		credentialing and privileging processes meet, at a	internally reviews services provided by the distant-site
		minimum, the Medicare Conditions of Participation at 42	physician or other licensed practitioner and sends the
		CFR 485.616(c)(1)(i) through (c)(1)(vii).	distant-site hospital or telemedicine entity information
		Note: For the language of the Medicare Conditions of	for use in the periodic evaluation of the practitioner. At a
		Participation pertaining to telemedicine, see Appendix A.	minimum, this information includes adverse events that
		If the originating site chooses to use the credentialing and	result from the telemedicine services provided by the
		privileging decision of the distant-site telemedicine	distant-site physician or other licensed practitioner to
		provider, then the following requirements apply:	the critical access hospital's patients and complaints
		- The governing body of the distant site is responsible for	the critical access hospital has received about the
		having a process that is consistent with the credentialing	distant-site physician or other licensed practitioner.
		and privileging requirements in the "Medical Staff" (MS)	Note 1: In the case of distant-site physicians and
		chapter (Standards MS.06.01.01 through MS.06.01.13).	licensed practitioners providing telemedicine services
		- The governing body of the originating site grants	to the critical access hospital's patients under a written
		privileges to a distant-site physician or other licensed	agreement between the critical access hospital and a
		practitioner based on the originating site's medical staff	distant-site telemedicine entity, the distant-site
		recommendations, which rely on information provided by	telemedicine entity is not required to be a Medicare
		the distant site.	participating
			provider or supplier.
		MS.13.01.01, EP 1	Note 2: For rehabilitation and psychiatric distinct part
		All physicians or other licensed practitioners who are	units in critical access hospitals: The distant-site
		responsible for the patient's care, treatment, and services	telemedicine entity's medical staff credentialing and
		via telemedicine link are credentialed and privileged to do	privileging process and standards at least meet the
		so at the originating site through one of the following	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		mechanisms:	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		- The originating site fully credentials and privileges the	482.22(a)(1) through (a)(2).
		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	

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	

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.)	
§485.616(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	- The individual distant-site physician or other licensed
		are the governing body.	practitioner is privileged at the distant-site hospital or
			telemedicine entity providing the telemedicine services,
		MS.13.01.01, EP 1	and the distant-site hospital or telemedicine entity
		All physicians or other licensed practitioners who are	provides a current list of the distant-site physician's or
		responsible for the patient's care, treatment, and services	practitioner's privileges at the distant-site hospital or
		via telemedicine link are credentialed and privileged to do	telemedicine entity.
		so at the originating site through one of the following	- The individual distant-site physician or other licensed
		mechanisms:	practitioner holds a license issued or recognized by the
		- The originating site fully credentials and privileges the	state in which the critical access hospital whose
		physician or other licensed practitioner according to	patients are receiving the telemedicine services is
		Standards MS.06.01.03 through MS.06.01.13.	located.
		Or	- For distant-site physicians or other licensed
		- The originating site privileges physicians or other	practitioners privileged by the originating critical access
		licensed practitioners using credentialing information	hospital, the originating critical access hospital
		from the distant site if the distant site is a Joint	internally reviews services provided by the distant-site
		Commission–accredited or a Medicare-participating	physician or other licensed practitioner and sends the
		organization. The distant-site physician or other licensed	distant-site hospital or telemedicine entity information
		practitioner has a license that is issued or recognized by	for use in the periodic evaluation of the practitioner. At a
		the state in which the patient is receiving telemedicine	minimum, this information includes adverse events that
		services.	result from the telemedicine services provided by the
		Or	distant-site physician or other licensed practitioner to
		- The originating site may choose to use the credentialing	the critical access hospital's patients and complaints
		and privileging decision from the distant site to make a	the critical access hospital has received about the
		final privileging decision if all the following requirements	distant-site physician or other licensed practitioner.
		are met:	Note 1: In the case of distant-site physicians and
		- The distant site is a Joint Commission–accredited or a	licensed practitioners providing telemedicine services
		Medicare-participating organization.	to the critical access hospital's patients under a written
		- The physician or other licensed practitioner is	agreement between the critical access hospital and a
		privileged at the distant site for those services to be	distant-site telemedicine entity, the distant-site
		provided at the originating site.	telemedicine entity is not required to be a Medicare
		- The distant site provides the originating site with a	participating
		current list of the physician's or other licensed	provider or supplier.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		practitioner's privileges.	Note 2: For rehabilitation and psychiatric distinct part
		- The originating site has evidence of an internal review	units in critical access hospitals: The distant-site
		of the physician's or other licensed practitioner's	telemedicine entity's medical staff credentialing and
		performance of these privileges and sends to the distant	privileging process and standards at least meet the
		site information that is useful to assess the physician's or	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		other licensed practitioner's quality of care, treatment,	482.22(a)(1) through (a)(2).
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
CoP Requirement	CoP Text	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	Future EP Mapping
		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	- The distant site telemedicine entity provides services
		organization. The distant-site physician or other licensed	in accordance with contract service requirements.
		practitioner has a license that is issued or recognized by	- The distant-site telemedicine entity's medical staff
		the state in which the patient is receiving telemedicine	credentialing and privileging process and standards is
		services.	consistent with the critical access hospital's process
		Or	and standards, at a minimum.
		- The originating site may choose to use the credentialing	- The distant-site hospital providing the telemedicine
		and privileging decision from the distant site to make a	services is a Medicare-participating hospital.
		final privileging decision if all the following requirements	- The individual distant-site physician or other licensed
		are met:	practitioner is privileged at the distant-site hospital or
		- The distant site is a Joint Commission–accredited or a	telemedicine entity providing the telemedicine services,
		Medicare-participating organization.	and the distant-site hospital or telemedicine entity
		- The physician or other licensed practitioner is	provides a current list of the distant-site physician's or
		privileged at the distant site for those services to be	practitioner's privileges at the distant-site hospital or
		provided at the originating site.	telemedicine entity.
		- The distant site provides the originating site with a	- The individual distant-site physician or other licensed
		current list of the physician's or other licensed	practitioner holds a license issued or recognized by the
		practitioner's privileges.	state in which the critical access hospital whose
		- The originating site has evidence of an internal review	patients are receiving the telemedicine services is
		of the physician's or other licensed practitioner's	located.
		performance of these privileges and sends to the distant	- For distant-site physicians or other licensed
		site information that is useful to assess the physician's or	practitioners privileged by the originating critical access
		other licensed practitioner's quality of care, treatment,	hospital, the originating critical access hospital
		and services for use in privileging and performance	internally reviews services provided by the distant-site
		improvement. At a minimum, this information includes all	physician or other licensed practitioner and sends the
		adverse outcomes related to sentinel events considered	distant-site hospital or telemedicine entity information
		reviewable by The Joint Commission that result from the	for use in the periodic evaluation of the practitioner. At a
		telemedicine services provided and complaints about the	minimum, this information includes adverse events that
		distant site physician or other licensed practitioner from	result from the telemedicine services provided by the
		patients, physicians or other licensed practitioners, or	distant-site physician or other licensed practitioner to
		staff at the originating site. This occurs in a way	the critical access hospital's patients and complaints
		consistent with any hospital policies or procedures	the critical access hospital has received about the
		intended to preserve any confidentiality or privilege of	distant-site physician or other licensed practitioner.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		information established by applicable law.	Note 1: In the case of distant-site physicians and
		- When telemedicine services are provided by a distant-	licensed practitioners providing telemedicine services
		site Medicare-participating hospital, the distant-site	to the critical access hospital's patients under a written
		hospital evaluates the quality and appropriateness of the	agreement between the critical access hospital and a
		diagnosis, treatment, and treatment outcomes furnished	distant-site telemedicine entity, the distant-site
		in the critical access hospital.	telemedicine entity is not required to be a Medicare
		- When telemedicine services are provided by a distant-	participating
		site telemedicine entity (a non-Medicare-participating	provider or supplier.
		provider or supplier), the quality and appropriateness of	Note 2: For rehabilitation and psychiatric distinct part
		the diagnosis, treatment, and treatment outcomes	units in critical access hospitals: The distant-site
		furnished in the critical access hospital are evaluated by	telemedicine entity's medical staff credentialing and
		a hospital that is a member of the network, a QIO or	privileging process and standards at least meet the
		equivalent entity, or an appropriate and qualified entity identified in the state rural health plan.	standards at 42 CFR 482.12(a)(1) through (a)(7) and 482.22(a)(1) through (a)(2).
		- The distant-site physician or other licensed	462.22(a)(1) tillough (a)(2).
		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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	LD.04.03.09, EP 2	MS.20.01.01, EP 1
	physician or practitioner, who	The critical access hospital describes, in writing, the	When telemedicine services are furnished to the critical
	holds current privileges at the CAH	nature and scope of services provided through	access hospital's patients through an agreement with a
	whose patients are receiving the	contractual agreements.	distant-site hospital or telemedicine entity, the
	telemedicine services, the CAH		governing body of the originating critical access
	has evidence of an internal review	LD.04.03.09, EP 4	hospital may choose to rely upon the credentialing and
	of the distant-site physician's or	Leaders monitor contracted services by establishing	privileging decisions made by the distant-site hospital
	practitioner's performance of	expectations for the performance of the contracted	or telemedicine entity for the individual distant-site
	these privileges and sends the	services.	physicians and other licensed practitioners providing
	distant-site telemedicine entity	Note 1: When the critical access hospital contracts with	such services if the critical access hospital's governing
	such information for use in the	another accredited organization for patient care,	body includes all of the following provisions in its
	periodic appraisal of the distant-	treatment, and services to be provided off site, it can do	written agreement with the distant-site hospital or
	site physician or practitioner. At a	the following:	telemedicine entity:
	minimum, this information must	- Verify that all physicians and other licensed	- The distant site telemedicine entity provides services
	include all adverse events that	practitioners who will be providing patient care,	in accordance with contract service requirements.
	result from the telemedicine	treatment, and services have appropriate privileges by	- The distant-site telemedicine entity's medical staff
	services provided by the distant-	obtaining, for example, a copy of the list of privileges.	credentialing and privileging process and standards is
	site physician or practitioner to the	- Specify in the written agreement that the contracted	consistent with the critical access hospital's process
	CAH's patients and all complaints	organization will ensure that all contracted services	and standards, at a minimum.
	the CAH has received about the	provided by physicians and other licensed practitioners	- The distant-site hospital providing the telemedicine
	distant-site physician or	will be within the scope of their privileges.	services is a Medicare-participating hospital.
	practitioner.	Note 2: The leaders who monitor the contracted services	- The individual distant-site physician or other licensed
		are the governing body.	practitioner is privileged at the distant-site hospital or
			telemedicine entity providing the telemedicine services,
		MS.13.01.01, EP 1	and the distant-site hospital or telemedicine entity
		All physicians or other licensed practitioners who are	provides a current list of the distant-site physician's or
		responsible for the patient's care, treatment, and services	practitioner's privileges at the distant-site hospital or
		via telemedicine link are credentialed and privileged to do	telemedicine entity.
		so at the originating site through one of the following	- The individual distant-site physician or other licensed

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		mechanisms:	practitioner holds a license issued or recognized by the
		- The originating site fully credentials and privileges the	state in which the critical access hospital whose
		physician or other licensed practitioner according to	patients are receiving the telemedicine services is
		Standards MS.06.01.03 through MS.06.01.13.	located.
		Or	- For distant-site physicians or other licensed
		- The originating site privileges physicians or other	practitioners privileged by the originating critical access
		licensed practitioners using credentialing information	hospital, the originating critical access hospital
		from the distant site if the distant site is a Joint	internally reviews services provided by the distant-site
		Commission–accredited or a Medicare-participating	physician or other licensed practitioner and sends the
		organization. The distant-site physician or other licensed	distant-site hospital or telemedicine entity information
		practitioner has a license that is issued or recognized by	for use in the periodic evaluation of the practitioner. At a
		the state in which the patient is receiving telemedicine	minimum, this information includes adverse events that
		services.	result from the telemedicine services provided by the
		Or	distant-site physician or other licensed practitioner to
		- The originating site may choose to use the credentialing	the critical access hospital's patients and complaints
		and privileging decision from the distant site to make a	the critical access hospital has received about the
		final privileging decision if all the following requirements	distant-site physician or other licensed practitioner.
		are met:	Note 1: In the case of distant-site physicians and
		- The distant site is a Joint Commission–accredited or a	licensed practitioners providing telemedicine services
		Medicare-participating organization.	to the critical access hospital's patients under a written
		- The physician or other licensed practitioner is	agreement between the critical access hospital and a
		privileged at the distant site for those services to be	distant-site telemedicine entity, the distant-site
		provided at the originating site.	telemedicine entity is not required to be a Medicare
		- The distant site provides the originating site with a	participating
		current list of the physician's or other licensed	provider or supplier.
		practitioner's privileges.	Note 2: For rehabilitation and psychiatric distinct part
		- The originating site has evidence of an internal review	units in critical access hospitals: The distant-site
		of the physician's or other licensed practitioner's	telemedicine entity's medical staff credentialing and
		performance of these privileges and sends to the distant	privileging process and standards at least meet the
		site information that is useful to assess the physician's or	standards at 42 CFR 482.12(a)(1) through (a)(7) and
		other licensed practitioner's quality of care, treatment,	482.22(a)(1) through (a)(2).
		and services for use in privileging and performance	
		improvement. At a minimum, this information includes all	

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	

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	
\$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 lifethreatening injuries and acute illnesses. Note: Emergency services are available 24-hours a day, 7 days a week.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		supplies, and other resources.	
		LD.04.03.01, EP 4	
		Emergency services are provided on site and are available	
\$405.040(-)	SAOF CAO(a) Charadayd, Availability	on a 24-hour basis.	LD 40 00 04 FD 0
§485.618(a)	\$485.618(a) Standard: Availability	LD.04.03.01, EP 4	LD.13.03.01, EP 6
	Emergency services are available on a 24-hours a day basis.	Emergency services are provided on site and are available on a 24-hour basis.	The critical access hospital provides emergency medical services that meet the needs of its inpatients
	on a 24-nours a day basis.	on a 24-nour basis.	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,	MM.03.01.03, EP 1	PC.12.01.07, EP 1
	Supplies, and Medication	Critical access hospital leaders, in conjunction with	The critical access hospital maintains equipment,
	Equipment, supplies, and	members of the medical staff and licensed practitioners,	supplies, and drugs and biologicals commonly used in
	medication used in treating	decide which emergency medications and their	life-saving procedures. These items are kept at the
	emergency cases are kept at the	associated supplies will be readily accessible in patient	critical access hospital and are available for treating
	CAH and are readily available for	care areas based on the population served.	emergency cases.
	treating emergency cases. The items available must include the	MM 02 04 02 FD 4	Note 1: The drugs and biologicals commonly used in
	following:	MM.03.01.03, EP 4 Medications available for treating emergency cases	life-saving procedures include but are not limited to analgesics, local anesthetics, antibiotics,
	lottowing.	include analgesics, local anesthetics, antibiotics,	anticonvulsants, antidotes and emetics, serums and
		anticonvulsants, antidotes and emetics, serums and	toxoids, antiarrythmics, cardiac glycosides,
		toxoids, antiarrythmics, cardiac glycosides,	antihypertensives, diuretics, and electrolytes and
		antihypertensives, diuretics, and electrolytes and	replacement solutions.
		replacement solutions.	Note 2: Equipment and supplies commonly used life-
			saving procedures include but are not limited to
		MM.03.01.03, EP 6	airways, endotracheal tubes, ambu bag/valve/mask,
		When emergency medications or supplies are used or	oxygen, tourniquets, immobilization devices,
		expired, the critical access hospital replaces them as	nasogastric tubes, splints, IV therapy supplies, suction
		soon as possible to maintain a full stock.	machine, defibrillator, cardiac monitor, chest tubes,
		DC 02 01 00 ED 9	and indwelling urinary catheters.
		PC.02.01.09, EP 8	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	devices, nasogastric tubes,	defibrillators, cardiac monitors, chest tubes, and	Note 1: The drugs and biologicals commonly used in
	splints, IV therapy supplies,	indwelling urinary catheters.	life-saving procedures include but are not limited to
	suction machine, defibrillator,		analgesics, local anesthetics, antibiotics,
	cardiac monitor, chest tubes, and		anticonvulsants, antidotes and emetics, serums and
	indwelling urinary catheters.		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,	LD.04.03.01, EP 5	LD.13.03.01, EP 16
	safekeeping, and transfusion of	The critical access hospital provides services directly or	The critical access hospital provides services, directly
	blood, including the availability of	by arrangement, for the procurement, safekeeping, and	or by arrangement, for the procurement, safekeeping,
	blood products needed for	transfusion of blood, and services for making blood	and transfusion of blood and provides services for
	emergencies on a 24-hours a day	products available for emergencies on a 24-hour basis.	making blood products available for emergencies on a
\$405.040(=)(0)	basis.	I D 04 00 04 ED 0	24-hour basis.
§485.618(c)(2)	(2) Blood storage facilities that	LD.04.03.01, EP 6	LD.13.03.01, EP 17
	meet the requirements of 42 CFR	The critical access hospital provides blood storage	The critical access hospital provides blood storage
	part 493, subpart K, and are under	facilities, either directly or by arrangement, that meet the	facilities, either directly or by arrangement, that meet
	the control and supervision of a	requirements of 42 CFR part 493, subpart K, and are	the requirements of 42 CFR part 493, subpart K, and are
	pathologist or other qualified	under the control and supervision of a pathologist or	under the control and supervision of a pathologist or
	doctor of medicine or osteopathy.	other qualified doctor of medicine or osteopathy.	other qualified doctor of medicine or osteopathy.
	If blood banking services are	ID 04 02 00 ED 1	Note: If blood banking services are provided under an
	provided under an arrangement,	LD.04.03.09, EP 1	arrangement, the arrangement is approved by the
	the arrangement is approved by	Clinical leaders and medical staff have an opportunity to	critical access hospital's medical staff and by the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	the facility's medical staff and by	provide advice about the sources of clinical services to be	persons directly responsible for the operation of the
	the persons directly responsible	provided through contractual agreement.	critical access hospitals.
	for the operation of the facility.		
		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.	
§485.618(d)	§485.618(d) Standard: Personnel		
§485.618(d)(1)	(1) Except as specified in		NPG.12.01.01, EP 5
	paragraph (d)(3) of this section,		A doctor of medicine or osteopathy, a physician
	there must be a doctor of		assistant, a nurse practitioner, or a clinical nurse
	medicine or osteopathy, a		specialist with training or experience in emergency care
	physician assistant, a nurse		is on call and immediately available by telephone or
	practitioner, or a clinical nurse		radio contact, and they are available on site within 30
	specialist, with training or		minutes, 24 hours a day, 7 days a week .
	experience in emergency care, on		Note: If all of the following criteria are met, these
	call and immediately available by		practitioners are available on site within 60 minutes:
	telephone or radio contact, and		- The critical access hospital is located in an area
	available on site within the		designated as a frontier (that is, an area with fewer than
	following timeframes:		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 & Dan and Approved by the Centers for Medicare & Dan Britania
			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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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	HR.01.02.05, EP 4	NPG.12.01.01, EP 5
	a day basis, if the CAH is located in	A doctor of medicine or osteopathy, a physician assistant,	A doctor of medicine or osteopathy, a physician
	an area other than an area	a nurse practitioner, or a clinical nurse specialist with	assistant, a nurse practitioner, or a clinical nurse
	described in paragraph (d)(1)(ii) of	training or experience in emergency care is on call and	specialist with training or experience in emergency care
	this section; or	immediately available by telephone or radio contact, and	is on call and immediately available by telephone or
		available on-site within 30 minutes, 24 hours a day, if the	radio contact, and they are available on site within 30
		critical access hospital is located in an area other than an	minutes, 24 hours a day, 7 days a week .
		area described in 42 CFR 485.618(d)(1)(ii).	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 & Dedicaid
			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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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 & Damp; 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 & Descrite (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
§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		needed to stabilize a patient in an emergency.
§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:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The registered nurse is on site and immediately available at the critical access hospital when a patient requests	- The registered nurse is on site and immediately available at the critical access hospital when a patient
		medical care. - The patient's request for medical care is within the scope of practice of a registered nurse and consistent	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.	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 & Amp;	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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- The state in which the critical access hospital is located	- The state in which the critical access hospital is
		submits a letter to the Centers for Medicare & Description 2015	located submits a letter to the Centers for Medicare
		Medicaid Services (CMS) signed by the governor,	& Medicaid Services (CMS) signed by the governor,
		following consultation on the issue of using registered	following consultation on the issue of using registered
		nurses on a temporary basis as part of its state rural	nurses on a temporary basis as part of its state rural
		health care plan with the State Boards of Medicine and	health care plan with the state boards of medicine and
		Nursing, and in accordance with state law, requesting	nursing and in accordance with state law, requesting
		that a registered nurse with training and experience in	that a registered nurse with training and experience in
		emergency care be included in the list of personnel	emergency care be included in the list of personnel
		specified in 42 CFR 485.618(d)(1). The letter from the	specified in 42 CFR 485.618(d)(1). The letter from the
		governor must attest that they have consulted with the	governor attests that they have consulted with the state
		State Boards of Medicine and Nursing about issues	boards of medicine and nursing about issues related to
		related to access to and the quality of emergency	access to and the quality of emergency services in the
		services in the state. The letter from the governor must	state. The letter from the governor also describes the
		also describe the circumstances and duration of the	circumstances and duration of the temporary request
		temporary request to include the registered nurses on the	to include the registered nurses on the list of personnel
		list of personnel specified in 42 CFR 485.618(d)(1).	specified in 42 CFR 485.618(d)(1).
		- Once a governor submits a letter, as specified in 42 CFR	- Once the governor submits a letter, the critical access
		485.618(d)(3)(ii), a critical access hospital must submit	hospital submits documentation to the state survey
		documentation to the state survey agency demonstrating	agency demonstrating that it has been unable, due to
		that it has been unable, due to the shortage of such	the shortage of such personnel in the area, to provide
		personnel in the area, to provide adequate coverage as	adequate coverage as specified in 42 CFR 485.618(d).
		specified in 42 CFR 485.618(d).	Note: The critical access hospital's request for using
		Note: The critical access hospital's request for using RNs	registered nurses on a temporary basis or its withdrawal
		on a temporary basis or its withdrawal of this request can	of this request can be submitted to CMS at any time
		be submitted to CMS at any time and is effective upon	and is effective upon submission.
		submission.	
§485.618(d)(3)(iii)	(iii) The State in which the CAH is	HR.01.02.05, EP 15	NPG.12.02.01, EP 8
	located submits a letter to CMS	A registered nurse satisfies the personnel requirements in	A registered nurse satisfies the personnel availability
	signed by the Governor, following	42 CFR 485.618(d)(1) for a temporary period if all of the	requirements in 42 CFR 485.618(d)(1) for a temporary
	consultation on the issue of using	following conditions are met:	period if all of the following conditions are met:
	RNs on a temporary basis as part	- The critical access hospital has no more than 10 beds.	- The critical access hospital has no more than 10 beds.
	of their State rural healthcare plan	- The critical access hospital is located in an area	- 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	designated as a frontier area or remote location as	designated as a frontier area or remote location as
	and Nursing, and in accordance	described in 42 CFR 485.618(d)(1)(ii)(A).	described in 42 CFR 485.618(d)(1)(ii)(A).
	with State law, requesting that a	- The state in which the critical access hospital is located	- The state in which the critical access hospital is
	registered nurse with training and	submits a letter to the Centers for Medicare & Description 2015	located submits a letter to the Centers for Medicare
	experience in emergency care be	Medicaid Services (CMS) signed by the governor,	& Medicaid Services (CMS) signed by the governor,
	included in the list of personnel	following consultation on the issue of using registered	following consultation on the issue of using registered
	specified in paragraph (d)(1) of this	nurses on a temporary basis as part of its state rural	nurses on a temporary basis as part of its state rural
	section. The letter from the	health care plan with the State Boards of Medicine and	health care plan with the state boards of medicine and
	Governor must attest that he or	Nursing, and in accordance with state law, requesting	nursing and in accordance with state law, requesting
	she has consulted with State	that a registered nurse with training and experience in	that a registered nurse with training and experience in
	Boards of Medicine and Nursing	emergency care be included in the list of personnel	emergency care be included in the list of personnel
	about issues related to access to	specified in 42 CFR 485.618(d)(1). The letter from the	specified in 42 CFR 485.618(d)(1). The letter from the
	and the quality of emergency	governor must attest that they have consulted with the	governor attests that they have consulted with the state
	services in the States. The letter	State Boards of Medicine and Nursing about issues	boards of medicine and nursing about issues related to
	from the Governor must also	related to access to and the quality of emergency	access to and the quality of emergency services in the
	describe the circumstances and	services in the state. The letter from the governor must	state. The letter from the governor also describes the
	duration of the temporary request	also describe the circumstances and duration of the	circumstances and duration of the temporary request
	to include the registered nurses on	temporary request to include the registered nurses on the	to include the registered nurses on the list of personnel
	the list of personnel specified in	list of personnel specified in 42 CFR 485.618(d)(1).	specified in 42 CFR 485.618(d)(1).
	paragraph (d)(1) of this section;	- Once a governor submits a letter, as specified in 42 CFR	- Once the governor submits a letter, the critical access
		485.618(d)(3)(ii), a critical access hospital must submit	hospital submits documentation to the state survey
		documentation to the state survey agency demonstrating	agency demonstrating that it has been unable, due to
		that it has been unable, due to the shortage of such	the shortage of such personnel in the area, to provide
		personnel in the area, to provide adequate coverage as	adequate coverage as specified in 42 CFR 485.618(d).
		specified in 42 CFR 485.618(d).	Note: The critical access hospital's request for using
		Note: The critical access hospital's request for using RNs	registered nurses on a temporary basis or its withdrawal
		on a temporary basis or its withdrawal of this request can	of this request can be submitted to CMS at any time
		be submitted to CMS at any time and is effective upon	and is effective upon submission.
		submission.	
§485.618(d)(3)(iv)	(iv) Once a Governor submits a	HR.01.02.05, EP 15	NPG.12.02.01, EP 8
	letter, as specified in paragraph	A registered nurse satisfies the personnel requirements in	A registered nurse satisfies the personnel availability
	(d)(3)(iii) of this section, a CAH	42 CFR 485.618(d)(1) for a temporary period if all of the	requirements in 42 CFR 485.618(d)(1) for a temporary
	must submit documentation to the	following conditions are met:	period if all of the following conditions are met:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	State survey agency	- The critical access hospital has no more than 10 beds.	- The critical access hospital has no more than 10 beds.
	demonstrating that it has been	- The critical access hospital is located in an area	- The critical access hospital is located in an area
	unable, due to the shortage of	designated as a frontier area or remote location as	designated as a frontier area or remote location as
	such personnel in the area, to	described in 42 CFR 485.618(d)(1)(ii)(A).	described in 42 CFR 485.618(d)(1)(ii)(A).
	provide adequate coverage as	- The state in which the critical access hospital is located	- The state in which the critical access hospital is
	specified in this paragraph (d).	submits a letter to the Centers for Medicare & Description 2015	located submits a letter to the Centers for Medicare
		Medicaid Services (CMS) signed by the governor,	& Medicaid Services (CMS) signed by the governor,
		following consultation on the issue of using registered	following consultation on the issue of using registered
		nurses on a temporary basis as part of its state rural	nurses on a temporary basis as part of its state rural
		health care plan with the State Boards of Medicine and	health care plan with the state boards of medicine and
		Nursing, and in accordance with state law, requesting	nursing and in accordance with state law, requesting
		that a registered nurse with training and experience in	that a registered nurse with training and experience in
		emergency care be included in the list of personnel	emergency care be included in the list of personnel
		specified in 42 CFR 485.618(d)(1). The letter from the	specified in 42 CFR 485.618(d)(1). The letter from the
		governor must attest that they have consulted with the	governor attests that they have consulted with the state
		State Boards of Medicine and Nursing about issues	boards of medicine and nursing about issues related to
		related to access to and the quality of emergency	access to and the quality of emergency services in the
		services in the state. The letter from the governor must	state. The letter from the governor also describes the
		also describe the circumstances and duration of the	circumstances and duration of the temporary request
		temporary request to include the registered nurses on the	to include the registered nurses on the list of personnel
		list of personnel specified in 42 CFR 485.618(d)(1).	specified in 42 CFR 485.618(d)(1).
		- Once a governor submits a letter, as specified in 42 CFR	- Once the governor submits a letter, the critical access
		485.618(d)(3)(ii), a critical access hospital must submit	hospital submits documentation to the state survey
		documentation to the state survey agency demonstrating	agency demonstrating that it has been unable, due to
		that it has been unable, due to the shortage of such	the shortage of such personnel in the area, to provide
		personnel in the area, to provide adequate coverage as	adequate coverage as specified in 42 CFR 485.618(d).
		specified in 42 CFR 485.618(d).	Note: The critical access hospital's request for using
		Note: The critical access hospital's request for using RNs	registered nurses on a temporary basis or its withdrawal
		on a temporary basis or its withdrawal of this request can	of this request can be submitted to CMS at any time
		be submitted to CMS at any time and is effective upon	and is effective upon submission.
		submission.	
§485.618(d)(4)	(4) The request, as specified in	HR.01.02.05, EP 15	NPG.12.02.01, EP 8
	paragraph(d)(3)(iii) of this section,	A registered nurse satisfies the personnel requirements in	A registered nurse satisfies the personnel availability

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	and the withdrawal of the request,	42 CFR 485.618(d)(1) for a temporary period if all of the	requirements in 42 CFR 485.618(d)(1) for a temporary
	may be submitted to us at any	following conditions are met:	period if all of the following conditions are met:
	time, and are effective upon	- The critical access hospital has no more than 10 beds.	- The critical access hospital has no more than 10 beds.
	submission.	- The critical access hospital is located in an area	- The critical access hospital is located in an area
		designated as a frontier area or remote location as	designated as a frontier area or remote location as
		described in 42 CFR 485.618(d)(1)(ii)(A).	described in 42 CFR 485.618(d)(1)(ii)(A).
		- The state in which the critical access hospital is located	- The state in which the critical access hospital is
		submits a letter to the Centers for Medicare & Description 2015	located submits a letter to the Centers for Medicare
		Medicaid Services (CMS) signed by the governor,	& Medicaid Services (CMS) signed by the governor,
		following consultation on the issue of using registered	following consultation on the issue of using registered
		nurses on a temporary basis as part of its state rural	nurses on a temporary basis as part of its state rural
		health care plan with the State Boards of Medicine and	health care plan with the state boards of medicine and
		Nursing, and in accordance with state law, requesting	nursing and in accordance with state law, requesting
		that a registered nurse with training and experience in	that a registered nurse with training and experience in
		emergency care be included in the list of personnel	emergency care be included in the list of personnel
		specified in 42 CFR 485.618(d)(1). The letter from the	specified in 42 CFR 485.618(d)(1). The letter from the
		governor must attest that they have consulted with the	governor attests that they have consulted with the state
		State Boards of Medicine and Nursing about issues	boards of medicine and nursing about issues related to
		related to access to and the quality of emergency	access to and the quality of emergency services in the
		services in the state. The letter from the governor must	state. The letter from the governor also describes the
		also describe the circumstances and duration of the	circumstances and duration of the temporary request
		temporary request to include the registered nurses on the	to include the registered nurses on the list of personnel
		list of personnel specified in 42 CFR 485.618(d)(1).	specified in 42 CFR 485.618(d)(1).
		- Once a governor submits a letter, as specified in 42 CFR	- Once the governor submits a letter, the critical access
		485.618(d)(3)(ii), a critical access hospital must submit	hospital submits documentation to the state survey
		documentation to the state survey agency demonstrating	agency demonstrating that it has been unable, due to
		that it has been unable, due to the shortage of such	the shortage of such personnel in the area, to provide
		personnel in the area, to provide adequate coverage as	adequate coverage as specified in 42 CFR 485.618(d).
		specified in 42 CFR 485.618(d).	Note: The critical access hospital's request for using
		Note: The critical access hospital's request for using RNs	registered nurses on a temporary basis or its withdrawal
		on a temporary basis or its withdrawal of this request can	of this request can be submitted to CMS at any time
		be submitted to CMS at any time and is effective upon	and is effective upon submission.
		submission.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.618(e)	§485.618(e) Standard:	HR.01.02.05, EP 3	LD.13.01.09, EP 8
	Coordination With Emergency	In coordination with area emergency response systems,	In coordination with area emergency response systems,
	Response Systems The CAH	the critical access hospital establishes procedures under	the critical access hospital establishes procedures
	must, in coordination with	which a doctor of medicine or osteopathy is immediately	under which a doctor of medicine or osteopathy is
	emergency response systems in	available by telephone or radio contact on a 24-hour-a-	immediately available by telephone or radio contact 24
	the area, establish procedures	day basis to receive emergency calls, provide information	hours a day, 7 days a week, to receive emergency calls,
	under which a doctor of medicine	on treatment of emergency patients, and refer patients to	provide information on treatment of emergency
	or osteopathy is immediately	the critical access hospital or other appropriate locations	patients, and refer patients to the critical access
	available by telephone or radio	for treatment.	hospital or other appropriate locations for treatment.
	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.		
§485.620	§485.620 Condition of		
	Participation: Number of Beds and		
	Length of Stay		
§485.620(a)	§485.620(a) Standard: Number of	LD.04.01.01, EP 6	LD.13.01.01, EP 3
	Beds Except as permitted for	Except as permitted for critical access hospitals having	Except as permitted for critical access hospitals having
	CAHs having distinct part units	distinct part units under 42 CFR 485.647, the critical	distinct part units under 42 CFR 485.647, the critical
	under \$485.647, the CAH	access hospital maintains no more than 25 inpatient	access hospital maintains no more than 25 inpatient
	maintains no more than 25	beds that can be used for either inpatient or swing bed	beds that can be used for either inpatient or swing bed
	inpatient beds. Inpatient beds may	services.	services.
	be used for either inpatient or	Note: Any bed in a unit of the facility that is licensed as a	Note: Any bed in a unit of the facility that is licensed as
	swing-bed services.	distinct-part skilled nursing facility at the time the facility	a distinct part skilled nursing facility at the time the
		applies to the state for designation as a critical access	facility applies to the state for designation as a critical
0.405.000(1.)	0.405.000(1) 0: 1 1 1 1 1 1 1	hospital is not counted in this 25-bed count.	access hospital is not counted in this 25-bed count.
§485.620(b)	\$485.620(b) Standard: Length of	LD.04.01.01, EP 7	LD.13.01.01, EP 5
	Stay The CAH provides acute	The critical access hospital provides acute inpatient care	The critical access hospital provides acute inpatient
	inpatient care for a period that	for a period that does not exceed, on an annual average	care for a period that does not exceed, on an annual
	does not exceed, on an annual	basis, 96 hours per patient.	average basis, 96 hours per patient.

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 selftesting, 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:	
		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)	
		(1 01 1011 toxt, 16161 to 141 FA 33-2012. 0.4.4.1)	
		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.	
		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:	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.
		- 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.04.01.05, 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	measures, and end-use points
		- Semiannually for valve supervisory switches	Note: An example would be a flow chart with symbols
		- Annually for other supervisory initiating devices	showing sinks, showers, water fountains, ice machines,
		The results and completion dates are documented.	and so forth.
		Note 1: For additional guidance on performing tests, see	- A water risk management plan based on the diagram
		NFPA 72-2010: Table 14.4.5.	that includes an evaluation of the physical and
		Note 2: Water storage tanks and associated water storage	chemical conditions of each step of the water flow
		equipment do not require testing.	diagram to identify any areas where potentially
			hazardous conditions may occur (these conditions are
		EC.02.03.05, EP 2	most likely to occur in areas with slow or stagnant
		Every 6 months, the critical access hospital tests vane-	water)
		type and pressure-type water flow devices and valve	Note: Refer to the Centers for Disease Control and
		tamper switches on the inventory. The results and	Prevention's "Water Infection Control Risk Assessment
		completion dates are documented.	(WICRA) for Healthcare Settings" tool as an example for
		Note 1: For additional guidance on performing tests, see	conducting a water-related risk assessment.
		NFPA 72-2010: Table 14.4.5.	- A plan for addressing the use of water in areas of
		Note 2: Mechanical water flow devices (including, but not	buildings where water may have been stagnant for a
		limited to, water motor gongs) should be tested quarterly.	period of time (for example, unoccupied or temporarily
		The results and completion dates are documented. (For	closed areas)
		full text, refer to NFPA 25-2011: Table 5.1.1.2)	- An evaluation of the patient populations served to
			identify patients who are immunocompromised
		EC.02.03.05, EP 3	- Monitoring protocols and acceptable ranges for
		Every 12 months, the critical access hospital tests duct	control measures
		detectors, heat detectors, manual fire alarm boxes, and	Note: Critical access hospitals should consider
		smoke detectors on the inventory. The results and	incorporating basic practices for water monitoring
		completion dates are documented.	within their water management programs that include
		Note: For additional guidance on performing tests, see	monitoring of water temperature, residual disinfectant,
		NFPA 72-2010: Table 14.4.5; 17.14.	and pH. In addition, protocols should include
			specificity around the parameters measured, locations
		EC.02.03.05, EP 4	where measurements are made, and appropriate
		Every 12 months, the critical access hospital tests visual	corrective actions taken when parameters are out of
		and audible fire alarms, including speakers and door-	range.
		releasing devices on the inventory. The results and	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		completion dates are documented.	PE.04.01.05, EP 3
		Note: For additional guidance on performing tests, see	The individual or team responsible for the water
		NFPA 72-2010: Table 14.4.5.	management program manages the following:
			- Documenting results of all monitoring activities
		EC.02.03.05, EP 5	- Corrective actions and procedures to follow if a test
		Every 12 months, the critical access hospital tests fire	result outside of acceptable limits is obtained,
		alarm equipment on the inventory for notifying off-site fire	including when a probable or confirmed waterborne
		responders. The results and completion dates are	pathogen(s) indicates action is necessary
		documented.	- Documenting corrective actions taken when control
		Note: For additional guidance on performing tests, see	limits are not maintained
		NFPA 72-2010: Table 14.4.5.	Note: See PE.07.01.01, EP 1 for the process of
			monitoring, reporting, and investigating utility system
		EC.02.03.05, EP 6	issues.
		For automatic sprinkler systems: The critical access	
		hospital tests electric motor–driven fire pumps monthly	PE.04.01.05, EP 4
		and diesel engine–driven fire pumps every week under	The individual or team responsible for the water
		no-flow conditions. The results and completion dates are	management program reviews the program annually
		documented.	and when the following occurs:
		Note: For additional guidance on performing tests, see	- Changes have been made to the water system that
		NFPA 25-2011: 8.3.1; 8.3.2.	would add additional risk.
			- New equipment or an at-risk water system(s) has been
		EC.02.03.05, EP 9	added that could generate aerosols or be a potential
		For automatic sprinkler systems: Every 12 months, the	source for Legionella. This includes the commissioning
		critical access hospital tests main drains at system low	of a new wing or building.
		point or at all system risers. The results and completion	Note 1: The Joint Commission and the Centers for
		dates are documented.	Medicare & Dedicated Services (CMS) do not
		Note: For additional guidance on performing tests, see	require culturing for Legionella or other waterborne
		NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table	pathogens. Testing protocols are at the discretion of the
		13.8.1.	critical access hospital unless required by law or
			regulation.
		EC.02.03.05, EP 10	Note 2: Refer to ASHRAE Standard 188-2018
		For automatic sprinkler systems: Every quarter, the	"Legionellosis: Risk Management for Building Water
		critical access hospital inspects all fire department 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	Prevention Toolkit "Developing a Water Management
		are documented.	Program to Reduce Legionella Growth and Spread in
		Note: For additional guidance on performing tests, see	Buildings" for guidance on creating a water
		NFPA 25-2011: 13.7; Table 13.1.1.2.	management plan. For additional guidance, consult
			ANSI/ASHRAE Guideline 12-2020 "Managing the Risk of
		EC.02.03.05, EP 11	Legionellosis Associated with Building Water Systems."
		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:	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
COP Requirement	COF TEXT	- 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.	Future of Mapping
		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.	
		2010. 0.3.	
		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.	
		3.2.7, 0.0.1.7, NI FA 103-2010. 3.2.1.	
		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)	
		FO 00 04 04 FD 0	
		EC.02.04.01, EP 2 The critical access hospital maintains a written inventory	
		of all medical equipment.	
		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 02 ED 1	
		EC.02.04.03, EP 1 Before initial use and after major repairs or upgrades of	
		Defore 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.	
		50 00 05 04 5D 0	
		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 & Description (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)	
		0.3.2.2.0.4, 0.3.2.2.0.7, 0.4.4.2)	
		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)	
		FO 00 05 04 FD 05	
		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)	
		99-2012. 3.1.4.6.7, 3.1.9.3)	
		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 & mp; 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.	
		compensation indecides 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.	
		FO 00 05 05 FD 0	
		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	

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)	
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6.3.2.2.11.5)	
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	other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3;

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)	
		0.0.1.1, 0.0.1.3, 0.1.14.2)	
		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	EC.01.01.01, EP 6	PE.02.01.01, EP 6
	and prompt disposal of trash;	The critical access hospital has a written plan for	The critical access hospital has procedures for the
		managing the following: Hazardous materials and waste.	proper routine storage and prompt disposal of trash and regulated medical waste.
		EC.02.02.01, EP 1	

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.	
		50 00 00 01 5D 0	
		EC.02.02.01, EP 8 The critical access hospital minimizes risks associated	
		with disposing of hazardous medications.	
		, 5	

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.	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.
		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,	

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 & December 1: Centers for Medicare 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.	
		301 vices 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	EC.02.03.03, EP 1	PE.03.01.01, EP 3
	applicable provisions and must	The critical access hospital conducts fire drills once per	The critical access hospital meets the applicable
	proceed in accordance with the	shift per quarter in each building defined as a health care	provisions of the Life Safety Code (NFPA 101-2012 and
	Life Safety Code (NFPA 101 and	occupancy by the Life Safety Code. The critical access	Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3,
	Tentative Interim Amendments TIA	hospital conducts quarterly fire drills in each building	and 12-4).
	12–1, TIA 12–2, TIA 12–3, and TIA	defined as an ambulatory health care occupancy by the	Note 1: Outpatient surgical departments meet the
	12–4.)	Life Safety Code.	provisions applicable to ambulatory health care
		Note 1: Evacuation of patients during drills is not	occupancies, regardless of the number of patients
		required.	served.
		Note 2: When drills are conducted between 9:00 P.M. and	Note 2: The provisions of the Life Safety Code do not
		6:00 A.M., the critical access hospital may use a coded	apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Center in a state where the cen
		announcement to notify staff instead of activating audible	Medicaid Services (CMS) finds that a fire and safety
		alarms. For full text, refer to NFPA 101-2012: 18/19: 7.1.7.	code imposed by state law adequately protects
		Note 3: In leased or rented facilities, drills need be	patients in critical access hospitals.
		conducted only in areas of the building that the critical	Note 3: In consideration of a recommendation by the
		access hospital occupies.	state survey agency or accrediting organization or at the
			discretion of the Secretary for the US Department of
		EC.02.03.03, EP 3	Health & map; Human Services, CMS may waive, for
		When quarterly fire drills are required, they are	periods deemed appropriate, specific provisions of the
		unannounced and held at unexpected times and under	Life Safety Code, which would result in unreasonable
		varying conditions. Fire drills include transmission of fire	hardship upon a critical access hospital, but only if the
		alarm signal and simulation of emergency fire conditions.	waiver will not adversely affect the health and safety of
		Note 1: When drills are conducted between 9:00 P.M. and	the patients.
		6:00 A.M., the critical access hospital may use a coded	Note 4: After consideration of state survey agency
		announcement to notify staff instead of activating audible	findings, CMS may waive specific provisions of the Life
		alarms.	Safety Code that, if rigidly applied, would result in
		Note 2: Fire drills vary by at least one hour for each shift	unreasonable hardship on the critical access hospital,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		from quarter to quarter, through four consecutive	but only if the waiver does not adversely affect the
		quarters.	health and safety of patients.
		Note 3: For full text, refer to NFPA 101-2012: 18/19: 7.1;	Note 5: All inspecting activities are documented with
		7.1.7; 7.2; 7.3.	the name of the activity; date of the activity; inventory of
			devices, equipment, or other items; required frequency;
		EC.02.03.03, EP 4	name and contact information of person who
		Staff who work in buildings where patients are housed or	performed the activity; NFPA standard(s) referenced for
		treated participate in drills according to the critical	the activity; and results of the activity.
		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	

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.	
		10040404504	
		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 & Description for Medicare & Descri	
		and safety code imposed by state law adequately	
		protects patients in critical access hospitals.	
		1.C 04 00 04 FD 4	
		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)	
		3, 11, 17, 20, 20, 11, 17, 20, 20, 11, 10, 20, 20, 20, 20, 20, 20, 20, 20, 20, 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).	
		10 00 04 40 FB4	
		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.	
		40.7, diffeed by 14177 101 2012. 10/10.1.1.4.2.	
		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)	
		14174 101 2012. 0.0.0)	
		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; 18/19.2.2.2.5.1; 18/19.2.2.2.5.2)	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
CoP Requirement	CoP Text	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	Future EP Mapping
		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)	
		10 00 04 00 50 5	
		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)	
		10 NFFA 101-2012. 10/19.2.2.3, 7.2.2.3.4)	
		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	
		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, havely or astragal at the meeting edge, and at least one of	
		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)	
		10.00.04.00. FD.04	
		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
CoP Requirement	CoP Text	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;	Future EP Mapping
		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 Text	Current EP Mapping	Future EP Mapping
	sprinkler system is at least Class II. Existing floor finishes	
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	18/19.3.3; 10.2.7)	
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	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	
	- ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	
	refer to NFPA 101-2012: 18/19.3.6.2)	
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	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)	
	LC 00 04 20 FD 45	
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	CoP Text	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

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)	

ILS.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 ceillings and interstitial spaces), and extend continuously from exterior viall 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 of to resist fire for not less than 20 minutes, and fitted 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 tess 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 to Light (such as 1, 296 to Light).	CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	COP Requirement	COPTEXT	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	Future EP Mapping

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	LS.02.01.30, EP 2	PE.03.01.01, EP 6
	(c)(1)(i) of this section, corridor	All new hazardous areas have doors that are self-closing	Regardless of the provisions of the Life Safety Code,
	doors and doors to rooms	or automatic-closing, except for laboratories using	corridor doors and doors to rooms containing
	containing flammable or	flammable or combustible materials deemed less than a	flammable or combustible materials have positive
	combustible materials must be	severe hazard and storage rooms greater than 50 square	latching hardware. Roller latches are prohibited on
	provided with positive latching	feet, but less than 100 square feet that are used for	these doors.
	hardware. Roller latches are	storage of combustible material. Hazardous areas have a	
	prohibited on such doors.	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	

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)	
		10.3.0.3.11)	
		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	LS.01.01.01, EP 2	PE.03.01.01, EP 3
,	recommendation by the State	In time frames defined by the critical access hospital, the	The critical access hospital meets the applicable
	survey agency or Accrediting	critical access hospital performs a building assessment	provisions of the Life Safety Code (NFPA 101-2012 and
	Organization or at the discretion of	to determine compliance with the "Life Safety" (LS)	Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3,
	the Secretary, may waive, for	chapter.	and 12-4).
	periods deemed appropriate,		Note 1: Outpatient surgical departments meet the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	specific provisions of the Life	LS.01.01.01, EP 4	provisions applicable to ambulatory health care
	Safety Code, which would result in	When the critical access hospital plans to resolve a	occupancies, regardless of the number of patients
	unreasonable hardship upon a	deficiency through a Survey-Related Plan for	served.
	CAH, but only if the waiver will not	Improvement (SPFI), the critical access hospital meets	Note 2: The provisions of the Life Safety Code do not
	adversely affect the health and	the 60-day time frame.	apply in a state where the Centers for Medicare & Description (1997)
	safety of the patients.	Note 1: If the corrective action will exceed the 60-day	Medicaid Services (CMS) finds that a fire and safety
		time frame, the critical access hospital must request a	code imposed by state law adequately protects
		time-limited waiver within 30 days from the end of survey.	patients in critical access hospitals.
		Note 2: If there are alternative systems, methods, or	Note 3: In consideration of a recommendation by the
		devices considered equivalent, the critical access	state survey agency or accrediting organization or at the
		hospital may submit an equivalency request using its	discretion of the Secretary for the US Department of
		Statement of Conditions (SOC).	Health & map; Human Services, CMS may waive, for
		Note 3: For further information on waiver and equivalency	periods deemed appropriate, specific provisions of the
		requests, see	Life Safety Code, which would result in unreasonable
		https://www.jointcommission.org/resources/patient-	hardship upon a critical access hospital, but only if the
		safety-topics/the-physical-environment/life-safety-code-	waiver will not adversely affect the health and safety of
		information-and-resources/ and NFPA 101-2012: 1.4.	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
\$40F_000(a)(0)	(2) After a posideration of Chate		the activity; and results of the activity.
§485.623(c)(3)	(3) After consideration of State		PE.03.01.01, EP 3
	survey agency findings, CMS may		The critical access hospital meets the applicable
	waive specific provisions of the		provisions of the Life Safety Code (NFPA 101-2012 and
	Life Safety Code that, if rigidly		Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	applied, would result in		and 12-4).
	unreasonable hardship on the		Note 1: Outpatient surgical departments meet the
	CAH, but only if the waiver does		provisions applicable to ambulatory health care
	not adversely affect the health and		occupancies, regardless of the number of patients
	safety of patients.		served.
			Note 2: The provisions of the Life Safety Code do not
			apply in a state where the Centers for Medicare & Description (1975)
			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 & mp; 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	LS.01.01.01, EP 5	PE.03.01.01, EP 5
	evidence of regular inspection and	The critical access hospital maintains documentation of	The critical access hospital maintains written evidence

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	approval by State or local fire	any inspections and approvals made by state or local fire	of regular inspection and approval by state or local fire
	control agencies.	control agencies.	control agencies.
§485.623(c)(5)	(5) A CAH may install alcohol-	LS.02.01.30, EP 6	PE.03.01.01, EP 7
	based hand rub dispensers in its	Alcohol-based hand rubs (ABHR) are stored and handled	When the critical access hospital installs alcohol-
	facility if the dispensers are	in accordance with NFPA 101-2012: 8.7.3.1, unless all of	based hand rub dispensers, it installs the dispensers in
	installed in a manner that	the following conditions are met:	a manner that protects against inappropriate access.
	adequately protects against	- Corridor is at least six feet wide.	
	inappropriate access.	- 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.	

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.	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	LS.02.01.30, EP 24	PE.03.01.01, EP 9
	not apply to newborn nurseries	Every patient sleeping room has an outside window or	Buildings have an outside window or outside door in
	and rooms intended for	outside door except newborn nurseries or rooms	every sleeping room. For any building constructed after
	occupancy for less than 24 hours.	intended for less than 24-hour stays (such as obstetrical	July 5, 2016, the sill height does not exceed 36 inches
		labor beds, recovery beds, and observation beds in the	above the floor.
		emergency department).	Note 1: Windows in atrium walls are considered outside
		Note: Windows in atrium walls are considered outside	windows for the purposes of this requirement.
		windows.	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
\$40E C22(a)(7)(ii)	(ii) Special purging care areas of	LC 02 04 20 ED 25	new occupancies does not exceed 60 inches.
§485.623(c)(7)(ii)	(ii) Special nursing care areas of new occupancies shall not exceed	LS.02.01.30, EP 25 In new buildings constructed after July 5, 2016, the	PE.03.01.01, EP 9 Buildings have an outside window or outside door in
	60 inches.	window sill height in patient sleeping rooms does not	every sleeping room. For any building constructed after
	ou iliciles.	exceed 36 inches from the floor, except in special nursing	July 5, 2016, the sill height does not exceed 36 inches
		care areas (for example, intensive care units, coronary	above the floor.
		care units, hemodialysis units, and neonatal intensive	Note 1: Windows in atrium walls are considered outside
		care units), where window sill height does not exceed 60	windows for the purposes of this requirement.
		inches above the floor.	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	EC.01.01.01, EP 12	PE.04.01.01, EP 1
	Safety Except as otherwise	The critical access hospital complies with the 2012	The critical access hospital meets the applicable
	provided in this section, the CAH	edition of NFPA 99: Health Care Facilities Code, including	provisions and proceeds in accordance with the Health
	must meet the applicable	Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
	provisions and must proceed in	5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
	accordance with the Health Care	Facilities Code do not apply.	12-6).
	Facilities Code (NFPA 99 and		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	EC.02.01.03, EP 4	Facilities Code do not apply.
	12–2, TIA 12–3, TIA 12–4, TIA 12–5	Smoking materials are removed from patients receiving	Note 2: If application of the Health Care Facilities Code
	and TIA 12–6).	respiratory therapy. When a nasal cannula is delivering	would result in unreasonable hardship for the critical
		oxygen outside of a patient's room, no sources of ignition	access hospital, the Centers for Medicare & Decision 1.
		are within the site of intentional expulsion (within 1 foot).	Medicaid Services may waive specific provisions of the
		When other oxygen delivery equipment is used or oxygen	Health Care Facilities Code, but only if the waiver does
		is delivered inside a patient's room, no sources of ignition	not adversely affect the health and safety of patients.
		are within the area of administration (within 15 feet). Solid	Note 3: All inspecting activities are documented with
		fuel-burning appliances are not in the area of	the name of the activity; date of the activity; inventory of
		administration. Nonmedical appliances with hot surfaces	devices, equipment, or other items; required frequency;
		or sparking mechanisms are not within oxygen-delivery	name and contact information of person who
		equipment or site of intentional expulsion. (For full text, refer to NFPA 99-2012: 11.5.1.1; Tentative Interim	performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.
		Amendment [TIA] 12-6)	the activity, and results of the activity.
		Amendment [naj 12-0)	
		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.	
		interim Americinent (IIA) 12-3.	
		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	

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 & Description 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	EC.01.01.01, EP 1	PE.04.01.01, EP 1
	Care Facilities Code required	Leaders identify an individual(s) to manage risk,	The critical access hospital meets the applicable
	under paragraph (d) of this section	coordinate risk reduction activities in the physical	provisions and proceeds in accordance with the Health
	would result in unreasonable	environment, collect deficiency information, and	Care Facilities Code (NFPA 99-2012 and Tentative
	hardship for the CAH, CMS may	disseminate summaries of actions and results.	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
	waive specific provisions of the	Note: Deficiencies include injuries, problems, or use	12-6).
	Health Care Facilities Code, but	errors.	Note 1: Chapters 7, 8, 12, and 13 of the Health Care
	only if the waiver does not		Facilities Code do not apply.
	adversely affect the health and		Note 2: If application of the Health Care Facilities Code
	safety of patients.		would result in unreasonable hardship for the critical
			access hospital, the Centers for Medicare & Decision of t
			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		the detivity, and results of the detivity.
3.00.020(0)	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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
Cor nequirement	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_r egister/code_of_federal_regulation s/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	Current Lir Mapping	Tuture Li Mapping
§485.623(e)(1)	the changes. (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 & December 10 among 11 meets 12 meets 13 meets 14 meets 15 meet

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	EC.01.01.01, EP 12	PE.04.01.01, EP 1
	August 11, 2011.	The critical access hospital complies with the 2012	The critical access hospital meets the applicable
		edition of NFPA 99: Health Care Facilities Code, including	provisions and proceeds in accordance with the Health
		Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
		5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
		Facilities Code do not apply.	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 & Decision 1.
			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	EC.01.01.01, EP 12	PE.04.01.01, EP 1
	August 9, 2012.	The critical access hospital complies with the 2012	The critical access hospital meets the applicable
		edition of NFPA 99: Health Care Facilities Code, including	provisions and proceeds in accordance with the Health
		Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
		5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
		Facilities Code do not apply.	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
\$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	would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Description 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.04.01.01, EP 1 The critical access hospital meets the applicable provisions and proceeds in accordance with the Health
		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.	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 & Description 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	EC.01.01.01, EP 12	PE.04.01.01, EP 1
	August 1, 2013.	The critical access hospital complies with the 2012	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	provisions and proceeds in accordance with the Health
		Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
		5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
		Facilities Code do not apply.	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 & Description (1997)
			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	EC.01.01, EP 12	PE.04.01.01, EP 1
	March 3, 2014.	The critical access hospital complies with the 2012	The critical access hospital meets the applicable
		edition of NFPA 99: Health Care Facilities Code, including	provisions and proceeds in accordance with the Health
		Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
		5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
		Facilities Code do not apply.	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 & Described Provided Pro
			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.
			1
			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,	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	2012 edition, issued August 11,	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
	2011;	Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Description (1988)
			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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	August 11, 2011.	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
		Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Centers for Medica
			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 & Dervices, 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
			Safety Code that, if rigidty applied, would result in

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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	LS.01.01, EP 8	PE.03.01.01, EP 3
	October 30, 2012.	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
		Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Composition (Composition of Composition of Com
			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 & Description of the periods deemed appropriate appoints providing of the
			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
			INDIE 4. AITEI CONSIDERATION OF STATE SULVEY AGENCY

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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	LS.01.01, EP 8	PE.03.01.01, EP 3
	October 22, 2013.	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
		Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Company;
			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 & Description of the Health & He
			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	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	October 22, 2013.	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
		Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Comp;
			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 & Dervices, CMS may waive, for
			periods deemed appropriate, specific provisions of the
			Life Safety Code, which would result in unreasonable

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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	EM.09.01.01, EP 1	EM.09.01.01, EP 1
	Participation: Emergency	The critical access hospital has a written comprehensive	The critical access hospital has a written
	Preparedness The CAH must	emergency management program that utilizes an all-	comprehensive emergency management program that
	comply with all applicable Federal,	hazards approach. The program includes, but is not	utilizes an all-hazards approach. The program includes,
	State, and local emergency	limited to, the following:	but is not limited to, the following:
	preparedness requirements. The	- Leadership structure and program accountability	- Leadership structure and program accountability
	CAH must develop and maintain a	- Hazard vulnerability analysis	- Hazard vulnerability analysis
	comprehensive emergency	- Mitigation and preparedness activities	- Mitigation and preparedness activities
	preparedness program, utilizing an	- Emergency operations plan and policies and procedures	- Emergency operations plan and policies and
	all-hazards approach. The	- Education and training	procedures
	emergency preparedness plan	- Exercises and testing	- Education and training
	must include, but not be limited to,	- Continuity of operations plan	- Exercises and testing
	the following elements:	- Disaster recovery	- Continuity of operations plan
		- Program evaluation	- Disaster recovery
		FM 00 04 04 FB 0	- Program evaluation
		EM.09.01.01, EP 3	
		The critical access hospital complies with all applicable	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	federal, state, and local emergency preparedness laws
		and regulations.	and regulations.
§485.625(a)	(a) Emergency plan. The CAH must	EM.12.01.01, EP 1	EM.12.01.01, EP 1
	develop and maintain an	The critical access hospital has a written all-hazards	The critical access hospital has a written all-hazards
	emergency preparedness plan that	emergency operations plan (EOP) with supporting	emergency operations plan (EOP) with supporting
	must be reviewed and updated at	policies and procedures that provides guidance to staff	policies and procedures that provides guidance to staff
	least every 2 years. The plan must	and volunteers on actions to take during emergency or	and volunteers on actions to take during emergency or
	do all of the following:	disaster incidents. The EOP and policies and procedures	disaster incidents. The EOP and policies and
		include, but are not limited to, the following:	procedures include, but are not limited to, the
		- Mobilizing incident command	following:
		- Communications plan	- Mobilizing incident command
		- Maintaining, expanding, curtailing, or closing operations	- Communications plan
		- Protecting critical systems and infrastructure	- Maintaining, expanding, curtailing, or closing
		- Conserving and/or supplementing resources	operations
		- Surge plans (such as flu or pandemic plans)	- Protecting critical systems and infrastructure
		- Identifying alternate treatment areas or locations	- Conserving and/or supplementing resources
		- Sheltering in place	- Surge plans (such as flu or pandemic plans)
		- Evacuating (partial or complete) or relocating services	- Identifying alternate treatment areas or locations
		- Safety and security	- Sheltering in place
		- Securing information and records	- Evacuating (partial or complete) or relocating services
			- Safety and security
		EM.17.01.01, EP 3	- Securing information and records
		The critical access hospital reviews and makes necessary	
		updates based on after-action reports or opportunities for	EM.17.01.01, EP 3
		improvement to the following items every two years, or	The critical access hospital reviews and makes
		more frequently if necessary:	necessary updates based on after-action reports or
		- Hazard vulnerability analysis	opportunities for improvement to the following items
		- Emergency management program	every two years, or more frequently if necessary:
		- Emergency operations plan, policies, and procedures	- Hazard vulnerability analysis
		- Communications plan	- Emergency management program
		- Continuity of operations plan	- Emergency operations plan, policies, and procedures
		- Education and training program	- Communications plan
		- Testing program	- 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	EM.11.01.01, EP 1	EM.11.01.01, EP 1
	documented, facility-based and	The critical access hospital conducts a facility-based	The critical access hospital conducts a facility-based
	community-based risk assessment, utilizing an all-	hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following:	hazard vulnerability analysis (HVA) using an all-hazards approach that includes the following:
	hazards approach.	- Hazards that are likely to impact the critical access	- Hazards that are likely to impact the critical access
		hospital's geographic region, community, facility, and patient population	hospital's geographic region, community, facility, and patient population
		- A community-based risk assessment (such as those	- A community-based risk assessment (such as those
		developed by external emergency management agencies) - Separate HVAs for its other accredited facilities if they	developed by external emergency management agencies)
		significantly differ from the main site	- Separate HVAs for its other accredited facilities if they
		The findings are documented.	significantly differ from the main site
		Note: A separate HVA is only required if the accredited	The findings are documented.
		facilities are in different geographic locations, experience	Note: A separate HVA is only required if the accredited
		different hazards or threats, or the patient population and	facilities are in different geographic locations,
		services offered are unique to this facility.	experience different hazards or threats, or the patient population and services offered are unique to this
		EM.11.01.01, EP 2	facility.
		The critical access hospital's hazard vulnerability analysis	
		includes the following:	EM.11.01.01, EP 2
		- Natural hazards (such as flooding, wildfires)	The critical access hospital's hazard vulnerability
		- Human-caused hazards (such as bomb threats or	analysis includes the following:
		cyber/information technology crimes)	- Natural hazards (such as flooding, wildfires)
		- Technological hazards (such as utility or information	- Human-caused hazards (such as bomb threats or
		technology outages)	cyber/information technology crimes)
		- Hazardous materials (such as radiological, nuclear,	- Technological hazards (such as utility or information
		chemical)	technology outages)
		- Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)	- Hazardous materials (such as radiological, nuclear, chemical)
			- Emerging infectious diseases (such as the Ebola, Zika, or SARS-CoV-2 viruses)

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(a)(2)	(2) Include strategies for	EM.11.01.01, EP 3	EM.11.01.01, EP 3
	addressing emergency events identified by the risk assessment.	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	The critical access hospital evaluates and prioritizes the findings of the hazard vulnerability analysis to determine what presents the highest likelihood of
		impacts those hazards will have on the operating status of the critical access hospital and its ability to provide services. The findings are documented.	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 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.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.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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		their duties. EM.13.01.01, EP 4	assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.
		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.	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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(b)(1)(i)	(i) Food, water, medical, and	EM.12.01.01, EP 4	EM.12.01.01, EP 4
	pharmaceutical supplies;	The emergency operations plan includes written	The emergency operations plan includes written
		procedures for how the critical access hospital will	procedures for how the critical access hospital will
		provide essential needs for its staff, volunteers, and	provide essential needs for its staff, volunteers, and
		patients, whether they shelter in place or evacuate, that	patients, whether they shelter in place or evacuate, that
		includes, but is not limited to, the following:	includes, but is not limited to, the following:
		- Food and other nutritional supplies	- Food and other nutritional supplies
		- Medications and related supplies	- Medications and related supplies
		- Medical/surgical supplies	- Medical/surgical supplies
		- Medical oxygen and supplies	- Medical oxygen and supplies
		- Potable or bottled water	- 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	EM.12.02.11, EP 4	EM.12.02.11, EP 4
	health and safety and for the safe	The critical access hospital's plan for managing utilities	The critical access hospital's plan for managing utilities
	and sanitary storage of provisions;	includes alternate sources for maintaining energy to the	includes alternate sources for maintaining energy to the
		following:	following:
		- Temperatures to protect patient health and safety and	- Temperatures to protect patient health and safety and
		for the safe and sanitary storage of provisions	for the safe and sanitary storage of provisions
		- Emergency lighting	- Emergency lighting
		- Fire detection, extinguishing, and alarm systems	- Fire detection, extinguishing, and alarm systems
		- Sewage and waste disposal	- Sewage and waste disposal
		Note: It is important for critical access hospitals to	Note: It is important for critical access hospitals to
		consider alternative means for maintaining temperatures	consider alternative means for maintaining
		at a level that protects the health and safety of all persons	temperatures at a level that protects the health and
		within the facility. For example, when safe temperature	safety of all persons within the facility. For example,
		levels cannot be maintained, the critical access hospital	when safe temperature levels cannot be maintained,
		considers partial or full evacuation or closure.	the critical access hospital considers partial or full
\$405 C25(b)(4)(::\/D)	(D) Engage poulighting.	FM 40 00 44 FD 4	evacuation or closure.
§485.625(b)(1)(ii)(B)	(B) Emergency lighting;	EM.12.02.11, EP 4 The critical access heapital's plan for managing utilities	EM.12.02.11, EP 4 The critical access hospital's plan for managing utilities
		The critical access hospital's plan for managing utilities	
		includes alternate sources for maintaining energy to the	includes alternate sources for maintaining energy to the
		following:	following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Temperatures to protect patient health and safety and	- Temperatures to protect patient health and safety and
		for the safe and sanitary storage of provisions	for the safe and sanitary storage of provisions
		- Emergency lighting	- Emergency lighting
		- Fire detection, extinguishing, and alarm systems	- Fire detection, extinguishing, and alarm systems
		- Sewage and waste disposal	- Sewage and waste disposal
		Note: It is important for critical access hospitals to	Note: It is important for critical access hospitals to
		consider alternative means for maintaining temperatures	consider alternative means for maintaining
		at a level that protects the health and safety of all persons	temperatures at a level that protects the health and
		within the facility. For example, when safe temperature	safety of all persons within the facility. For example,
		levels cannot be maintained, the critical access hospital	when safe temperature levels cannot be maintained,
		considers partial or full evacuation or closure.	the critical access hospital considers partial or full
			evacuation or closure.
§485.625(b)(1)(ii)(C)	(C) Fire detection, extinguishing,	EM.12.02.11, EP 4	EM.12.02.11, EP 4
	and alarm systems; and	The critical access hospital's plan for managing utilities	The critical access hospital's plan for managing utilities
		includes alternate sources for maintaining energy to the	includes alternate sources for maintaining energy to the
		following:	following:
		- Temperatures to protect patient health and safety and	- Temperatures to protect patient health and safety and
		for the safe and sanitary storage of provisions	for the safe and sanitary storage of provisions
		- Emergency lighting	- Emergency lighting
		- Fire detection, extinguishing, and alarm systems	- Fire detection, extinguishing, and alarm systems
		- Sewage and waste disposal	- Sewage and waste disposal
		Note: It is important for critical access hospitals to	Note: It is important for critical access hospitals to
		consider alternative means for maintaining temperatures	consider alternative means for maintaining
		at a level that protects the health and safety of all persons	temperatures at a level that protects the health and
		within the facility. For example, when safe temperature	safety of all persons within the facility. For example,
		levels cannot be maintained, the critical access hospital	when safe temperature levels cannot be maintained,
		considers partial or full evacuation or closure.	the critical access hospital considers partial or full
0.405,005(1.)(4)(")(D)	(5) 6	FM 40 00 44 FD 4	evacuation or closure.
§485.625(b)(1)(ii)(D)	(D) Sewage and waste disposal.	EM.12.02.11, EP 4	EM.12.02.11, EP 4
		The critical access hospital's plan for managing utilities	The critical access hospital's plan for managing utilities
		includes alternate sources for maintaining energy to the	includes alternate sources for maintaining energy to the
		following:	following:
		- Temperatures to protect patient health and safety and	- 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	for the safe and sanitary storage of provisions
		- Emergency lighting	- Emergency lighting
		- Fire detection, extinguishing, and alarm systems	- Fire detection, extinguishing, and alarm systems
		- Sewage and waste disposal	- Sewage and waste disposal
		Note: It is important for critical access hospitals to	Note: It is important for critical access hospitals to
		consider alternative means for maintaining temperatures	consider alternative means for maintaining
		at a level that protects the health and safety of all persons	temperatures at a level that protects the health and
		within the facility. For example, when safe temperature	safety of all persons within the facility. For example,
		levels cannot be maintained, the critical access hospital	when safe temperature levels cannot be maintained,
		considers partial or full evacuation or closure.	the critical access hospital considers partial or full
			evacuation or closure.
§485.625(b)(2)	(2) A system to track the location	EM.12.02.07, EP 2	EM.12.02.07, EP 2
	of on-duty staff and sheltered	The critical access hospital's plan for safety and security	The critical access hospital's plan for safety and
	patients in the CAH's care during	measures includes a system to track the location of its	security measures includes a system to track the
	an emergency. If on-duty staff and	on-duty staff and volunteers and patients when sheltered	location of its on-duty staff and volunteers and patients
	sheltered patients are relocated	in place, relocated, or evacuated. If on-duty staff and	when sheltered in place, relocated, or evacuated. If on-
	during the emergency, the CAH	volunteers and patients are relocated during an	duty staff and volunteers and patients are relocated
	must document the specific name	emergency, the critical access hospital documents the	during an emergency, the critical access hospital
	and location of the receiving	specific name and location of the receiving facility or	documents the specific name and location of the
	facility or other location.	evacuation location.	receiving facility or evacuation location.
		Note: Examples of systems used for tracking purposes	Note: Examples of systems used for tracking purposes
		include the use of established technology or tracking	include the use of established technology or tracking
		systems or taking head counts at defined intervals.	systems or taking head counts at defined intervals.
§485.625(b)(3)	(3) Safe evacuation from the CAH,	EM.12.01.01, EP 3	EM.12.01.01, EP 3
	which includes consideration of	The critical access hospital's emergency operations plan	The critical access hospital's emergency operations
	care and treatment needs of	includes written procedures for when and how it will	plan includes written procedures for when and how it
	evacuees; staff responsibilities;	shelter in place or evacuate (partial or complete) its staff,	will shelter in place or evacuate (partial or complete) its
	transportation; identification of	volunteers, and patients.	staff, volunteers, and patients.
	evacuation location(s); and	Note 1: Shelter-in-place plans may vary by department	Note 1: Shelter-in-place plans may vary by department
	primary and alternate means of	and facility and may vary based on the type of emergency	and facility and may vary based on the type of
	communication with external	or situation.	emergency or situation.
	sources of assistance.	Note 2: Safe evacuation from the critical access hospital	Note 2: Safe evacuation from the critical access
		includes consideration of care, treatment, and service	hospital includes consideration of care, treatment, and

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		needs of evacuees, staff responsibilities, and	service needs of evacuees, staff responsibilities, and
		transportation.	transportation.
§485.625(b)(5)	(5) A system of medical	IM.01.01.03, EP 1	IM.11.01.01, EP 1
	documentation that preserves	The critical access hospital follows a written plan for	The critical access hospital develops and implements
	patient information, protects	managing interruptions to its information processes	policies and procedures regarding medical
	confidentiality of patient	(paper-based, electronic, or a mix of paper-based and	documentation and patient information during
	information, and secures and	electronic).	emergencies and other interruptions to information
	maintains the availability of		management systems, including security and
	records.	IM.01.01.03, EP 2	availability of patient records to support continuity of
		The critical access hospital's plan for managing	Care.
		interruptions to information processes addresses the following:	Note: These policies and procedures are based on the emergency plan, risk assessment, and emergency
		- Scheduled and unscheduled interruptions of electronic	communication plan and are reviewed and updated at
		information systems	least every 2 years.
		- 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.	

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

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	EM.12.01.01, EP 9	EM.12.01.01, EP 7
	waiver declared by the Secretary,	The critical access hospital must develop and implement	The critical access hospital must develop and
	in accordance with section 1135 of	emergency preparedness policies and procedures that	implement emergency preparedness policies and
	the Act, in the provision of care	address the role of the critical access hospital under a	procedures that address the role of the critical access
	and treatment at an alternate care	waiver declared by the Secretary, in accordance with	hospital under a waiver declared by the Secretary, in
	site identified by emergency	section 1135 of the Social Security Act, in the provision of	accordance with section 1135 of the Social Security
	management officials.	care and treatment at an alternate care site identified by	Act, in the provision of care and treatment at an
		emergency management officials.	alternate care site identified by emergency
		Note 1: This element of performance is applicable only to	management officials.
		critical access hospitals that receive Medicare, Medicaid,	Note 1: This element of performance is applicable only
		or Children's Health Insurance Program reimbursement.	to critical access hospitals that receive Medicare,
		Note 2: For more information on 1135 waivers, visit	Medicaid, or Children's Health Insurance Program
		https://www.cms.gov/about-cms/what-we-	reimbursement.
		do/emergency-response/how-can-we-help/waivers-flexibilities and https://www.cms.gov/about-cms/agency-	Note 2: For more information on 1135 waivers, visit https://www.cms.gov/about-cms/what-we-
		information/emergency/downloads/consolidated_medica	do/emergency-response/how-can-we-help/waivers-
		re_ffs_emergency_qsas.pdf.	flexibilities and https://www.cms.gov/about-
		re_ns_emergency_qsas.pui.	cms/agency-
			information/emergency/downloads/consolidated_medi
			care_ffs_emergency_qsas.pdf.
§485.625(c)	(c) Communication plan. The CAH	EM.09.01.01, EP 3	EM.09.01.01, EP 3
	must develop and maintain an	The critical access hospital complies with all applicable	The critical access hospital complies with all applicable
	emergency preparedness	federal, state, and local emergency preparedness laws	federal, state, and local emergency preparedness laws
	communication plan that	and regulations.	and regulations.
	complies with Federal, State, and		
	local laws and must be reviewed	EM.12.01.01, EP 1	EM.12.01.01, EP 1
	and updated at least every 2 years.	The critical access hospital has a written all-hazards	The critical access hospital has a written all-hazards
	The communication plan must	emergency operations plan (EOP) with supporting	emergency operations plan (EOP) with supporting
	include all of the following:	policies and procedures that provides guidance to staff	policies and procedures that provides guidance to staff
		and volunteers on actions to take during emergency or	and volunteers on actions to take during emergency or
		disaster incidents. The EOP and policies and procedures	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:	procedures include, but are not limited to, the
		- Mobilizing incident command	following:
		- Communications plan	- Mobilizing incident command
		- Maintaining, expanding, curtailing, or closing operations	- Communications plan
		- Protecting critical systems and infrastructure	- Maintaining, expanding, curtailing, or closing
		- Conserving and/or supplementing resources	operations
		- Surge plans (such as flu or pandemic plans)	- Protecting critical systems and infrastructure
		- Identifying alternate treatment areas or locations	- Conserving and/or supplementing resources
		- Sheltering in place	- Surge plans (such as flu or pandemic plans)
		- Evacuating (partial or complete) or relocating services	- Identifying alternate treatment areas or locations
		- Safety and security	- Sheltering in place
		- Securing information and records	- Evacuating (partial or complete) or relocating services
			- Safety and security
		EM.17.01.01, EP 3	- Securing information and records
		The critical access hospital reviews and makes necessary	
		updates based on after-action reports or opportunities for	EM.17.01.01, EP 3
		improvement to the following items every two years, or	The critical access hospital reviews and makes
		more frequently if necessary:	necessary updates based on after-action reports or
		- Hazard vulnerability analysis	opportunities for improvement to the following items
		- Emergency management program	every two years, or more frequently if necessary:
		- Emergency operations plan, policies, and procedures	- Hazard vulnerability analysis
		- Communications plan	- Emergency management program
		- Continuity of operations plan	- Emergency operations plan, policies, and procedures
		- Education and training program	- Communications plan
		- Testing program	- 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	EM.12.02.01, EP 1
		The critical access hospital maintains a contact list of	The critical access hospital maintains a contact list of
		individuals and entities that are to be notified in response	individuals and entities that are to be notified in
		to an emergency. The list of contacts includes the	response to an emergency. The list of contacts includes

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

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

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

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

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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	procedures, including prompt	of staff at and away from a fire's point of origin, including	and training in emergency management to all new and
	reporting and extinguishing of	when and how to sound and report fire alarms, how to	existing staff, individuals providing services under
	fires, protection, and where	contain smoke and fire, how to use a fire extinguisher,	arrangement, and volunteers that are consistent with
	necessary, evacuation of patients,	how to assist and relocate patients, how to evacuate to	their roles and responsibilities in an emergency. The
	personnel, and guests, fire	areas of refuge, and how staff will cooperate with	initial education and training include the following:
	prevention, and cooperation with	firefighting authorities. Staff are periodically instructed on	- Activation and deactivation of the emergency
	firefighting and disaster	and kept informed of their duties under the plan,	operations plan
	authorities, to all new and existing	including cooperation with firefighting and disaster	- Communications plan
	staff, individuals providing	authorities. A copy of the plan is readily available with the	- Emergency response policies and procedures
	services under arrangement, and	telephone operator or security.	- Evacuation, shelter-in-place, lockdown, and surge
	volunteers, consistent with their	Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.	procedures
	expected roles.		- Where and how to obtain resources and supplies for
		EM.15.01.01, EP 2	emergencies (such as procedure manuals or
		The critical access hospital provides initial education and	equipment)
		training in emergency management to all new and existing	Documentation is required.
		staff, individuals providing services under arrangement,	
		and volunteers that are consistent with their roles and	PE.03.01.01, EP 4
		responsibilities in an emergency. The initial education and	The critical access hospital has written fire control
		training include the following:	plans that include provisions for prompt reporting of
		- Activation and deactivation of the emergency operations	fires; extinguishing fires; protection of patients, staff,
		plan	and guests; evacuation; and cooperation with
		- Communications plan	firefighting authorities.
		- 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.	
§485.625(d)(1)(ii)	(ii) Provide emergency	EM.15.01.01, EP 3	EM.15.01.01, EP 3
	preparedness training at least	The critical access hospital provides ongoing education	The critical access hospital provides ongoing education
	every 2 years.	and training to all staff, individuals providing services	and training to all staff, individuals providing services
		under arrangement, and volunteers that are consistent	under arrangement, and volunteers that are consistent
		with their roles and responsibilities in an emergency. The	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:	The education and training occur at the following times:
		- At least every two years	- At least every two years
		- When roles or responsibilities change	- When roles or responsibilities change
		- When there are significant revisions to the emergency	- When there are significant revisions to the emergency
		operations plan, policies, and/or procedures	operations plan, policies, and/or procedures
		- When procedural changes are made during an	- When procedural changes are made during an
		emergency or disaster incident requiring just-in-time	emergency or disaster incident requiring just-in-time
		education and training.	education and training.
		Documentation is required.	Documentation is required.
		Note 1: Staff demonstrate knowledge of emergency	Note 1: Staff demonstrate knowledge of emergency
		procedures through participation in drills and exercises,	procedures through participation in drills and exercises,
		as well as post-training tests, participation in instructor-	as well as post-training tests, participation in instructor-
		led feedback (for example, questions and answers), or	led feedback (for example, questions and answers), or
		other methods determined and documented by the	other methods determined and documented by the
		organization.	organization.
		Note 2: Critical access hospitals are not required to	Note 2: Critical access hospitals are not required to
		retrain staff on the entire emergency operations plan but	retrain staff on the entire emergency operations plan
		can choose to provide education and training specific to	but can choose to provide education and training
		the new or revised elements of the emergency	specific to the new or revised elements of the
		management program.	emergency management program.
§485.625(d)(1)(iii)	(iii) Maintain documentation of the	EM.15.01.01, EP 2	EM.15.01.01, EP 2
	training.	The critical access hospital provides initial education and	The critical access hospital provides initial education
		training in emergency management to all new and existing	and training in emergency management to all new and
		staff, individuals providing services under arrangement,	existing staff, individuals providing services under
		and volunteers that are consistent with their roles and	arrangement, and volunteers that are consistent with
		responsibilities in an emergency. The initial education and	their roles and responsibilities in an emergency. The
		training include the following:	initial education and training include the following:
		- Activation and deactivation of the emergency operations	- Activation and deactivation of the emergency
		plan	operations plan
		- Communications plan	- Communications plan
		- Emergency response policies and procedures	- Emergency response policies and procedures
		- Evacuation, shelter-in-place, lockdown, and surge	- Evacuation, shelter-in-place, lockdown, and surge
		procedures	procedures

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

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

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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	12-2, TIA 12-3, TIA 12-4, TIA 12-5,		provisions applicable to ambulatory health care
	and TIA 12-6), Life Safety Code	EC.02.05.07, EP 11	occupancies, regardless of the number of patients
	(NFPA 101 and Tentative Interim	The critical access hospital meets all other emergency	served.
	Amendments TIA 12-1, TIA 12-2,	power system requirements found in NFPA 99-2012	Note 2: The provisions of the Life Safety Code do not
	TIA 12-3, and TIA 12-4), and NFPA	Health Care Facilities Code, NFPA 110-2010 Standard for	apply in a state where the Centers for Medicare & Description (1975)
	110, when a new structure is built	Emergency and Standby Power Systems, and NFPA 101-	Medicaid Services (CMS) finds that a fire and safety
	or when an existing structure or	2012 Life Safety Code requirements.	code imposed by state law adequately protects
	building is renovated.		patients in critical access hospitals.
		EC.02.06.05, EP 1	Note 3: In consideration of a recommendation by the
		When planning for new, altered, or renovated space, the	state survey agency or accrediting organization or at the
		critical access hospital uses one of the following design	discretion of the Secretary for the US Department of
		criteria:	Health & map; Human Services, CMS may waive, for
		- State rules and regulations	periods deemed appropriate, specific provisions of the
		- The most current edition of the Guidelines for Design	Life Safety Code, which would result in unreasonable
		and Construction of Hospitals published by the Facility	hardship upon a critical access hospital, but only if the
		Guidelines Institute	waiver will not adversely affect the health and safety of
		When the above rules, regulations, and guidelines do not	the patients.
		meet specific design needs, use other reputable	Note 4: After consideration of state survey agency
		standards and guidelines that provide equivalent design	findings, CMS may waive specific provisions of the Life
		criteria.	Safety Code that, if rigidly applied, would result in
			unreasonable hardship on the critical access hospital,
		LS.01.01, EP 8	but only if the waiver does not adversely affect the
		The critical access hospital complies with the Life Safety	health and safety of patients.
		Code (NFPA 101-2012 and Tentative Interim Amendments	Note 5: All inspecting activities are documented with
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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 & Description 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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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 ED 9	
		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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
		Chapter 6.	
		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.	EM.12.02.09, EP 1	EM.12.02.09, EP 1
	CAHs that maintain an onsite fuel	The critical access hospital's plan for managing its	The critical access hospital's plan for managing its
	source to power emergency	resources and assets describes in writing how it will	resources and assets describes in writing how it will
	generators must have a plan for how it will keep emergency power	document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets	document, track, monitor, and locate the following resources (on-site and off-site inventories) and assets
	now it will keep emergency power	resources (on-site and on-site inventories) and assets	resources (on-site and on-site inventories) and assets

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		to acquire and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications).	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.	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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
COT REQUIREMENT		- 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
§485.625(f)(3)	(3) Demonstrate that each	EM.09.01.01, EP 2	- Training and testing program EM.09.01.01, EP 2
3.33.323(1)(0)	separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.	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	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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		financial services, security systems,	access hospital will continue to perform its essential
		communications/telecommunications, and building	business functions to deliver essential or critical
		operations to support essential and critical services that	services. Essential business functions to consider
		cannot be deferred during an emergency; these activities	include administrative/vital records, information
		must be performed continuously or resumed quickly	technology, financial services, security systems,
		following a disruption.	communications/telecommunications, and building
			operations to support essential and critical services
		EM.13.01.01, EP 2	that cannot be deferred during an emergency; these
		The critical access hospital's continuity of operations	activities must be performed continuously or resumed
		plan identifies in writing how and where it will continue to	quickly following a disruption.
		provide its essential business functions when the location	
		of the essential or critical service has been compromised	EM.13.01.01, EP 2
		due to an emergency or disaster incident.	The critical access hospital's continuity of operations
		Note: Example of options to consider for providing	plan identifies in writing how and where it will continue
		essential services include use of off-site locations, space	to provide its essential business functions when the
		maintained by another organization, existing facilities or	location of the essential or critical service has been
		space, telework (remote work), or telehealth.	compromised due to an emergency or disaster
			incident.
		EM.13.01.01, EP 3	Note: Example of options to consider for providing
		The critical access hospital has a written order of	essential services include use of off-site locations,
		succession plan that identifies who is authorized to	space maintained by another organization, existing
		assume a particular leadership or management role when	facilities or space, telework (remote work), or
		that person(s) is unable to fulfill their function or perform	telehealth.
		their duties.	FM 40 04 04 FD 0
		FN 40 04 04 FD 4	EM.13.01.01, EP 3
		EM.13.01.01, EP 4	The critical access hospital has a written order of
		The critical access hospital has a written delegation of	succession plan that identifies who is authorized to
		authority plan that provides the individual(s) with the legal authorization to act on behalf of the critical access	assume a particular leadership or management role
			when that person(s) is unable to fulfill their function or
		hospital for specified purposes and to carry out specific duties.	perform their duties.
		Note: Delegations of authority are an essential part of an	EM.13.01.01, EP 4
		,	·
		organization's continuity program and should be	The critical access hospital has a written delegation of

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Coordinated communication plan	- Unified and integrated emergency plan
		- Training and testing program	- Integrated policies and procedures
			- Coordinated communication plan
			- Training and testing program
§485.625(f)(5)	(5) Include integrated policies and	EM.09.01.01, EP 2	EM.09.01.01, EP 2
	procedures that meet the	If the critical access hospital is part of a health care	If the critical access hospital is part of a health care
	requirements set forth in	system that has a unified and integrated emergency	system that has a unified and integrated emergency
	paragraph (b) of this section, a	management program and it chooses to participate in the	management program and it chooses to participate in
	coordinated communication plan	program, the following must be demonstrated within the	the program, the following must be demonstrated
	and training and testing programs	coordinated emergency management program:	within the coordinated emergency management
	that meet the requirements of	- Each separately certified critical access hospital within	program:
	paragraphs (c) and (d) of this	the system actively participates in the development of the	- Each separately certified critical access hospital
	section, respectively.	unified and integrated emergency management program	within the system actively participates in the
		- The program is developed and maintained in a manner	development of the unified and integrated emergency
		that takes into account each separately certified critical	management program
		access hospital's unique circumstances, patient	- The program is developed and maintained in a manner
		population, and services offered	that takes into account each separately certified critical
		- Each separately certified critical access hospital is	access hospital's unique circumstances, patient
		capable of actively using the unified and integrated	population, and services offered
		emergency management program and is in compliance	- Each separately certified critical access hospital is
		with the program	capable of actively using the unified and integrated
		- Documented community-based risk assessment	emergency management program and is in compliance
		utilizing an all-hazards approach	with the program
		- Documented individual, facility-based risk assessment	- Documented community-based risk assessment
		utilizing an all-hazards approach for each separately	utilizing an all-hazards approach
		certified critical access hospital within the health care	- Documented individual, facility-based risk
		system	assessment utilizing an all-hazards approach for each
		- Unified and integrated emergency plan	separately certified critical access hospital within the
		- Integrated policies and procedures	health care system
		- Coordinated communication plan	- Unified and integrated emergency plan
		- Training and testing program	- Integrated policies and procedures
			- Coordinated communication plan
		EM.09.01.01, EP 3	- 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	EM.09.01.01, EP 3
		and regulations.	The critical access hospital complies with all applicable
			federal, state, and local emergency preparedness laws
		EM.12.01.01, EP 1	and regulations.
		The critical access hospital has a written all-hazards	
		emergency operations plan (EOP) with supporting	EM.12.01.01, EP 1
		policies and procedures that provides guidance to staff	The critical access hospital has a written all-hazards
		and volunteers on actions to take during emergency or	emergency operations plan (EOP) with supporting
		disaster incidents. The EOP and policies and procedures	policies and procedures that provides guidance to staff
		include, but are not limited to, the following:	and volunteers on actions to take during emergency or
		- Mobilizing incident command	disaster incidents. The EOP and policies and
		- Communications plan	procedures include, but are not limited to, the
		- Maintaining, expanding, curtailing, or closing operations	following:
		- Protecting critical systems and infrastructure	- Mobilizing incident command
		- Conserving and/or supplementing resources	- Communications plan
		- Surge plans (such as flu or pandemic plans)	- Maintaining, expanding, curtailing, or closing
		- Identifying alternate treatment areas or locations	operations
		- Sheltering in place	- Protecting critical systems and infrastructure
		- Evacuating (partial or complete) or relocating services	- Conserving and/or supplementing resources
		- Safety and security	- Surge plans (such as flu or pandemic plans)
		- Securing information and records	- Identifying alternate treatment areas or locations
			- Sheltering in place
		EM.15.01.01, EP 1	- Evacuating (partial or complete) or relocating services
		The critical access hospital has a written education and	- Safety and security
		training program in emergency management that is based	- Securing information and records
		on the critical access hospital's prioritized risks identified	
		as part of its hazard vulnerability analysis, emergency	EM.15.01.01, EP 1
		operations plan, communications plan, and policies and	The critical access hospital has a written education and
		procedures.	training program in emergency management that is
		Note: If the critical access hospital has developed	based on the critical access hospital's prioritized risks
		multiple hazard vulnerability analyses based on the	identified as part of its hazard vulnerability analysis,
		location of other services offered, the education and	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.	policies and procedures.
			Note: If the critical access hospital has developed
		EM.16.01.01, EP 1	multiple hazard vulnerability analyses based on the
		The critical access hospital describes in writing a plan for	location of other services offered, the education and
		when and how it will conduct annual testing of its	training for those facilities are specific to their needs.
		emergency operations plan (EOP). The planned exercises	
		are based on the following:	EM.16.01.01, EP 1
		- Likely emergencies or disaster scenarios	The critical access hospital describes in writing a plan
		- EOP and policies and procedures	for when and how it will conduct annual testing of its
		- After-action reports (AAR) and improvement plans	emergency operations plan (EOP). The planned
		- Six critical areas (communications, staffing, patient care	exercises are based on the following:
		and clinical support, safety and security, resources and	- Likely emergencies or disaster scenarios
		assets, utilities)	- EOP and policies and procedures
		Note 1: The planned exercises should attempt to stress	- After-action reports (AAR) and improvement plans
		the limits of its emergency response procedures to	- Six critical areas (communications, staffing, patient
		assess how prepared the critical access hospital may be	care and clinical support, safety and security, resources
		if a real event or disaster were to occur based on past	and assets, utilities)
		experiences.	Note 1: The planned exercises should attempt to stress
		Note 2: An AAR is a detailed critical summary or analysis	the limits of its emergency response procedures to
		of an emergency or disaster incident, including both	assess how prepared the critical access hospital may
		planned and unplanned events. The report summarizes	be if a real event or disaster were to occur based on
		what took place during the event, analyzes the actions	past experiences.
		taken by participants, and provides areas needing	Note 2: An AAR is a detailed critical summary or
		improvement.	analysis of an emergency or disaster incident, including
			both planned and unplanned events. The report
		EM.17.01.01, EP 3	summarizes what took place during the event, analyzes
		The critical access hospital reviews and makes necessary	the actions taken by participants, and provides areas
		updates based on after-action reports or opportunities for	needing improvement.
		improvement to the following items every two years, or	
		more frequently if necessary:	EM.17.01.01, EP 3
		- Hazard vulnerability analysis	The critical access hospital reviews and makes
		- Emergency management program	necessary updates based on after-action reports or
		- Emergency operations plan, policies, and procedures	opportunities for improvement to the following items

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Communications plan	every two years, or more frequently if necessary:
		- Continuity of operations plan	- Hazard vulnerability analysis
		- Education and training program	- Emergency management program
		- Testing 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_r		
	egister/code_of_federal_regulation		
	s/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 & Description 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
\$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.	would result in unreasonable hardship for the critical access hospital, the Centers for Medicare & Dedicare &
			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	EC.01.01.01, EP 12	PE.04.01.01, EP 1
	March 7, 2013.	The critical access hospital complies with the 2012	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	provisions and proceeds in accordance with the Health
		Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
		5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
		Facilities Code do not apply.	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 & Decision 1.
			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
0.405,005(,)(4)(,)	() TIA 40 T : AUT DA 00 :		the activity; and results of the activity.
§485.625(g)(1)(v)	(v) TIA 12-5 to NFPA 99, issued	EC.01.01, EP 12	PE.04.01.01, EP 1
	August 1, 2013.	The critical access hospital complies with the 2012	The critical access hospital meets the applicable
		edition of NFPA 99: Health Care Facilities Code, including	provisions and proceeds in accordance with the Health
		Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
		5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6).
		Facilities Code do not apply.	·
			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 & Camp;
			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
			Note of All mapeding 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	EC.01.01.01, EP 12	PE.04.01.01, EP 1
	March 3, 2014.	The critical access hospital complies with the 2012	The critical access hospital meets the applicable
		edition of NFPA 99: Health Care Facilities Code, including	provisions and proceeds in accordance with the Health
		Tentative Interim Amendments (TIA) 12-2, 12-3, 12-4, 12-	Care Facilities Code (NFPA 99-2012 and Tentative
		5, and 12-6. Chapters 7, 8, 12, and 13 of the Health Care	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
		Facilities Code do not apply.	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 & Decided access hospital ac
			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,	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	2012 edition, issued August 11,	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
	2011.	Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Description (1988)
			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 & map; 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	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	August 11, 2011.	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
		Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Description (1975)
			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 & mp; 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
0.405.005(.)(1)(1)	(1) 714 40 0 1 1157 1151 1	1.0.4.4.4.5.5	the activity; and results of the activity.
§485.625(g)(1)(ix)	(ix) TIA 12-2 to NFPA 101, issued	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	October 30, 2012.	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
		Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Description (1988)
			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 & map; 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	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	October 22, 2013.	The critical access hospital complies with the Life Safety	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	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Centers for Medicare & Description apply in a state where the Center in the Cen
			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 & mp; 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.
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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.625(g)(1)(xi)	(xi) TIA 12-4 to NFPA 101, issued	LS.01.01.01, EP 8	PE.03.01.01, EP 3
	October 22, 2013.	The critical access hospital complies with the Life Safety	The critical access hospital meets the applicable
		Code (NFPA 101-2012 and Tentative Interim Amendments	provisions of the Life Safety Code (NFPA 101-2012 and
		[TIA] 12-1, 12-2, 12-3, and 12-4).	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 & Description (1975)
			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 & Dervices, 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	EC.02.05.07, EP 11	PE.04.01.03, EP 3
	Emergency and Standby Power	The critical access hospital meets all other emergency	The critical access hospital meets the emergency
	Systems, 2010 edition, including	power system requirements found in NFPA 99-2012	power system and generator requirements found in
	TIAs to chapter 7, issued August 6,	Health Care Facilities Code, NFPA 110-2010 Standard for	NFPA 99-2012 Health Care Facilities Code, NFPA 110-
	2009.	Emergency and Standby Power Systems, and NFPA 101-	2010 Standard for Emergency and Standby Power
		2012 Life Safety Code requirements.	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	LD.01.03.01, EP 1	LD.11.01.01, EP 1
	Body or Responsible Individual	The governing body defines in writing its responsibilities.	The critical access hospital has a governing body or an
	The CAH has a governing body or		individual that assumes full legal responsibility for
	an individual that assumes full	LD.01.03.01, EP 5	determining, implementing, and monitoring policies
	legal responsibility for	The governing body provides for the resources needed to	governing the critical access hospital's total operation
	determining, implementing and	maintain safe, quality care, treatment, and services.	and for administering those policies to provide quality
	monitoring policies governing the	LD 04 03 04 FD 0	health care in a safe environment.
	CAH's total operation and for ensuring that those policies are	LD.01.03.01, EP 6 The governing body works with the senior managers and	
	administered so as to provide	leaders of the organized medical staff to annually	
	quality health care in a safe	evaluate the critical access hospital's performance in	
	environment.	relation to its mission, vision, and goals.	
	onvironment.	Totation to ite inicolon, violen, and godie.	
		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	

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.	
		eversor 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	LD.04.02.03, EP 23	LD.13.02.01, EP 1
	responsible for the operation of	The critical access hospital discloses the names and	The critical access hospital discloses the names and
	the CAH; and	addresses of the following:	addresses of the following:
		- The person principally responsible for the operation of	- Person principally responsible for the operation of the
		the critical access hospital - The person responsible for medical direction of the	critical access hospital - Person responsible for medical direction of the critical
		critical access hospital	access hospital
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CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- 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	HR.01.02.05, EP 7	NPG.12.01.01, EP 4
	osteopathy, nurse practitioner,	A doctor of medicine or osteopathy, physician's assistant,	A doctor of medicine or osteopathy, physician's
	clinical nurse specialist, or	nurse practitioner, or clinical nurse specialist is available	assistant, nurse practitioner, or clinical nurse specialist
	physician assistant is available to	to provide patient care when the critical access hospital	is available to provide patient care at all times when the
	furnish patient care services at all	is in operation.	critical access hospital is in operation.
	times the CAH operates.		
§485.631(a)(5)	(5) A registered nurse, clinical	HR.01.02.05, EP 14	NPG.12.02.01, EP 3
	nurse specialist, or licensed	A registered nurse, clinical nurse specialist, or licensed	A registered nurse, clinical nurse specialist, or licensed
	practical nurse is on duty	practical nurse is on duty whenever the critical access	practical nurse is on duty whenever the critical access
	whenever the CAH has one or	hospital has one or more patients.	hospital has one or more inpatients.
	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		
0.00 00.00	osteopathy		112 12 12 12 12
§485.631(b)(1)(i)	(i) Provides medical direction for	MS.03.01.03, EP 7	MS.16.01.03, EP 6
	the CAH'S health care activities	The doctor of medicine or osteopathy provides medical	The doctor of medicine or osteopathy provides medical
	and consultation for, and medical	direction for the critical access hospital's health care	direction for the critical access hospital's health care

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	supervision of, the health care	activities and consultation for, and medical staff	activities and consultation for, and medical staff
	staff;	supervision of, the health care staff.	supervision of, the health care staff.
§485.631(b)(1)(ii)	(ii) In conjunction with the	LD.04.01.07, EP 4	LD.13.01.09, EP 2
	physician assistant and/or nurse	The doctor of medicine or osteopathy, in conjunction with	The doctor of medicine or osteopathy, in conjunction
	practitioner member(s),	the physician assistant, nurse practitioner, or clinical	with the physician assistant, nurse practitioner, or
	participates in developing,	nurse specialist, participates in developing, executing,	clinical nurse specialist, participates in developing,
	executing, and periodically	and periodically reviewing the critical access hospital's	executing, and periodically reviewing the critical access
	reviewing the CAH'S written	written policies governing the services furnished.	hospital's written policies governing the services
	policies governing the services it		provided.
	furnishes.		
§485.631(b)(1)(iii)	(iii) In conjunction with the	MS.03.01.03, EP 8	MS.16.01.03, EP 8
	physician assistant and/or nurse	The doctor of medicine or osteopathy, in conjunction with	The doctor of medicine or osteopathy, in conjunction
	practitioner members, periodically	the physician assistant and/or nurse practitioner	with the physician assistant and/or nurse practitioner
	reviews the CAH'S patient records,	members, periodically reviews the critical access	members of the critical access hospital staff, provides
	provides medical orders, and	hospital's patient records, provides medical orders, and	medical orders and medical care services to the critical
	provides medical care services to	provides medical care services to the patients of the	access hospital's patients.
	the patients of the CAH; and	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(b)(1)(iv)	(iv) Periodically reviews and signs	MS.03.01.03, EP 9	MS.16.01.03, EP 11
(3)(7)(7)	the records of all inpatients cared	The doctor of medicine or osteopathy periodically reviews	The doctor of medicine or osteopathy periodically
	for by nurse practitioners, clinical	and signs the records of all inpatients cared for by nurse	reviews and signs the records of all inpatients cared for
	nurse specialists, certified nurse	practitioners, clinical nurse specialists, certified nurse	by nurse practitioners, clinical nurse specialists,
	midwives, or physician assistants.	midwives, or physician assistants.	certified nurse midwives, or physician assistants.
§485.631(b)(1)(v)	(v) Periodically reviews and signs a	MS.03.01.03, EP 11	MS.16.01.03, EP 12
	sample of outpatient records of	When state law requires outpatient record reviews, or co-	The doctor of medicine or osteopathy periodically
	patients cared for by nurse	signatures, or both, by a collaborating physician, a doctor	reviews and signs a sample of outpatient records of
	practitioners, clinical nurse	of medicine or osteopathy periodically reviews and signs	patients cared for by nurse practitioners, clinical nurse
	specialists, certified nurse	a sample of outpatient records of patients cared for by	specialists, certified nurse midwives, or physician

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	midwives, or physician assistants	nurse practitioners, clinical nurse specialists, certified	assistants.
	only to the extent required under	nurse midwives, or physician assistants.	Note: Outpatient records are reviewed to the extent
	State law where State law requires	Note: When state law requires review of such outpatient	required by state law where state law requires
	record reviews or co-signatures, or	records, the critical access hospital determines by policy	outpatient record reviews, cosignatures, or both by a
	both, by a collaborating physician.	the size of the sample reviewed and signed.	collaborating physician.
§485.631(b)(2)	(2) A doctor of medicine or	MS.03.01.03, EP 10	MS.16.01.03, EP 13
	osteopathy is present for sufficient	A doctor of medicine or osteopathy is present for	A doctor of medicine or osteopathy is present for
	periods of time to provide medical	sufficient periods of time to provide medical direction,	sufficient periods of time to provide medical direction,
	direction, consultation, and	consultation, and supervision for the services provided in	consultation, and supervision for the services provided
	supervision for the services	the critical access hospital, and is available through	in the critical access hospital, and is available through
	provided in the CAH, and is	direct radio, telephone, or electronic communication for	direct radio, telephone, or electronic communication
	available through direct radio or	consultation, assistance with medical emergencies, or	for consultation, assistance with medical emergencies,
	telephone communication or	patient referral.	or patient referral.
	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		
0.405,0044,04040	staff		
§485.631(c)(1)(i)	(i) Participate in the development,	LD.04.01.07, EP 4	LD.13.01.09, EP 2
	execution and periodic review of	The doctor of medicine or osteopathy, in conjunction with	The doctor of medicine or osteopathy, in conjunction
	the written policies governing the	the physician assistant, nurse practitioner, or clinical	with the physician assistant, nurse practitioner, or
	services the CAH furnishes; and	nurse specialist, participates in developing, executing,	clinical nurse specialist, participates in developing,
		and periodically reviewing the critical access hospital's	executing, and periodically reviewing the critical access
		written policies governing the services furnished.	hospital's written policies governing the services
			provided.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.631(c)(1)(ii)	(ii) Participate with a doctor of	MS.03.01.03, EP 8	MS.16.01.03, EP 10
	medicine or osteopathy in a	The doctor of medicine or osteopathy, in conjunction with	The doctor of medicine or osteopathy, in conjunction
	periodic review of the patients'	the physician assistant and/or nurse practitioner	with the physician assistant, the nurse practitioner,
	health records.	members, periodically reviews the critical access	and/or clinical nurse specialist members of the critical
		hospital's patient records, provides medical orders, and	access hospital staff, periodically review the patients'
		provides medical care services to the patients of the	records.
		critical access hospital.	
§485.631(c)(2)	(2) The physician assistant, nurse	LD.04.01.07, EP 4	
	practitioner, or clinical nurse	The doctor of medicine or osteopathy, in conjunction with	
	specialist performs the following	the physician assistant, nurse practitioner, or clinical	
	functions to the extent they are not	nurse specialist, participates in developing, executing,	
	being performed by a doctor of	and periodically reviewing the critical access hospital's	
	medicine or osteopathy:	written policies governing the services furnished.	
§485.631(c)(2)(i)	(i) Provides services in accordance	LD.04.01.07, EP 1	MS.16.01.03, EP 9
	with the CAH'S policies.	Leaders review, approve, and manage the	If not being performed by a doctor of medicine or
		implementation of policies and procedures that guide	osteopathy, the physician assistant, nurse practitioner,
		and support patient care, treatment, and services.	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
\$40F C24(a)(2)(ii)	(ii) A was not a few as water a nation to	DC 04 04 02 FD 0	are referred
§485.631(c)(2)(ii)	(ii) Arranges for, or refers patients	PC.04.01.03, EP 2	MS.16.01.03, EP 9
	to, needed services that cannot be	The critical access hospital identifies any needs the	If not being performed by a doctor of medicine or
	furnished at the CAH, and assures	patient may have for psychosocial or physical care,	osteopathy, the physician assistant, nurse practitioner,
	that adequate patient health records are maintained and	treatment, and services after discharge or transfer.	or clinical nurse specialist performs the following functions:
	transferred as required when	PC.04.01.03, EP 4	- Provides services in accordance with the critical
	patients are referred.	Prior to discharge, the critical access hospital arranges or	access hospital's policies
	patients are referred.	assists in arranging the services required by the patient	- Arranges for, or refers patients to, needed services that
			-
		after discharge in order to meet the patient's ongoing	cannot be furnished at the critical access hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		needs for care and services.	- Maintains and transfers patient records when patients
			are referred
		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.	
		patient with nood.	
		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.	
		DC 04 02 01 ED 1	
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	
0.405.0047.1/01	(0)))	- Comprehensive care plan goals	NO 40 04 00
§485.631(c)(3)	(3) Whenever a patient is admitted	LD.04.01.07, EP 5	MS.16.01.03, EP 7
	to the CAH by a nurse practitioner,	Whenever a patient is admitted to the critical access	Whenever a patient is admitted to the critical access
	physician assistant, or clinical	hospital by a nurse practitioner, physician assistant, or	hospital by a nurse practitioner, physician assistant, or
	nurse specialist, a doctor of	clinical nurse specialist, a doctor of medicine or	clinical nurse specialist, a doctor of medicine or
	medicine or osteopathy on the staff of the CAH is notified of the	osteopathy on the staff is notified of the admission.	osteopathy on the staff is notified of the admission.
	admission.		
§485.631(d)	(d) Standard: Periodic review of		
3403.031(u)	clinical privileges and		
	performance. The CAH requires		
	that—		
§485.631(d)(1)	(1) The quality and	MS.05.01.01, EP 12	MS.17.01.03, EP 8
()()	appropriateness of the diagnosis	The quality and appropriateness of the diagnosis and	The quality and appropriateness of the diagnosis and
	and treatment furnished by nurse	treatment furnished by nurse practitioners, clinical nurse	treatment provided by nurse practitioners, clinical
	practitioners, clinical nurse	specialists, and physician assistants are evaluated by a	nurse specialists, and physician assistants are
	specialist, and physician	member of the organization staff who is a doctor of	evaluated by a member of the critical access hospital's
	assistants at the CAH are	medicine or osteopathy or by another doctor of medicine	medical staff who is a doctor of medicine or osteopathy
	evaluated by a member of the CAH	or osteopathy under contract with the organization.	or by another doctor of medicine or osteopathy under
	staff who is a doctor of medicine		contract with the organization.
	or osteopathy or by another doctor		
	of medicine or osteopathy under		
	contract with the CAH.		
§485.631(d)(2)	(2) The quality and		
	appropriateness of the diagnosis		
	and treatment furnished by		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	doctors of medicine or osteopathy		
	at the CAH are evaluated by—		
§485.631(d)(2)(i)	(i) One hospital that is a member	MS.05.01.01, EP 13	MS.17.01.03, EP 9
	of the network, when applicable;	The quality and appropriateness of the diagnosis and	The quality and appropriateness of the diagnosis and
		treatment furnished by doctors of medicine or osteopathy	treatment provided by doctors of medicine or
		at the critical access hospital are evaluated by one of the	osteopathy at the critical access hospital are evaluated
		following:	by one of the following:
		- A hospital that is a member of the network, when applicable	- A hospital that is a member of the network, when applicable
		- A Quality Improvement Organization (QIO) or equivalent	- A quality improvement organization or equivalent
		entity Another appropriate and qualified antituid antified in the	entity Another conversions and sublified entity identified in
		- Another appropriate and qualified entity identified in the state's rural health care plan	- Another appropriate and qualified entity identified in the state's rural health care plan
		State Siturat neattificare 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	MS.05.01.01, EP 13	MS.17.01.03, EP 9
	Organization (QIO) or equivalent	The quality and appropriateness of the diagnosis and	The quality and appropriateness of the diagnosis and
	entity;	treatment furnished by doctors of medicine or osteopathy	treatment provided by doctors of medicine or
		at the critical access hospital are evaluated by one of the	osteopathy at the critical access hospital are evaluated
		following:	by one of the following:
		- A hospital that is a member of the network, when	- A hospital that is a member of the network, when
		applicable	applicable
		- A Quality Improvement Organization (QIO) or equivalent	- A quality improvement organization or equivalent
		entity	entity
		- Another appropriate and qualified entity identified in the	- Another appropriate and qualified entity identified in
		state's rural health care plan	the state's rural health care plan

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	agreement between the CAH and a	Note 1: When the critical access hospital contracts with	by one of the following:
	distant-site hospital, the distant-	another accredited organization for patient care,	- A hospital that is a member of the network, when
	site hospital; or	treatment, and services to be provided off site, it can do	applicable
		the following:	- A quality improvement organization or equivalent
		- Verify that all physicians and other licensed	entity
		practitioners who will be providing patient care,	- Another appropriate and qualified entity identified in
		treatment, and services have appropriate privileges by	the state's rural health care plan
		obtaining, for example, a copy of the list of privileges.	Note: In the case of distant-site physicians and
		- Specify in the written agreement that the contracted	practitioners providing telemedicine services to the
		organization will ensure that all contracted services	critical access hospital's patients under an agreement
		provided by physicians and other licensed practitioners	between the critical access hospital and a distant
		will be within the scope of their privileges.	hospital or between the critical access hospital and a
		Note 2: The leaders who monitor the contracted services	distant-site telemedicine entity, the quality and
		are the governing body.	appropriateness of the diagnosis and treatment
			provided is evaluated by one of the entities listed in this
		MS.13.01.01, EP 1	element of performance.
		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	
		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.	
		301 V1003.	

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	

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	
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	services.	
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		- 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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.631(d)(2)(v)	(v) In the case of distant-site	LD.04.03.09, EP 4	MS.17.01.03, EP 9
	physicians and practitioners	Leaders monitor contracted services by establishing	The quality and appropriateness of the diagnosis and
	providing telemedicine services to	expectations for the performance of the contracted	treatment provided by doctors of medicine or
	the CAH's patients under a written	services.	osteopathy at the critical access hospital are evaluated
	agreement between the CAH and a	·	by one of the following:
	distant-site telemedicine entity,	another accredited organization for patient care,	- A hospital that is a member of the network, when
	one of the entities listed in	treatment, and services to be provided off site, it can do	applicable
	paragraphs (d)(2)(i) through (iii) of	the following:	- A quality improvement organization or equivalent
	this section.	- Verify that all physicians and other licensed	entity
		practitioners who will be providing patient care,	- Another appropriate and qualified entity identified in
		treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.	the state's rural health care plan Note: In the case of distant-site physicians and
		- Specify in the written agreement that the contracted	practitioners providing telemedicine services to the
		organization will ensure that all contracted services	critical access hospital's patients under an agreement
		provided by physicians and other licensed practitioners	between the critical access hospital and a distant
		will be within the scope of their privileges.	hospital or between the critical access hospital and a
		Note 2: The leaders who monitor the contracted services	distant-site telemedicine entity, the quality and
		are the governing body.	appropriateness of the diagnosis and treatment
			provided is evaluated by one of the entities listed in this
		MS.05.01.01, EP 13	element of performance.
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	
		uistant site made its decision using the process	

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.)	
§485.631(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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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 reprivileging 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:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	which include a process for the		- Process for self-governance, appointment,
	members of the medical staff of	MS.01.01.01, EP 26	credentialing, privileging, and oversight, as well as its
	each separately certified CAH	The medical staff bylaws include the following	peer review policies and due process rights guarantees
	(that is, all medical staff members	requirements: The process for credentialing and re-	- Description of the process by which medical staff
	who hold specific privileges to	credentialing physicians and other licensed practitioners.	members at each separately accredited hospital (that
	practice at that CAH) to be advised		is, all medical staff members who hold privileges to
	of their rights to opt out of the	MS.01.01.01, EP 27	practice at that specific hospital) are advised of their
	unified and integrated medical	The medical staff bylaws include the following	right to opt out of the unified and integrated medical
	staff structure after a majority vote	requirements: The process for appointment and re-	staff structure after a majority vote by the members to
	by the members to maintain a	appointment to membership on the medical staff.	maintain a separate and distinct medical staff for their
	separate and distinct medical staff	NO 04 04 04 FD 04	respective critical access hospital
	for their CAH;	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 scrieduting hearings and appeals - The process for conducting hearings and appeals	
		- The process for conducting hearings and appears	
		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.	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	LD.04.01.01, EP 2	LD.13.01.09, EP 1
	are furnished in accordance with	The critical access hospital provides care, treatment, and	The critical access hospital develops and implements
	appropriate written policies that	services in accordance with licensure requirements, laws	written policies and procedures that guide health care
	are consistent with applicable	(including state law), and rules and regulations.	services. The policies and procedures are consistent
	State law.		with state law and include the following:
		LD.04.01.07, EP 1	- Description of the services furnished by the critical
		Leaders review, approve, and manage the	access hospital, including those provided through
		implementation of policies and procedures that guide	agreement or arrangement
		and support patient care, treatment, and services.	- 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	LD.04.01.07, EP 6	LD.13.01.09, EP 3
3 - 00.000(a)(2)	the advice of members of the	Health care service policies are developed with the	The critical access hospital develops health care
	CAH's professional healthcare	advice of members of the critical access hospital's	service policies and procedures with the advice of
	staff, including one or more	professional health care staff, including one or more	members of its professional health care staff, including
	stan, motating one of more	professional meathr care starr, metaling one of more	mombors of its professional health care stall, including

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
\$405.025(-)(0)	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		implementation of policies and procedures that guide	written policies and procedures that guide health care
		and support patient care, treatment, and services.	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	LD.04.01.07, EP 1	LD.13.01.09, EP 1
	management of health problems	Leaders review, approve, and manage the	The critical access hospital develops and implements
	that include the conditions	implementation of policies and procedures that guide	written policies and procedures that guide health care
	requiring medical consultation	and support patient care, treatment, and services.	services. The policies and procedures are consistent
	and/or patient referral, the		with state law and include the following:
	maintenance of health care	MS.03.01.03, EP 4	- Description of the services furnished by the critical
	records, and procedures for the	The organized medical staff, through its designated	access hospital, including those provided through
	periodic review and evaluation of	mechanism, determines the circumstances under which	agreement or arrangement
	the services furnished by the CAH.	consultation or management by a doctor of medicine or	- Emergency medical services
		osteopathy, or other licensed practitioner, is required.	- Guidelines for the medical management of health
			problems that include the conditions requiring medical
		PC.01.01.01, EP 2	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	health care records, and procedures for the periodic
		accepting a patient that addresses the following:	review and evaluation of the services provided by the
		- Criteria to determine the patient's eligibility for care,	critical access hospital
		treatment, and services	- Rules for the storage, handling, dispensation, and
		- Procedures for accepting referrals	administration of drugs and biologicals
		Note: For rehabilitation distinct part units in critical	- Guidelines for addressing post–acute care needs of
		access hospitals: A rehabilitation physician reviews and	the patients receiving critical access hospital services
		approves the patient's preadmission screening prior to	Note: If patients are transferred or discharged to a
		the patient's admission to the unit.	provider for which there is no agreement or
		DO 04 04 04 FD 4	arrangement, the critical access hospital verifies that
		RC.01.01, EP 1	the patient has been accepted and treated.
		The critical access hospital defines the components of a	
849E 62E(a)(2)(iv)	(iv) Rules for the storage, handling,	complete medical record. LD.03.06.01, EP 2	LD.13.01.09, EP 1
§485.635(a)(3)(iv)	dispensation, and administration	Leaders provide for a sufficient number and mix of	The critical access hospital develops and implements
	of drugs and biologicals. These	individuals to support safe, quality care, treatment, and	written policies and procedures that guide health care
	rules must provide that there is a	services.	services. The policies and procedures that guide health care
	drug storage area that is	Note: The number and mix of individuals is appropriate to	with state law and include the following:
	administered in accordance with	the scope and complexity of the services offered.	- Description of the services furnished by the critical
	accepted professional principles,	the doops and somptoxity of the services energy.	access hospital, including those provided through
	that current and accurate records	LD.03.06.01, EP 3	agreement or arrangement
	are kept of the receipt and	Those who work in the critical access hospital are	- Emergency medical services
	disposition of all scheduled drugs,	competent to complete their assigned responsibilities.	- Guidelines for the medical management of health
	and that outdated, mislabeled, or	Competent to compete to their disorgeness responsibilities	problems that include the conditions requiring medical
	otherwise unusable drugs are not	LD.04.01.05, EP 1	consultation and/or patient referral, the maintenance of
	available for patient use.	Leaders of the program, service, site, or department	health care records, and procedures for the periodic
	·	oversee operations.	review and evaluation of the services provided by the
		·	critical access hospital
		LD.04.01.07, EP 1	- Rules for the storage, handling, dispensation, and
		Leaders review, approve, and manage the	administration of drugs and biologicals
		implementation of policies and procedures that guide	- Guidelines for addressing post–acute care needs of
		and support patient care, treatment, and services.	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	provider for which there is no agreement or
		The critical access hospital identifies, in writing, its high-	arrangement, the critical access hospital verifies that
		alert and hazardous medications. *	the patient has been accepted and treated.
		Note: This element of performance is also applicable to	
		sample medications.	MM.13.01.01, EP 1
		Footnote *: For a list of high-alert medications, see	The critical access hospital maintains current and
		https://www.ismp.org/recommendations. For a list of	accurate records of the receipt and disposition of all
		hazardous drugs, see	scheduled drugs.
		https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-	
		161.pdf.	MM.13.01.01, EP 4
			The critical access hospital removes all expired,
		MM.01.01.03, EP 2	damaged, mislabeled, contaminated, or otherwise
		The critical access hospital follows a process for	unusable medications and stores them separately from
		managing high-alert and hazardous medications.	medications available for patient use.
		Note: This element of performance is also applicable to	Note: This element of performance is also applicable to
		sample medications.	sample medications.
		MM.03.01.01, EP 2	MM.15.01.03, EP 1
		The critical access hospital stores medications according	Medication containers are labeled whenever
		to the manufacturers' recommendations or, in the	medications are prepared but not immediately
		absence of such recommendations, according to a	administered.
		pharmacist's instructions.	Note 1: An immediately administered medication is one
		Note: This element of performance is also applicable to	that an authorized staff member prepares or obtains,
		sample medications.	takes directly to a patient, and administers to that
			patient without any break in the process.
		MM.03.01.01, EP 3	Note 2: This element of performance is also applicable
		The critical access hospital stores all medications and	to sample medications.
		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	

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 00 04 04 FD 0	
		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.	
		products continued to the continued to t	
		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 04 07 5D 0	
		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.	
		access nospital policies.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	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.
		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	

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 04 00 57 0	
		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.	
		DI 04 04 04 ED 42	
		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	LD.04.01.07, EP 1	PC.12.01.01, EP 1
	the nutritional needs of inpatients	Leaders review, approve, and manage the	Prior to providing care, treatment, and services, the
	are met in accordance with	implementation of policies and procedures that guide	critical access hospital obtains or renews orders (verbal
	recognized dietary practices. All	and support patient care, treatment, and services.	or written) from a physician or other licensed
	patient diets, including		practitioner in accordance with professional standards
	therapeutic diets, must be ordered	PC.02.01.03, EP 1	of practice; law and regulation; critical access hospital
	by the practitioner responsible for	Prior to providing care, treatment, and services, the	policies; and medical staff bylaws, rules, and
	the care of the patients or by a	critical access hospital obtains or renews orders (verbal	regulations.
	qualified dietitian or qualified	or written) from a physician or other licensed practitioner	Note 1: This includes but is not limited to respiratory

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	nutrition professional as	in accordance with professional standards of practice;	services, radiology services, rehabilitation services,
	authorized by the medical staff in	law and regulation; critical access hospital policies; and	nuclear medicine services, and dietetic services, if
	accordance with State law	medical staff bylaws, rules, and regulations.	provided.
	governing dietitians and nutrition	Note 1: For rehabilitation and psychiatric distinct part	Note 2: Patient diets, including therapeutic diets, are
	professionals and that the	units in critical access hospitals: Outpatient services may	ordered by the physician or other licensed practitioner
	requirement of § 483.25(i) of this	be ordered by a physician or other licensed practitioner	responsible for the patient's care or by a qualified
	chapter is met with respect to	not appointed to the medical staff as long as the	dietitian or qualified nutrition professional who is
	inpatients receiving post CAH SNF	practitioner meets the following:	authorized by the medical staff and acting in
	care.	- Responsible for the care of the patient	accordance with state law governing dietitians and
		- Licensed to practice in the state where the practitioner	nutrition professionals. The requirement of 42 CFR
		provides care to the patient or in accordance with	483.25(i) is met for inpatients receiving care at a skilled
		Veterans Administration and Department of Defense	nursing facility subsequent to critical access hospital
		licensure requirements	care.
		- Acting within the practitioner's scope of practice under	
		state law	PC.12.01.09, EP 1
		- Authorized in accordance with state law and policies	The nutritional needs of the individual patient are met in
		adopted by the medical staff and approved by the	accordance with clinical practice guidelines and
		governing body to order the applicable outpatient	recognized dietary practices.
		services	Note 1: Diet menus meet the needs of the patients.
		Note 2: Patient diets, including therapeutic diets, are	Note 2: For swing beds in critical access hospitals: The
		ordered by the physician or other licensed practitioner	critical access hospital meets the assisted nutrition
		responsible for the patient's care, or by a qualified	and hydration requirement at 42 CFR 483.25(g) with
		dietitian or qualified nutrition professional who is	respect to inpatients receiving posthospital skilled
		authorized by the medical staff and acting in accordance	nursing facility care.
		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.02.03, EP 6	
		The critical access hospital prepares food and nutrition	
		products using proper sanitation, temperature, light,	
		moisture, ventilation, and security.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
\$485.635(a)(3)(vii)	(viii) Policies and procedures that address the post-acute care needs of patients receiving CAH services.	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. 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	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.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.
	conditions.	LD.04.03.01, EP 4 Emergency services are provided on site and are available	

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.	
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		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.	
		Tor a variety of modifications.	
		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	LD.04.03.01, EP 27	LD.13.03.01, EP 3
	care inpatient services.	The critical access hospital provides acute care inpatient	The critical access hospital provides acute care
	·	services.	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	LD.04.01.01, EP 1	LD.13.03.01, EP 12
	by stick or tablet method or both	The critical access hospital is licensed, is certified, or has	The critical access hospital provides the following basic
	(including urine ketones).	a permit, in accordance with law and regulation, to	laboratory services essential to the immediate
		provide the care, treatment, or services for which the	diagnosis and treatment of the patient:
		critical access hospital is seeking accreditation from The	- Chemical examination of urine by the stick method,
		Joint Commission.	the tablet method, or both (including urine ketones)
		Note 1: Each service location that performs laboratory	- Hemoglobin or hematocrit tests
		testing (waived or nonwaived) must have a Clinical	- Blood glucose tests
		Laboratory Improvement Amendments of 1988 (CLIA '88)	- Examination of stool specimens for occult blood
		certificate as specified by the federal CLIA regulations (42	- Pregnancy tests
		CFR 493.55 and 493.3) and applicable state law.	- Primary culturing for transmittal to a certified
		Note 2: For more information on how to obtain a CLIA	laboratory
		certificate, see http://www.cms.gov/Regulations-and-	Note 1: The laboratory meets the standards imposed
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_C	under section 353 of the Public Health Service Act (42
		ertificate_International_Laboratories.html.	U.S.C. 263a). (Refer to the laboratory requirements

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			specified in 42 CFR 493)
		LD.04.03.01, EP 9	Note 2: For rehabilitation and psychiatric distinct part
		The critical access hospital provides the following basic	units in critical access hospitals: The critical access
		laboratory services essential to the immediate diagnosis	hospital has laboratory services available, either
		and treatment of the patient:	directly or through a contractual agreement with a
		- The chemical examination of urine by the stick method,	Clinical Laboratory Improvement Amendments (CLIA)–
		the tablet method, or both	certified laboratory that meets the requirements of 42
		- Hemoglobin or hematocrit tests	CFR 493.
		- Blood glucose tests	
		- Examination of stool specimens for occult blood	
		- Pregnancy tests	
		- Primary culturing for transmittal to a certified laboratory	
§485.635(b)(2)(ii)	(ii) Hemoglobin or hematocrit.	LD.04.01.01, EP 1	LD.13.03.01, EP 12
		The critical access hospital is licensed, is certified, or has	The critical access hospital provides the following basic
		a permit, in accordance with law and regulation, to	laboratory services essential to the immediate
		provide the care, treatment, or services for which the	diagnosis and treatment of the patient:
		critical access hospital is seeking accreditation from The	- Chemical examination of urine by the stick method,
		Joint Commission.	the tablet method, or both (including urine ketones)
		Note 1: Each service location that performs laboratory	- Hemoglobin or hematocrit tests
		testing (waived or nonwaived) must have a Clinical	- Blood glucose tests
		Laboratory Improvement Amendments of 1988 (CLIA '88)	- Examination of stool specimens for occult blood
		certificate as specified by the federal CLIA regulations (42	- Pregnancy tests
		CFR 493.55 and 493.3) and applicable state law.	- Primary culturing for transmittal to a certified
		Note 2: For more information on how to obtain a CLIA	laboratory
		certificate, see http://www.cms.gov/Regulations-and-	Note 1: The laboratory meets the standards imposed
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_C	under section 353 of the Public Health Service Act (42
		ertificate_International_Laboratories.html.	U.S.C. 263a). (Refer to the laboratory requirements
			specified in 42 CFR 493)
		LD.04.03.01, EP 9	Note 2: For rehabilitation and psychiatric distinct part
		The critical access hospital provides the following basic	units in critical access hospitals: The critical access
		laboratory services essential to the immediate diagnosis	hospital has laboratory services available, either
		and treatment of the patient:	directly or through a contractual agreement with a
		- The chemical examination of urine by the stick method,	Clinical Laboratory Improvement Amendments (CLIA)–

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the tablet method, or both	certified laboratory that meets the requirements of 42
		- Hemoglobin or hematocrit tests	CFR 493.
		- Blood glucose tests	
		- Examination of stool specimens for occult blood	
		- Pregnancy tests	
		- Primary culturing for transmittal to a certified laboratory	
§485.635(b)(2)(iii)	(iii) Blood glucose.	LD.04.01.01, EP 1	LD.13.03.01, EP 12
		The critical access hospital is licensed, is certified, or has	The critical access hospital provides the following basic
		a permit, in accordance with law and regulation, to	laboratory services essential to the immediate
		provide the care, treatment, or services for which the	diagnosis and treatment of the patient:
		critical access hospital is seeking accreditation from The	- Chemical examination of urine by the stick method,
		Joint Commission.	the tablet method, or both (including urine ketones)
		Note 1: Each service location that performs laboratory	- Hemoglobin or hematocrit tests
		testing (waived or nonwaived) must have a Clinical	- Blood glucose tests
		Laboratory Improvement Amendments of 1988 (CLIA '88)	- Examination of stool specimens for occult blood
		certificate as specified by the federal CLIA regulations (42	- Pregnancy tests
		CFR 493.55 and 493.3) and applicable state law.	- Primary culturing for transmittal to a certified
		Note 2: For more information on how to obtain a CLIA	laboratory
		certificate, see http://www.cms.gov/Regulations-and-	Note 1: The laboratory meets the standards imposed
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_C	under section 353 of the Public Health Service Act (42
		ertificate_International_Laboratories.html.	U.S.C. 263a). (Refer to the laboratory requirements specified in 42 CFR 493)
		LD.04.03.01, EP 9	Note 2: For rehabilitation and psychiatric distinct part
		The critical access hospital provides the following basic	units in critical access hospitals: The critical access
		laboratory services essential to the immediate diagnosis	hospital has laboratory services available, either
		and treatment of the patient:	directly or through a contractual agreement with a
		- The chemical examination of urine by the stick method,	Clinical Laboratory Improvement Amendments (CLIA)–
		the tablet method, or both	certified laboratory that meets the requirements of 42
		- Hemoglobin or hematocrit tests	CFR 493.
		- 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
§485.635(b)(2)(iv)	(iv) Examination of stool	LD.04.01.01, EP 1	LD.13.03.01, EP 12
	specimens for occult blood.	The critical access hospital is licensed, is certified, or has	The critical access hospital provides the following basic
		a permit, in accordance with law and regulation, to	laboratory services essential to the immediate
		provide the care, treatment, or services for which the	diagnosis and treatment of the patient:
		critical access hospital is seeking accreditation from The	- Chemical examination of urine by the stick method,
		Joint Commission.	the tablet method, or both (including urine ketones)
		Note 1: Each service location that performs laboratory	- Hemoglobin or hematocrit tests
		testing (waived or nonwaived) must have a Clinical	- Blood glucose tests
		Laboratory Improvement Amendments of 1988 (CLIA '88)	- Examination of stool specimens for occult blood
		certificate as specified by the federal CLIA regulations (42	- Pregnancy tests
		CFR 493.55 and 493.3) and applicable state law.	- Primary culturing for transmittal to a certified
		Note 2: For more information on how to obtain a CLIA	laboratory
		certificate, see http://www.cms.gov/Regulations-and-	Note 1: The laboratory meets the standards imposed
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_C	under section 353 of the Public Health Service Act (42
		ertificate_International_Laboratories.html.	U.S.C. 263a). (Refer to the laboratory requirements
			specified in 42 CFR 493)
		LD.04.03.01, EP 9	Note 2: For rehabilitation and psychiatric distinct part
		The critical access hospital provides the following basic	units in critical access hospitals: The critical access
		laboratory services essential to the immediate diagnosis	hospital has laboratory services available, either
		and treatment of the patient:	directly or through a contractual agreement with a
		- The chemical examination of urine by the stick method,	Clinical Laboratory Improvement Amendments (CLIA)–
		the tablet method, or both	certified laboratory that meets the requirements of 42
		- Hemoglobin or hematocrit tests	CFR 493.
		- Blood glucose tests	
		- Examination of stool specimens for occult blood	
		- Pregnancy tests	
		- Primary culturing for transmittal to a certified laboratory	
§485.635(b)(2)(v)	(v) Pregnancy tests.	LD.04.01.01, EP 1	LD.13.03.01, EP 12
		The critical access hospital is licensed, is certified, or has	The critical access hospital provides the following basic
		a permit, in accordance with law and regulation, to	laboratory services essential to the immediate
		provide the care, treatment, or services for which the	diagnosis and treatment of the patient:
		critical access hospital is seeking accreditation from The	- Chemical examination of urine by the stick method,
		Joint Commission.	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	- Hemoglobin or hematocrit tests
		testing (waived or nonwaived) must have a Clinical	- Blood glucose tests
		Laboratory Improvement Amendments of 1988 (CLIA '88)	- Examination of stool specimens for occult blood
		certificate as specified by the federal CLIA regulations (42	- Pregnancy tests
		CFR 493.55 and 493.3) and applicable state law.	- Primary culturing for transmittal to a certified
		Note 2: For more information on how to obtain a CLIA	laboratory
		certificate, see http://www.cms.gov/Regulations-and-	Note 1: The laboratory meets the standards imposed
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_C	under section 353 of the Public Health Service Act (42
		ertificate_International_Laboratories.html.	U.S.C. 263a). (Refer to the laboratory requirements
			specified in 42 CFR 493)
		LD.04.03.01, EP 9	Note 2: For rehabilitation and psychiatric distinct part
		The critical access hospital provides the following basic	units in critical access hospitals: The critical access
		laboratory services essential to the immediate diagnosis	hospital has laboratory services available, either
		and treatment of the patient:	directly or through a contractual agreement with a
		- The chemical examination of urine by the stick method,	Clinical Laboratory Improvement Amendments (CLIA)–
		the tablet method, or both	certified laboratory that meets the requirements of 42
		- Hemoglobin or hematocrit tests	CFR 493.
		- Blood glucose tests	
		- Examination of stool specimens for occult blood	
		- Pregnancy tests	
		- Primary culturing for transmittal to a certified laboratory	
§485.635(b)(2)(vi)	(vi) Primary culturing for	LD.04.01.01, EP 1	LD.13.03.01, EP 12
	transmittal to a certified	The critical access hospital is licensed, is certified, or has	The critical access hospital provides the following basic
	laboratory.	a permit, in accordance with law and regulation, to	laboratory services essential to the immediate
		provide the care, treatment, or services for which the	diagnosis and treatment of the patient:
		critical access hospital is seeking accreditation from The	- Chemical examination of urine by the stick method,
		Joint Commission.	the tablet method, or both (including urine ketones)
		Note 1: Each service location that performs laboratory	- Hemoglobin or hematocrit tests
		testing (waived or nonwaived) must have a Clinical	- Blood glucose tests
		Laboratory Improvement Amendments of 1988 (CLIA '88)	- Examination of stool specimens for occult blood
		certificate as specified by the federal CLIA regulations (42	- Pregnancy tests
		CFR 493.55 and 493.3) and applicable state law.	- Primary culturing for transmittal to a certified
		Note 2: For more information on how to obtain a CLIA	laboratory

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		certificate, see http://www.cms.gov/Regulations-and-	Note 1: The laboratory meets the standards imposed
		Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_C	under section 353 of the Public Health Service Act (42
		ertificate_International_Laboratories.html.	U.S.C. 263a). (Refer to the laboratory requirements
			specified in 42 CFR 493)
		LD.04.03.01, EP 9	Note 2: For rehabilitation and psychiatric distinct part
		The critical access hospital provides the following basic	units in critical access hospitals: The critical access
		laboratory services essential to the immediate diagnosis	hospital has laboratory services available, either
		and treatment of the patient:	directly or through a contractual agreement with a
		- The chemical examination of urine by the stick method,	Clinical Laboratory Improvement Amendments (CLIA)–
		the tablet method, or both	certified laboratory that meets the requirements of 42
		- Hemoglobin or hematocrit tests	CFR 493.
		- Blood glucose tests	
		- Examination of stool specimens for occult blood	
		- Pregnancy tests	
		- Primary culturing for transmittal to a certified laboratory	
§485.635(b)(3)	(3) Radiology services. Radiology	EC.01.01.01, EP 4	LD.13.03.01, EP 1
	services furnished by the CAH are	The critical access hospital has a written plan for	The critical access hospital provides services directly or
	provided by personnel qualified	managing the following: The environmental safety of	through referral, consultation, contractual
	under State law, and do not	patients and everyone else who enters the critical access	arrangements, or other agreements that meet the
	expose CAH patients or personnel	hospital's facilities.	needs of the population(s) served, are organized
	to radiation hazards.		appropriate to the scope and complexity of services
		EC.01.01.01, EP 8	offered, and are in accordance with accepted
		The critical access hospital has a written plan for	standards of practice. Services may include but are not
		managing the following: Medical equipment.	limited to the following:
			- Outpatient
		EC.02.02.01, EP 6	- Emergency
		The critical access hospital minimizes risks associated	- Medical records
		with selecting, handling, storing, transporting, using, and	- Diagnostic and therapeutic radiology
		disposing of radioactive materials.	- Nuclear medicine
			- Surgical
		UD 04 04 04 FD 2	- Anesthesia
		HR.01.04.01, EP 3	- Laboratory
		The critical access hospital orients staff on the following:	- Respiratory

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Relevant critical access hospitalwide and unit-specific	- Dietetic
		policies and procedures	
		- Their specific job duties, including those related to	NPG.12.01.01, EP 1
		infection prevention and control and assessing and	Leaders provide for an adequate number and mix of
		managing pain	qualified individuals to support safe, quality care,
		- Sensitivity to cultural diversity based on their job duties	treatment, and services.
		and responsibilities	Note 1: The number and mix of individuals is
		- Patient rights, including ethical aspects of care,	appropriate to the scope and complexity of the services
		treatment, or services and the process used to address	offered. Services may include but are not limited to the
		ethical issues based on their job duties and	following:
		responsibilities	- Rehabilitation services
		Completion of this orientation is documented.	- Emergency services
			- Outpatient services
		LD.04.01.07, EP 1	- Respiratory services
		Leaders review, approve, and manage the	- Pharmaceutical services, including emergency
		implementation of policies and procedures that guide	pharmaceutical services
		and support patient care, treatment, and services.	- Diagnostic and therapeutic radiology services
			Note 2: Emergency services staff are qualified in
		LD.04.03.01, EP 10	emergency care.
		The critical access hospital provides radiology services by	Note 3: For rehabilitation and psychiatric distinct part
		staff qualified in accordance with state law. These	units in critical access hospitals: As of the first day of
		services do not expose patients or staff to radiation	the first cost reporting period for which all other
		hazards.	exclusion requirements are met, the unit is fully
			equipped and staffed and is capable of providing
		MS.03.01.03, EP 4	hospital inpatient psychiatric or rehabilitation care
		The organized medical staff, through its designated	regardless of whether there are any inpatients in the
		mechanism, determines the circumstances under which	unit on that date.
		consultation or management by a doctor of medicine or	
		osteopathy, or other licensed practitioner, is required.	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	LD.04.03.01, EP 11	LD.13.03.01, EP 6
	accordance with the requirements	The critical access hospital provides medical services as	The critical access hospital provides emergency
	of §485.618, the CAH provides	a first response to common life-threatening injuries and	medical services that meet the needs of its inpatients
	medical services as a first	acute illnesses.	and outpatients as a first response to common life-
	response to common life-		threatening injuries and acute illnesses.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	threatening injuries and acute		Note: Emergency services are available 24-hours a day,
	illness.		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	LD.04.03.09, EP 1	LD.13.03.03, EP 7
	or osteopathy;	Clinical leaders and medical staff have an opportunity to	The critical access hospital has agreements or
		provide advice about the sources of clinical services to be	arrangements, as appropriate, with one or more
		provided through contractual agreement.	providers or suppliers participating under Medicare to
			furnish services not directly provided by the critical
		LD.04.03.09, EP 2	access hospital to its patients, including but not limited
		The critical access hospital describes, in writing, the	to the following:
		nature and scope of services provided through	- Services of doctors of medicine or osteopathy
		contractual agreements.	- Additional or specialized diagnostic and clinical
			laboratory services not available at the critical access
		LD.04.03.09, EP 3	hospital
		Designated leaders approve contractual agreements.	- Food and other services to meet inpatient nutritional
		I D 04 00 00 FD 4	needs to the extent they are not provided directly by the
		LD.04.03.09, EP 4	critical access hospital
		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	

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
S485.635(c)(1)(ii)	(ii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and	Current 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 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	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
		contractual agreements.	- Additional or specialized diagnostic and clinical laboratory services not available at the critical access
		LD.04.03.09, EP 3	hospital
		Designated leaders approve contractual agreements.	- Food and other services to meet inpatient nutritional needs to the extent they are not provided directly by the
		LD.04.03.09, EP 4	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	LD.04.03.09, EP 20	LD.13.03.03, EP 7
	meet inpatients' nutritional needs	The critical access hospital has agreements or	The critical access hospital has agreements or
	to the extent these services are not	arrangements, as appropriate, with one or more providers	arrangements, as appropriate, with one or more
	provided directly by the CAH.	or suppliers participating under Medicare to furnish other	providers or suppliers participating under Medicare to
		services to its patients, including the following:	furnish services not directly provided by the critical
		- Services of doctors of medicine or osteopathy	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	to the following:
		laboratory services not available at the critical access	- Services of doctors of medicine or osteopathy
		hospital	- Additional or specialized diagnostic and clinical
		- Food and other services to meet inpatient nutritional	laboratory services not available at the critical access
		needs to the extent they are not provided directly by the	hospital
		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	LD.04.03.09, EP 1	LD.13.01.09, EP 1
	arrangements are not in writing,	Clinical leaders and medical staff have an opportunity to	The critical access hospital develops and implements
	the CAH is able to present	provide advice about the sources of clinical services to be	written policies and procedures that guide health care
	evidence that patients referred by	provided through contractual agreement.	services. The policies and procedures are consistent
	the CAH are being accepted and		with state law and include the following:
	treated.	LD.04.03.09, EP 2	- Description of the services furnished by the critical
		The critical access hospital describes, in writing, the	access hospital, including those provided through
		nature and scope of services provided through	agreement or arrangement
		contractual agreements.	- Emergency medical services
			- Guidelines for the medical management of health
		LD.04.03.09, EP 3	problems that include the conditions requiring medical
		Designated leaders approve contractual agreements.	consultation and/or patient referral, the maintenance of
			health care records, and procedures for the periodic
		LD.04.03.09, EP 4	review and evaluation of the services provided by the
		Leaders monitor contracted services by establishing	critical access hospital
		expectations for the performance of the contracted	- Rules for the storage, handling, dispensation, and
		services.	administration of drugs and biologicals
		Note 1: When the critical access hospital contracts with	- Guidelines for addressing post–acute care needs of
		another accredited organization for patient care,	the patients receiving critical access hospital services
		treatment, and services to be provided off site, it can do	Note: If patients are transferred or discharged to a
		the following:	provider for which there is no agreement or
		- Verify that all physicians and other licensed	arrangement, the critical access hospital verifies that
		practitioners who will be providing patient care,	the patient has been accepted and treated.
		treatment, and services have appropriate privileges by	
		obtaining, for example, a copy of the list of privileges.	

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	LD.04.03.09, EP 2	LD.13.03.03, EP 1
	services furnished under	The critical access hospital describes, in writing, the	The critical access hospital maintains a current list of
	arrangements or agreements. The	nature and scope of services provided through	all patient care services provided under contract,
	list describes the nature and	contractual agreements.	arrangement, or agreement. The list describes nature
	scope of the services provided.		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	LD.01.02.01, EP 1	LD.11.01.03, EP 1
	whether or not they are furnished	Senior managers and leaders of the organized medical	The person responsible for the operation of the critical
	under arrangements or	staff work with the governing body to define their shared	access hospital under 42 CFR 485.627(b)(2) is also
	agreements.	and unique responsibilities and accountabilities.	responsible for the following:
			- Services provided in the critical access hospital
		LD.01.03.01, EP 1	whether or not they are furnished under arrangements
		The governing body defines in writing its responsibilities.	or agreements

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- Ensuring that contractors of services (including
		LD.01.03.01, EP 3	contractors for shared services and joint ventures)
		The governing body approves the critical access	provide services that enable the critical access hospital
		hospital's written scope of services.	to comply with all applicable Centers for Medicare
			& Medicaid (CMS) Conditions of Participation and
		LD.01.04.01, EP 1	standards for the contracted services
		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 02 00 ED 4	
		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,	

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	LD.01.04.01, EP 1	LD.11.01.03, EP 1
	services (including one for shared	The chief executive provides for the following:	The person responsible for the operation of the critical
	services and joint ventures)	- Information and support systems	access hospital under 42 CFR 485.627(b)(2) is also
	furnishes services that enable the	- Physical and financial assets	responsible for the following:
	CAH to comply with all applicable		- Services provided in the critical access hospital
	conditions of participation and	LD.04.01.01, EP 2	whether or not they are furnished under arrangements
	standards for the contracted	The critical access hospital provides care, treatment, and	or agreements
	services.	services in accordance with licensure requirements, laws	- Ensuring that contractors of services (including
		(including state law), and rules and regulations.	contractors for shared services and joint ventures)
			provide services that enable the critical access hospital
		LD.04.03.09, EP 4	to comply with all applicable Centers for Medicare
		Leaders monitor contracted services by establishing	& Amp; Medicaid (CMS) Conditions of Participation and
		expectations for the performance of the contracted	standards for the contracted services
		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	

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.	
		oxpostations.	
		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	
0.405,005(,)(5)	(5)	- Terminate the contract	NO 00 04 04 FD 4
§485.635(c)(5)	(5) In the case of distant-site	MS.13.01.01, EP 1	MS.20.01.01, EP 1
	physicians and practitioners	All physicians or other licensed practitioners who are	When telemedicine services are furnished to the critical
	providing telemedicine services to	responsible for the patient's care, treatment, and services	access hospital's patients through an agreement with a
	the CAH's patients under a written agreement between the CAH and a	via telemedicine link are credentialed and privileged to do so at the originating site through one of the following	distant-site hospital or telemedicine entity, the governing body of the originating critical access
	distant-site telemedicine entity,	mechanisms:	hospital may choose to rely upon the credentialing and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	the distant-site telemedicine	- The originating site fully credentials and privileges the	privileging decisions made by the distant-site hospital
	entity is not required to be a	physician or other licensed practitioner according to	or telemedicine entity for the individual distant-site
	Medicare-participating provider or	Standards MS.06.01.03 through MS.06.01.13.	physicians and other licensed practitioners providing
	supplier.	Or	such services if the critical access hospital's governing
		- The originating site privileges physicians or other	body includes all of the following provisions in its
		licensed practitioners using credentialing information	written agreement with the distant-site hospital or
		from the distant site if the distant site is a Joint	telemedicine entity:
		Commission–accredited or a Medicare-participating	- The distant site telemedicine entity provides services
		organization. The distant-site physician or other licensed	in accordance with contract service requirements.
		practitioner has a license that is issued or recognized by	- The distant-site telemedicine entity's medical staff
		the state in which the patient is receiving telemedicine	credentialing and privileging process and standards is
		services.	consistent with the critical access hospital's process
		Or	and standards, at a minimum.
		- The originating site may choose to use the credentialing	- The distant-site hospital providing the telemedicine
		and privileging decision from the distant site to make a	services is a Medicare-participating hospital.
		final privileging decision if all the following requirements	- The individual distant-site physician or other licensed
		are met:	practitioner is privileged at the distant-site hospital or
		- The distant site is a Joint Commission–accredited or a	telemedicine entity providing the telemedicine services,
		Medicare-participating organization.	and the distant-site hospital or telemedicine entity
		- The physician or other licensed practitioner is	provides a current list of the distant-site physician's or
		privileged at the distant site for those services to be	practitioner's privileges at the distant-site hospital or
		provided at the originating site.	telemedicine entity.
		- The distant site provides the originating site with a	- The individual distant-site physician or other licensed
		current list of the physician's or other licensed	practitioner holds a license issued or recognized by the
		practitioner's privileges.	state in which the critical access hospital whose
		- The originating site has evidence of an internal review	patients are receiving the telemedicine services is
		of the physician's or other licensed practitioner's	located.
		performance of these privileges and sends to the distant	- For distant-site physicians or other licensed
		site information that is useful to assess the physician's or	practitioners privileged by the originating critical access
		other licensed practitioner's quality of care, treatment,	hospital, the originating critical access hospital
		and services for use in privileging and performance	internally reviews services provided by the distant-site
		improvement. At a minimum, this information includes all	physician or other licensed practitioner and sends the
		adverse outcomes related to sentinel events considered	distant-site hospital or telemedicine entity information

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
8485 635(d)	8485 635(d) Standard: Nursing	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.)	ID 12 02 01 ED 2
§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.	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.
		NR.02.01.01, EP 4	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
CoP Requirement	CoP Text	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 - 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	Future EP Mapping
		The nurse executive is responsible for monitoring the effectiveness of the nurse staffing plan.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	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.
		- The implementation of organizationwide programs, policies, and procedures that address how nursing care	

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 & Description of the Centers for Medicare and the Centers for Medicare and the Centers for Medicare and the Centers for Medicare & Description of the Center & Description of the Center & Descriptio	
		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.	
		DO 04 00 05 ED 4	
		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	
\$40F 00F(-I)(0)	(0) A marginta and management and and	diagnostic testing.	ND 44 04 04 ED 4
§485.635(d)(2)	(2) A registered nurse or, where permitted by State law, a physician	LD.01.04.01, EP 5 The chief executive identifies a nurse leader at the	NR.11.01.01, EP 4 A registered nurse (or physician assistant, when
	assistant, must supervise and	executive level who participates in decision making.	permitted by state law) supervises and evaluates the
	evaluate the nursing care for each	executive tevet wito participates in decision making.	nursing care for each patient, including patients at a
	patient, including patients at a	LD.03.06.01, EP 2	skilled nursing facility-level of care in a swing-bed
	SNF level of care in a swing-bed	Leaders provide for a sufficient number and mix of	critical access hospital.
	CAH.	individuals to support safe, quality care, treatment, and	- Charles a coop in copinal
		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	

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,	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.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.
	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.	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.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
			and regulations, including applicable licensing
		MM.05.01.07, EP 5	requirements, and in accordance with the approved
		The critical access hospital properly stores compounded	medical staff policies and procedures.
		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	

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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.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.
		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	Note 3: For rehabilitation distinct part units in critical access hospitals: The plan is reviewed and revised as

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		meet those goals.	needed by a physician in consultation with other
		Note: For psychiatric distinct part units in critical access	professional staff who provide services to the patient.
		hospitals: The patient's goals include both short- and	
		long-term goals.	
§485.635(e)	§485.635(e) Standard:	HR.01.01.01, EP 1	HR.11.02.01, EP 1
	Rehabilitation Therapy Services.	The critical access hospital defines staff qualifications	The critical access hospital defines staff qualifications
	Physical therapy, occupational	specific to their job responsibilities.	specific to their job responsibilities.
	therapy, and speech-language	Note 1: Qualifications for infection control may be met	Note 1: Qualifications for infection control may be met
	pathology services furnished at	through ongoing education, training, experience, and/or	through ongoing education, training, experience, and/or
	the CAH, if provided, are provided	certification (such as that offered by the Certification	certification (such as that offered by the Certification
	by staff qualified under State law,	Board for Infection Control).	Board for Infection Control).
	and consistent with the	Note 2: For rehabilitation and psychiatric distinct part	Note 2: For rehabilitation and psychiatric distinct part
	requirements for therapy services	units in critical access hospitals: Qualified physical	units in critical access hospitals: Qualified physical
	in §409.17 of this subpart.	therapists, physical therapist assistants, occupational	therapists, physical therapist assistants, occupational
		therapists, occupational therapy assistants, speech-	therapists, occupational therapy assistants, speech-
		language pathologists, or audiologists (as defined in 42	language pathologists, or audiologists, as defined in 42
		CFR 484.4) provide physical therapy, occupational	CFR 484, provide physical therapy, occupational
		therapy, speech-language pathology, or audiology	therapy, speech-language pathology, or audiology
		services, if these services are provided by the critical	services, if these services are provided by the critical
		access hospital. The provision of care and staff	access hospital. See Glossary for definitions of physical
		qualifications are in accordance with national acceptable	therapist, physical therapist assistant, occupational
		standards of practice and also meet the requirements of	therapist, occupational therapy assistant, speech-
		409.17. See Appendix B for 409.17 requirements.	language pathologist, and audiologist.
		UD 04 04 04 ED 0	Note 3: For rehabilitation and psychiatric distinct part
		HR.01.01.01, EP 2	units in critical access hospitals: If respiratory care
		The critical access hospital verifies and documents the	services are provided, staff qualified to perform specific
		following:	respiratory care procedures and the amount of
		- Credentials of staff using the primary source when	supervision required to carry out the specific
		licensure, certification, or registration is required by law	procedures is designated in writing.
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	
		GVO gardotinos identinos in the Gtossary.	
		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.	
		ID 02 06 01 ED 2	
		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.04.03.01, 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, 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.	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.
		IM.02.01.03, EP 1	

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.	
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		IM.02.01.03, EP 6	
		The critical access hospital protects health information against loss, damage, unauthorized alteration,	
		unintentional change, and accidental destruction.	
		difficientional 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.	
		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:	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Results of diagnostic and therapeutic tests and	- Records of radiology and nuclear medicine services,
		procedures	including signed interpretation reports
		- Any medications dispensed or prescribed on discharge	- All care, treatment, and services provided to the
		- Discharge diagnosis	patient
		- Discharge plan and discharge planning evaluation	- Patient's response to care, treatment, and services
			- Medical history and physical examination, including
			any conclusions or impressions drawn from the
		RC.02.01.01, EP 4	information
		As needed to provide care, treatment, and services, the	- Discharge plan and discharge planning evaluation
		medical record contains the following additional	- Discharge summary with outcome of hospitalization,
		information:	disposition of case, and provisions for follow-up care,
		- Any advance directives	including any medications dispensed or prescribed on
		- Any informed consent, when required by critical access	discharge
		hospital policy	- Any diagnoses or conditions established during the
		Note: The properly executed informed consent is placed	patient's course of care, treatment, and services
		in the patient's medical record prior to surgery, except in	Note: Medical records are completed within 30 days
		emergencies. For rehabilitation and psychiatric distinct	following discharge, including final diagnosis.
		part units in critical access hospitals: A properly executed	
		informed consent contains documentation of a patient's	RC.12.01.01, EP 3
		mutual understanding of and agreement for care,	The medical record contains any informed consent,
		treatment, and services through written signature,	when required by critical access hospital policy or
		electronic signature, or when a patient is unable to	federal or state law or regulation.
		provide a signature, documentation of the verbal	Note: The properly executed informed consent is
		agreement by the patient or surrogate decision-maker.	placed in the patient's medical record prior to surgery,
		- Any records of communication with the patient, such as	except in emergencies. A properly executed informed
		telephone calls or e-mail	consent contains documentation of a patient's mutual
		- Any patient-generated information	understanding of and agreement for care, treatment,
		DO 00 04 04 ED 0	and services through written signature; electronic
		RC.02.04.01, EP 3	signature; or, when a patient is unable to provide a
		In order to provide information to other caregivers and	signature, documentation of the verbal agreement by
		facilitate the patient's continuity of care, the medical	the patient or surrogate decision-maker.
		record contains a discharge summary that includes the	
		following:	

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	RC.02.01.01, EP 2	RC.12.01.01, EP 2
	examinations, diagnostic and	The medical record contains the following clinical	The medical record contains the following clinical
	laboratory test results, including	information:	information:
	clinical laboratory services, and	- The reason(s) for admission for care, treatment, and	- Admitting diagnosis
	consultative findings;	services	- Any emergency care, treatment, and services provided
		- The patient's initial diagnosis, diagnostic impression(s),	to the patient before their arrival
		or condition(s)	- Any allergies to food and medications
		- Any findings of assessments and reassessments	- Any findings of assessments and reassessments
		- Any allergies to food	- Results of all consultative evaluations of the patient
		- Any allergies to medications	and findings by clinical and other staff involved in the
		- Any conclusions or impressions drawn from the	care of the patient
		patient's medical history and physical examination	- Treatment goals, plan of care, and revisions to the plan
		- Any diagnoses or conditions established during the	of care
		patient's course of care, treatment, and services	- Documentation of complications, health care–
		(including complications and hospital-acquired	acquired infections, and adverse reactions to drugs and
		infections). For psychiatric distinct part units in critical	anesthesia
		access hospitals: The diagnosis includes intercurrent	- All practitioners' orders
		diseases (diseases that occur during the course of	- Nursing notes, reports of treatment, laboratory
		another disease; for example, a patient with AIDS may	reports, vital signs, and other information necessary to
		develop an intercurrent bout of pneumonia) and the	monitor the patient's condition
		psychiatric diagnoses.	- Medication records, including the strength, dose,
		- Any consultation reports	route, date and time of administration, access site for
		- Any observations relevant to care, treatment, and	medication, administration devices used, and rate of
		services	administration
		- The patient's response to care, treatment, and services	Note: When rapid titration of a medication is necessary,
		- Any emergency care, treatment, and services provided	the critical access hospital defines in policy the
		to the patient before their arrival	urgent/emergent situations in which block charting
		- Any progress notes	would be an acceptable form of documentation. For the
		- All orders	definition and a further explanation of block charting,
		- Any medications ordered or prescribed	refer to the Glossary.
		- Any medications administered, including the strength,	- Administration of each self-administered medication,
		dose, route, date and time of administration	as reported by the patient (or the patient's caregiver or
		Note 1: When rapid titration of a medication is necessary,	support person where appropriate)

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		the critical access hospital defines in policy the	- Records of radiology and nuclear medicine services,
		urgent/emergent situations in which block charting would	including signed interpretation reports
		be an acceptable form of documentation.	- All care, treatment, and services provided to the
		Note 2: For the definition and a further explanation of	patient
		block charting, refer to the Glossary.	- Patient's response to care, treatment, and services
		- Any access site for medication, administration devices	- Medical history and physical examination, including
		used, and rate of administration	any conclusions or impressions drawn from the
		- Any adverse drug reactions	information
		- Treatment goals, plan of care, and revisions to the plan	- Discharge plan and discharge planning evaluation
		of care	- Discharge summary with outcome of hospitalization,
		- Results of diagnostic and therapeutic tests and	disposition of case, and provisions for follow-up care,
		procedures	including any medications dispensed or prescribed on
		- Any medications dispensed or prescribed on discharge	discharge
		- Discharge diagnosis	- Any diagnoses or conditions established during the
		- Discharge plan and discharge planning evaluation	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	RC.02.01.01, EP 2	RC.12.01.01, EP 2
	medicine or osteopathy or other	The medical record contains the following clinical	The medical record contains the following clinical
	practitioners, reports of	information:	information:
	treatments and medications,	- The reason(s) for admission for care, treatment, and	- Admitting diagnosis
	nursing notes and documentation	services	- Any emergency care, treatment, and services provided
	of complications, and other	- The patient's initial diagnosis, diagnostic impression(s),	to the patient before their arrival
	pertinent information necessary to	or condition(s)	- Any allergies to food and medications
	monitor the patient's progress,	- Any findings of assessments and reassessments	- Any findings of assessments and reassessments
	such as temperature graphics,	- Any allergies to food	- Results of all consultative evaluations of the patient
	progress notes describing the	- Any allergies to medications	and findings by clinical and other staff involved in the
	patient's response to treatment;	- Any conclusions or impressions drawn from the	care of the patient
	and	patient's medical history and physical examination	- Treatment goals, plan of care, and revisions to the plan
		- Any diagnoses or conditions established during the	of care
		patient's course of care, treatment, and services	- Documentation of complications, health care-
		(including complications and hospital-acquired	acquired infections, and adverse reactions to drugs and
		infections). For psychiatric distinct part units in critical	anesthesia

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access hospitals: The diagnosis includes intercurrent	- All practitioners' orders
		diseases (diseases that occur during the course of	- Nursing notes, reports of treatment, laboratory
		another disease; for example, a patient with AIDS may	reports, vital signs, and other information necessary to
		develop an intercurrent bout of pneumonia) and the	monitor the patient's condition
		psychiatric diagnoses.	- Medication records, including the strength, dose,
		- Any consultation reports	route, date and time of administration, access site for
		- Any observations relevant to care, treatment, and	medication, administration devices used, and rate of
		services	administration
		- The patient's response to care, treatment, and services	Note: When rapid titration of a medication is necessary,
		- Any emergency care, treatment, and services provided	the critical access hospital defines in policy the
		to the patient before their arrival	urgent/emergent situations in which block charting
		- Any progress notes	would be an acceptable form of documentation. For the
		- All orders	definition and a further explanation of block charting,
		- Any medications ordered or prescribed	refer to the Glossary.
		- Any medications administered, including the strength,	- Administration of each self-administered medication,
		dose, route, date and time of administration	as reported by the patient (or the patient's caregiver or
		Note 1: When rapid titration of a medication is necessary,	support person where appropriate)
		the critical access hospital defines in policy the	- Records of radiology and nuclear medicine services,
		urgent/emergent situations in which block charting would	including signed interpretation reports
		be an acceptable form of documentation.	- All care, treatment, and services provided to the
		Note 2: For the definition and a further explanation of	patient
		block charting, refer to the Glossary.	- Patient's response to care, treatment, and services
		- Any access site for medication, administration devices	- Medical history and physical examination, including
		used, and rate of administration	any conclusions or impressions drawn from the
		- Any adverse drug reactions	information
		- Treatment goals, plan of care, and revisions to the plan	- Discharge plan and discharge planning evaluation
		of care	- Discharge summary with outcome of hospitalization,
		- Results of diagnostic and therapeutic tests and	disposition of case, and provisions for follow-up care,
		procedures	including any medications dispensed or prescribed on
		- Any medications dispensed or prescribed on discharge	discharge
		- Discharge diagnosis	- Any diagnoses or conditions established during the
		- Discharge plan and discharge planning evaluation	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	RC.01.01.01, EP 7	RC.11.02.01, EP 1
	of medicine or osteopathy or other	All entries in the medical record are dated.	All orders, including verbal orders, are dated, timed,
	health care professional.		and authenticated by the ordering physician or other
		RC.01.02.01, EP 3	licensed practitioner who is responsible for the
		The author of each medical record entry is identified in	patient's care and who is authorized to write orders, in
		the medical record.	accordance with critical access hospital policy, law and
			regulation, and medical staff bylaws, rules, and
		RC.01.02.01, EP 4	regulations.
		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.	
§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	IM.02.01.01, EP 1	IM.12.01.01, EP 1
	confidentially of record	The critical access hospital follows a written policy	The critical access hospital develops and implements
	information and provides	addressing the privacy and confidentiality of health	policies and procedures addressing the privacy and
	safeguards against loss,	information.	confidentiality of health information.
	destruction, or unauthorized use.		Note: For swing beds in critical access hospitals:
		IM.02.01.03, EP 2	Policies and procedures also address the resident's
		The critical access hospital implements a written policy	personal records.
		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.	
§485.638(b)(2)	(2) Written policies and	IM.02.01.01, EP 1	IM.12.01.01, EP 3
	procedures govern the use and	The critical access hospital follows a written policy	The critical access hospital develops and implements
	removal of records from the CAH	addressing the privacy and confidentiality of health	policies and procedures for the release of medical
	and the conditions for the release	information.	records. The policies and procedures are in accordance
	of information.		with law and regulation, court orders, or subpoenas.
		IM.02.01.03, EP 1	Note: Information from or copies of records may be
		The critical access hospital follows a written policy that	released only to authorized individuals, and the critical
		addresses the security of health information, including	access hospital makes certain that unauthorized

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access, use, and disclosure.	individuals cannot gain access to or alter patient
			records.
		IM.02.01.03, EP 2	
		The critical access hospital implements a written policy	IM.12.01.03, EP 1
		addressing the following:	The critical access hospital develops and implements a
		- The integrity of health information against loss, damage,	written policy that addresses the security of health
		unauthorized alteration, unintentional change, and	information, including the following:
		accidental destruction	- Access and use
		- The intentional destruction of health information	- Integrity of health information against loss, damage,
		- When and by whom the removal of health information is permitted	unauthorized alteration or use, unintentional change, and accidental destruction
		Note: Removal refers to those actions that place health	- Intentional destruction of health information
		information outside the critical access hospital's control.	- When and by whom the removal of health information
		information outside the entitled decess hospital's control.	is permitted
		IM.02.01.03, EP 6	Note: Removal refers to those actions that place health
		The critical access hospital protects health information	information outside the critical access hospital's
		against loss, damage, unauthorized alteration,	control.
		unintentional change, and accidental destruction.	
		IM.02.01.03, EP 7	
		The critical access hospital controls the intentional	
		destruction of health information.	
§485.638(b)(3)	(3) The patient's written consent is	IM.02.01.01, EP 1	IM.12.01.01, EP 2
	required for release of information	The critical access hospital follows a written policy	The critical access hospital discloses health
	not required by law.	addressing the privacy and confidentiality of health	information only as authorized by the patient with the
		information.	patient's written consent or as otherwise required by
		IM 00 04 04 FD 2	law and regulation.
		IM.02.01.01, EP 3 The critical access hospital uses health information only	Note: For swing beds in critical access hospitals: The critical access hospital allows representatives of the
		for purposes permitted by law and regulation or as further	Office of the State Long-Term Care Ombudsman to
		limited by its policy on privacy.	examine a resident's medical, social, and
			administrative records in accordance with state law.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	RC.01.05.01, EP 2	RC.11.03.01, EP 2
	Records The records are retained	The medical record is retained for at least six years from	The medical record is retained for at least six years from
	for at least 6 years from date of	the date of its last entry and longer if required by state	the date of its last entry and longer if required by state
	last entry, and longer if required by	statute or if the record is needed in any pending	statute or if the record is needed in any pending
	State statute, or if the records may	proceeding.	proceeding.
	be 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	IM.02.02.07, EP 1	IM.13.01.05, EP 1
	capacity is fully operational and	The critical access hospital demonstrates that its	The critical access hospital demonstrates that its
	the CAH uses it in accordance	electronic health records system (or other electronic	electronic health records system's (or other electronic
	with all State and Federal statutes	administrative system) has a fully operational notification	administrative system's) notification capacity is fully
	and regulations applicable to the	capacity and is used in accordance with applicable state	operational and is used in accordance with applicable
	CAH's exchange of patient health	and federal laws and regulations for the exchange of	state and federal laws and regulations for the exchange
0.405.000(1)(0)	information.	patient health information.	of patient health information.
§485.638(d)(2)	(2) The system sends notifications	IM.02.02.07, EP 2	IM.13.01.05, EP 2
	that must include at least patient	The critical access hospital demonstrates that its	The critical access hospital demonstrates that its
	name, treating practitioner name,	electronic health records system (or other electronic	electronic health records system (or other electronic
	and sending institution name.	administrative system) sends notifications that include at	administrative system) sends notifications that include,
		least the patient's name, treating licensed practitioner's	at a minimum, the patient's name, treating licensed
		name, and sending institution's name.	practitioner's name, and sending institution's name.

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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		to receive patient event notifications in a manner	identifying recipients. In addition, some recipients may
		consistent with a critical access hospital system's	not be able to receive patient event notifications in a
		capabilities.	manner consistent with the critical access hospital
			system's capabilities.
§485.639	§485.639 Condition of	EC.02.03.01, EP 11	LD.13.03.01, EP 1
	Participation: Surgical Services.	Periodic evaluations, as determined by the critical access	The critical access hospital provides services directly or
	If a CAH provides surgical	hospital, are made of potential fire hazards that could be	through referral, consultation, contractual
	services, surgical procedures	encountered during surgical procedures. Written fire	arrangements, or other agreements that meet the
	must be performed in a safe	prevention and response procedures, including safety	needs of the population(s) served, are organized
	manner by qualified practitioners	precautions related to the use of flammable germicides	appropriate to the scope and complexity of services
	who have been granted clinical	or antiseptics, are established.	offered, and are in accordance with accepted
	privileges by the governing body, or		standards of practice. Services may include but are not
	responsible individual, of the CAH	EC.02.03.01, EP 12	limited to the following:
	in accordance with the	When flammable germicides or antiseptics are used	- Outpatient
	designation requirements under	during surgeries utilizing electrosurgery, cautery, or	- Emergency
	paragraph (a) of this section.	lasers, the following are required:	- Medical records
		- Nonflammable packaging	- Diagnostic and therapeutic radiology
		- Unit-dose applicators	- Nuclear medicine
		- Preoperative "time-out" prior to the initiation of any	- Surgical
		surgical procedure to verify the following:	- Anesthesia
		- Application site is dry prior to draping and use of	- Laboratory
		surgical equipment	- Respiratory
		- Pooling of solution has not occurred or has been	- Dietetic
		corrected	
		- Solution-soaked materials have been removed from the	LD.13.03.01, EP 10
		operating room prior to draping and use of surgical	If the critical access hospital provides outpatient
		devices	surgical services, the services are consistent with the
		(For full text, refer to NFPA 99-2012: 15.13)	quality of inpatient surgical care.
		HR.01.05.03, EP 1	MS.17.02.01, EP 6
		Staff participate in ongoing education and training to	The critical access hospital designates the practitioners
		maintain or increase their competency and, as needed,	who are allowed to perform surgery, in accordance with
		when staff responsibilities change. Staff participation is	appropriate policies and procedures, and with scope of

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		documented.	practice laws and regulations. Surgery is performed
			only by the following:
		HR.01.06.01, EP 1	- A doctor of medicine or osteopathy, including an
		The critical access hospital defines the competencies it	osteopathic practitioner recognized under section
		requires of its staff who provide patient care, treatment,	1101(a)(7) of the Social Security Act
		or services.	- A doctor of dental surgery or dental medicine
			- A doctor of podiatric medicine
		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.	
		Freezestation of Germanian and an accommentation	
		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	

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 ED 2	
		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.	
		a cosso nospitati	
		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	MS.06.01.05, EP 13	MS.17.02.01, EP 6
	dental medicine; or	The critical access hospital designates the practitioners	The critical access hospital designates the practitioners
		who are allowed to perform surgery, in accordance with	who are allowed to perform surgery, in accordance with
		appropriate policies and procedures, and with scope of	appropriate policies and procedures, and with scope of
		practice laws and regulations. Surgery is performed only by the following:	practice laws and regulations. Surgery is performed only by the following:
		- A doctor of medicine or osteopathy, including an	- A doctor of medicine or osteopathy, including an
		osteopathic practitioner recognized under section	osteopathic practitioner recognized under section
		1101(a)(7) of the Act	1101(a)(7) of the Social Security Act
		- A doctor of dental surgery or dental medicine	- A doctor of dental surgery or dental medicine
		- A doctor of podiatric 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	
§485.639(a)(3)	(3) A doctor of podiatric medicine.	MS.06.01.05, EP 13	MS.17.02.01, EP 6
		The critical access hospital designates the practitioners	The critical access hospital designates the practitioners
		who are allowed to perform surgery, in accordance with	who are allowed to perform surgery, in accordance with
		appropriate policies and procedures, and with scope of	appropriate policies and procedures, and with scope of
		practice laws and regulations. Surgery is performed only	practice laws and regulations. Surgery is performed
		by the following:	only by the following:
		- A doctor of medicine or osteopathy, including an	- A doctor of medicine or osteopathy, including an
		osteopathic practitioner recognized under section	osteopathic practitioner recognized under section
		1101(a)(7) of the Act	1101(a)(7) of the Social Security Act
		- A doctor of dental surgery or dental medicine	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- A doctor of podiatric medicine	- 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	
0.405.000(1.)	0.407.000// 0.41.41.41.41.41.41.41.41.41.41.41.41.41.	restricted	
§485.639(b)	§485.639(b) Standard: Anesthetic		
\$405.000(5)(4)	Risk and Evaluation	DO 00 04 00 FD 0	DO 40 04 00 ED 0
§485.639(b)(1)	(1) A qualified practitioner, as specified in paragraph (a) of this	PC.03.01.03, EP 8	PC.13.01.03, EP 3
	section, must examine the patient	A qualified physician or other licensed practitioner reevaluates the patient immediately before administering	A qualified physician or other licensed practitioner, in accordance with 42 CFR 485.639(a), reevaluates the
	immediately before surgery to	moderate or deep sedation or anesthesia.	patient immediately before surgery, to evaluate the risk
	evaluate the risk of the procedure	Note: The reevaluation is performed by a qualified	of the procedure to be performed.
	to be performed.	physician or other licensed practitioner in accordance	or this process and to be performed.
		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.	
§485.639(b)(2)	(2) A qualified practitioner, as	PC.03.01.03, EP 1	PC.13.01.03, EP 1
	specified in paragraph (c) of this	Before operative or other high-risk procedures are	A qualified physician or other licensed practitioner, in
	section, must examine each	initiated, or before moderate or deep sedation or	accordance with 42 CFR 485.639(c), conducts a
	patient before surgery to evaluate	anesthesia is administered: The critical access hospital	preanesthesia patient assessment to evaluate the risk
	the risk of anesthesia.	conducts a presedation or preanesthesia patient	of anesthesia.
		assessment.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.639(b)(3)	(3) Before discharge from the CAH,	PC.03.01.07, EP 1	PC.13.01.03, EP 6
	each patient must be evaluated for	The critical access hospital assesses the patient's	A qualified physician or other licensed practitioner
	proper anesthesia recovery by a	physiological status immediately after the operative or	evaluates the patient for proper anesthesia recovery, as
	qualified practitioner, as specified	other high-risk procedure and/or as the patient recovers	specified in 42 CFR 485.639(c), before discharging the
	in paragraph (c) of this section.	from moderate or deep sedation or anesthesia.	patient from the recovery area or from the critical
			access hospital.
		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	

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	PC.13.01.01, EP 1
		In accordance with the critical access hospital's policy	Anesthesia is administered only by the following
		and state scope of practice laws, anesthesia is	individuals:
		administered only by the following individuals:	- A qualified anesthesiologist
		- An anesthesiologist	- A doctor of medicine or osteopathy other than an
		- A doctor of medicine or osteopathy other than an	anesthesiologist, including an osteopathic practitioner
		anesthesiologist	recognized under section 1101(a)(7) of the Social
		- A doctor of dental surgery or dental medicine	Security Act
		- A doctor of podiatric medicine	- A doctor of dental surgery or dental medicine, who is
		- A certified registered nurse anesthetist (CRNA)	qualified to administer anesthesia under state law
		supervised by the operating practitioner except as	- A doctor of podiatric medicine, who is qualified to
		provided in 42 CFR 485.639(e) regarding the state	administer anesthesia under state law
		exemption for this supervision *	- A certified registered nurse anesthetist (CRNA), as
		- An anesthesiologist's assistant supervised by an	defined in 42 CFR 410.69(b) of this chapter, supervised
		anesthesiologist	by the operating practitioner, except as provided in 42
		- A supervised trainee in an approved educational	CFR 485.639(e) regarding the state exemption for this
		program	supervision
			- An anesthesiologist's assistant, as defined in 42 CFR
		Note: In accordance with 42 CFR 413.85(e), an approved	410.69(b), supervised by an anesthesiologist
		nursing and allied health education program is a planned	- A supervised trainee in an approved educational
		program of study that is licensed by state law, or if	program
		licensing is not required, is accredited by a recognized	Note 1: In accordance with 42 CFR 413.85(e), an
		national professional organization. Such national	approved nursing and allied health education program
		accrediting bodies include, but are not limited to, the	is a planned program of study that is licensed by state
		Commission on Accreditation of Allied Health Education	law, or if licensing is not required, is accredited by a
		Programs and the National League of Nursing Accrediting	recognized national professional organization. Such
		Commission.	national accrediting bodies include, but are not limited
		Footnote *: The CoP at 42 CFR 485.639(e) for state	to, the Commission on Accreditation of Allied Health
		exemption states: A critical access hospital may be	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	Nursing Accrediting Commission.
		osteopathy supervision of CRNAs if the state in which the	Note 2: See Glossary for the definition of certified
		critical access hospital is located submits a letter to the	registered nurse anesthetist (CRNA) and
		Centers for Medicare & Described Services (CMS)	anesthesiologist assistant.
		signed by the governor, following consultation with the	Note 3: The CoP at 42 CFR 485.639(e) for state
		state's Boards of Medicine and Nursing, requesting	exemption states: A critical access hospital may be
		exemption from doctor of medicine or osteopathy	exempted from the requirement for doctor of medicine
		supervision for CRNAs. The letter from the governor must	or osteopathy supervision of CRNAs if the state in
		attest that they have consulted with the state Boards of	which the critical access hospital is located submits a
		Medicine and Nursing about issues related to access to	letter to the Centers for Medicare & Dedicard
		and the quality of anesthesia services in the state and has	Services (CMS) signed by the governor, following
		concluded that it is in the best interests of the state's	consultation with the state's boards of medicine and
		citizens to opt out of the current doctor of medicine or	nursing, requesting exemption from doctor of medicine
		osteopathy supervision requirement, and that the opt-out	or osteopathy supervision for CRNAs. The letter from
		is consistent with state law. The request for exemption	the governor must attest that they have consulted with
		and recognition of state laws and the withdrawal of the	the state boards of medicine and nursing about issues
		request may be submitted at any time and are effective	related to access to and the quality of anesthesia
		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)(ii)	(ii) A doctor of medicine or	PC.03.01.01, EP 9	PC.13.01.01, EP 1
	osteopathy other than an	In accordance with the critical access hospital's policy	Anesthesia is administered only by the following
	anesthesiologist; including an	and state scope of practice laws, anesthesia is	individuals:
	osteopathic practitioner	administered only by the following individuals:	- A qualified anesthesiologist
	recognized under section	- An anesthesiologist	- A doctor of medicine or osteopathy other than an
	1101(a)(7) of the Act;	- 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	recognized under section 1101(a)(7) of the Social
		- A doctor of dental surgery or dental medicine	Security Act
		- A doctor of podiatric medicine	- A doctor of dental surgery or dental medicine, who is
		- A certified registered nurse anesthetist (CRNA)	qualified to administer anesthesia under state law
		supervised by the operating practitioner except as	- A doctor of podiatric medicine, who is qualified to
		provided in 42 CFR 485.639(e) regarding the state	administer anesthesia under state law
		exemption for this supervision *	- A certified registered nurse anesthetist (CRNA), as
		- An anesthesiologist's assistant supervised by an	defined in 42 CFR 410.69(b) of this chapter, supervised
		anesthesiologist	by the operating practitioner, except as provided in 42
		- A supervised trainee in an approved educational	CFR 485.639(e) regarding the state exemption for this
		program	supervision
			- An anesthesiologist's assistant, as defined in 42 CFR
		Note: In accordance with 42 CFR 413.85(e), an approved	410.69(b), supervised by an anesthesiologist
		nursing and allied health education program is a planned	- A supervised trainee in an approved educational
		program of study that is licensed by state law, or if	program
		licensing is not required, is accredited by a recognized	Note 1: In accordance with 42 CFR 413.85(e), an
		national professional organization. Such national	approved nursing and allied health education program
		accrediting bodies include, but are not limited to, the	is a planned program of study that is licensed by state
		Commission on Accreditation of Allied Health Education	law, or if licensing is not required, is accredited by a
		Programs and the National League of Nursing Accrediting	recognized national professional organization. Such
		Commission.	national accrediting bodies include, but are not limited
		Footnote *: The CoP at 42 CFR 485.639(e) for state	to, the Commission on Accreditation of Allied Health
		exemption states: A critical access hospital may be	Education Programs and the National League of
		exempted from the requirement for doctor of medicine or	Nursing Accrediting Commission.
		osteopathy supervision of CRNAs if the state in which the	Note 2: See Glossary for the definition of certified
		critical access hospital is located submits a letter to the	registered nurse anesthetist (CRNA) and
		Centers for Medicare & Medicaid Services (CMS)	anesthesiologist assistant.
		signed by the governor, following consultation with the	Note 3: The CoP at 42 CFR 485.639(e) for state
		state's Boards of Medicine and Nursing, requesting	exemption states: A critical access hospital may be
		exemption from doctor of medicine or osteopathy	exempted from the requirement for doctor of medicine
		supervision for CRNAs. The letter from the governor must	or osteopathy supervision of CRNAs if the state in
		attest that they have consulted with the state Boards of	which the critical access hospital is located submits a
		Medicine and Nursing about issues related to access to	letter to the Centers for Medicare & Dedicard

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		and the quality of anesthesia services in the state and has	Services (CMS) signed by the governor, following
		concluded that it is in the best interests of the state's	consultation with the state's boards of medicine and
		citizens to opt out of the current doctor of medicine or	nursing, requesting exemption from doctor of medicine
		osteopathy supervision requirement, and that the opt-out	or osteopathy supervision for CRNAs. The letter from
		is consistent with state law. The request for exemption	the governor must attest that they have consulted with
		and recognition of state laws and the withdrawal of the	the state boards of medicine and nursing about issues
		request may be submitted at any time and are effective	related to access to and the quality of anesthesia
		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)(iii)	(iii) A doctor of dental surgery or	PC.03.01.01, EP 9	PC.13.01.01, EP 1
	dental medicine;	In accordance with the critical access hospital's policy	Anesthesia is administered only by the following
		and state scope of practice laws, anesthesia is	individuals:
		administered only by the following individuals:	- A qualified anesthesiologist
		- An anesthesiologist	- A doctor of medicine or osteopathy other than an
		- A doctor of medicine or osteopathy other than an	anesthesiologist, including an osteopathic practitioner
		anesthesiologist	recognized under section 1101(a)(7) of the Social
		- A doctor of dental surgery or dental medicine	Security Act
		- A doctor of podiatric medicine	- A doctor of dental surgery or dental medicine, who is
		- A certified registered nurse anesthetist (CRNA)	qualified to administer anesthesia under state law
		supervised by the operating practitioner except as	- A doctor of podiatric medicine, who is qualified to
		provided in 42 CFR 485.639(e) regarding the state	administer anesthesia under state law
		exemption for this supervision *	- A certified registered nurse anesthetist (CRNA), as
		- An anesthesiologist's assistant supervised by an	defined in 42 CFR 410.69(b) of this chapter, supervised
		anesthesiologist - A supervised trainee in an approved educational	by the operating practitioner, except as provided in 42 CFR 485.639(e) regarding the state exemption for this
		- A supervised trainee in an approved educational	OFF 400.009(e) regarding the state exemption for this

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
Our requirement		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 & Description of 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 & Dedicare and 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
§485.639(c)(1)(v)	(v) A certified registered nurse	PC.03.01.01, EP 9	sedation/analgesia. PC.13.01.01, EP 1
3.33.000(0)(1)(1)	anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter;	In accordance with the critical access hospital's policy and state scope of practice laws, anesthesia is	Anesthesia is administered only by the following individuals:

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		request may be submitted at any time and are effective	services in the state and has concluded that it is in the
		upon submission.	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	PC.03.01.01, EP 9	PC.13.01.01, EP 1
	approved educational program, as	In accordance with the critical access hospital's policy	Anesthesia is administered only by the following
	described in §413.85 or §§ 413.76	and state scope of practice laws, anesthesia is	individuals:
	through 413.83 of this chapter.	administered only by the following individuals:	- A qualified anesthesiologist
		- An anesthesiologist	- A doctor of medicine or osteopathy other than an
		- A doctor of medicine or osteopathy other than an	anesthesiologist, including an osteopathic practitioner
		anesthesiologist	recognized under section 1101(a)(7) of the Social
		- A doctor of dental surgery or dental medicine	Security Act
		- A doctor of podiatric medicine	- A doctor of dental surgery or dental medicine, who is
		- A certified registered nurse anesthetist (CRNA)	qualified to administer anesthesia under state law
		supervised by the operating practitioner except as	- A doctor of podiatric medicine, who is qualified to
		provided in 42 CFR 485.639(e) regarding the state	administer anesthesia under state law
		exemption for this supervision *	- A certified registered nurse anesthetist (CRNA), as
		- An anesthesiologist's assistant supervised by an	defined in 42 CFR 410.69(b) of this chapter, supervised
		anesthesiologist	by the operating practitioner, except as provided in 42
		- A supervised trainee in an approved educational	CFR 485.639(e) regarding the state exemption for this
		program	supervision
		Note: In accordance with 42 OFP 412 OF(a)	- An anesthesiologist's assistant, as defined in 42 CFR
		Note: In accordance with 42 CFR 413.85(e), an approved	410.69(b), supervised by an anesthesiologist
		nursing and allied health education program is a planned	- A supervised trainee in an approved educational
		program of study that is licensed by state law, or if	program
		licensing is not required, is accredited by a recognized	Note 1: In accordance with 42 CFR 413.85(e), an
		national professional organization. Such national	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	is a planned program of study that is licensed by state
		Commission on Accreditation of Allied Health Education	law, or if licensing is not required, is accredited by a
		Programs and the National League of Nursing Accrediting	recognized national professional organization. Such
		Commission.	national accrediting bodies include, but are not limited
		Footnote *: The CoP at 42 CFR 485.639(e) for state	to, the Commission on Accreditation of Allied Health
		exemption states: A critical access hospital may be	Education Programs and the National League of
		exempted from the requirement for doctor of medicine or	Nursing Accrediting Commission.
		osteopathy supervision of CRNAs if the state in which the	Note 2: See Glossary for the definition of certified
		critical access hospital is located submits a letter to the	registered nurse anesthetist (CRNA) and
		Centers for Medicare & Description (CMS)	anesthesiologist assistant.
		signed by the governor, following consultation with the	Note 3: The CoP at 42 CFR 485.639(e) for state
		state's Boards of Medicine and Nursing, requesting	exemption states: A critical access hospital may be
		exemption from doctor of medicine or osteopathy	exempted from the requirement for doctor of medicine
		supervision for CRNAs. The letter from the governor must	or osteopathy supervision of CRNAs if the state in
		attest that they have consulted with the state Boards of	which the critical access hospital is located submits a
		Medicine and Nursing about issues related to access to	letter to the Centers for Medicare & Dedicard
		and the quality of anesthesia services in the state and has	Services (CMS) signed by the governor, following
		concluded that it is in the best interests of the state's	consultation with the state's boards of medicine and
		citizens to opt out of the current doctor of medicine or	nursing, requesting exemption from doctor of medicine
		osteopathy supervision requirement, and that the opt-out	or osteopathy supervision for CRNAs. The letter from
		is consistent with state law. The request for exemption	the governor must attest that they have consulted with
		and recognition of state laws and the withdrawal of the	the state boards of medicine and nursing about issues
		request may be submitted at any time and are effective	related to access to and the quality of anesthesia
		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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.639(c)(2)	(2) In those cases in which a CRNA	PC.03.01.01, EP 9	PC.13.01.01, EP 1
	administers the anesthesia, the	In accordance with the critical access hospital's policy	Anesthesia is administered only by the following
	anesthetist must be under the	and state scope of practice laws, anesthesia is	individuals:
	supervision of the operating	administered only by the following individuals:	- A qualified anesthesiologist
	practitioner except as provided in	- An anesthesiologist	- A doctor of medicine or osteopathy other than an
	paragraph (e) of this section. An	- A doctor of medicine or osteopathy other than an	anesthesiologist, including an osteopathic practitioner
	anesthesiologist's assistant who	anesthesiologist	recognized under section 1101(a)(7) of the Social
	administers anesthesia must be	- A doctor of dental surgery or dental medicine	Security Act
	under the supervision of an	- A doctor of podiatric medicine	- A doctor of dental surgery or dental medicine, who is
	anesthesiologist.	- A certified registered nurse anesthetist (CRNA)	qualified to administer anesthesia under state law
		supervised by the operating practitioner except as	- A doctor of podiatric medicine, who is qualified to
		provided in 42 CFR 485.639(e) regarding the state	administer anesthesia under state law
		exemption for this supervision *	- A certified registered nurse anesthetist (CRNA), as
		- An anesthesiologist's assistant supervised by an	defined in 42 CFR 410.69(b) of this chapter, supervised
		anesthesiologist	by the operating practitioner, except as provided in 42
		- A supervised trainee in an approved educational	CFR 485.639(e) regarding the state exemption for this
		program	supervision
			- An anesthesiologist's assistant, as defined in 42 CFR
		Note: In accordance with 42 CFR 413.85(e), an approved	410.69(b), supervised by an anesthesiologist
		nursing and allied health education program is a planned	- A supervised trainee in an approved educational
		program of study that is licensed by state law, or if	program
		licensing is not required, is accredited by a recognized	Note 1: In accordance with 42 CFR 413.85(e), an
		national professional organization. Such national	approved nursing and allied health education program
		accrediting bodies include, but are not limited to, the	is a planned program of study that is licensed by state
		Commission on Accreditation of Allied Health Education	law, or if licensing is not required, is accredited by a
		Programs and the National League of Nursing Accrediting	recognized national professional organization. Such
		Commission.	national accrediting bodies include, but are not limited
		Footnote *: The CoP at 42 CFR 485.639(e) for state	to, the Commission on Accreditation of Allied Health
		exemption states: A critical access hospital may be	Education Programs and the National League of
		exempted from the requirement for doctor of medicine or	Nursing Accrediting Commission.
		osteopathy supervision of CRNAs if the state in which the	Note 2: See Glossary for the definition of certified
		critical access hospital is located submits a letter to the	registered nurse anesthetist (CRNA) and
		Centers for Medicare & Medicaid Services (CMS)	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	PC.03.01.01, EP 9	PC.13.01.01, EP 1
	the requirement for MD/DO	In accordance with the critical access hospital's policy	Anesthesia is administered only by the following
	supervision of CRNAs as	and state scope of practice laws, anesthesia is	individuals:
	described in paragraph (c)(2) of	administered only by the following individuals:	- A qualified anesthesiologist
	this section, if the State in which	- An anesthesiologist	- A doctor of medicine or osteopathy other than an
	the CAH is located submits a letter	- A doctor of medicine or osteopathy other than an	anesthesiologist, including an osteopathic practitioner
	to CMS signed by the Governor,	anesthesiologist	recognized under section 1101(a)(7) of the Social
	following consultation with the	- A doctor of dental surgery or dental medicine	Security Act
	State's Boards of Medicine and	- A doctor of podiatric medicine	- A doctor of dental surgery or dental medicine, who is
	Nursing, requesting exemption	- A certified registered nurse anesthetist (CRNA)	qualified to administer anesthesia under state law
	from MD/DO supervision for	supervised by the operating practitioner except as	- A doctor of podiatric medicine, who is qualified to
	CRNAs. The letter from the	provided in 42 CFR 485.639(e) regarding the state	administer anesthesia under state law
	Governor must attest that he or	exemption for this supervision *	- A certified registered nurse anesthetist (CRNA), as
	she has consulted with the State	- An anesthesiologist's assistant supervised by an	defined in 42 CFR 410.69(b) of this chapter, supervised
	Boards of Medicine and Nursing	anesthesiologist	by the operating practitioner, except as provided in 42
	about issues related to access to	- A supervised trainee in an approved educational	CFR 485.639(e) regarding the state exemption for this
	and the quality of anesthesia	program	supervision
	services in the State and has		- An anesthesiologist's assistant, as defined in 42 CFR
	concluded that it is in the best	Note: In accordance with 42 CFR 413.85(e), an approved	410.69(b), supervised by an anesthesiologist
	interests of the State's citizens to	nursing and allied health education program is a planned	- A supervised trainee in an approved educational
	opt-out of the current MD/DO	program of study that is licensed by state law, or if	program
	supervision requirement, and that	licensing is not required, is accredited by a recognized	Note 1: In accordance with 42 CFR 413.85(e), an
	the opt-out is consistent with	national professional organization. Such national	approved nursing and allied health education program
	State law.	accrediting bodies include, but are not limited to, the	is a planned program of study that is licensed by state
		Commission on Accreditation of Allied Health Education	law, or if licensing is not required, is accredited by a
		Programs and the National League of Nursing Accrediting	recognized national professional organization. Such
		Commission.	national accrediting bodies include, but are not limited
		Footnote *: The CoP at 42 CFR 485.639(e) for state	to, the Commission on Accreditation of Allied Health
		exemption states: A critical access hospital may be	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	Nursing Accrediting Commission.
		osteopathy supervision of CRNAs if the state in which the	Note 2: See Glossary for the definition of certified
		critical access hospital is located submits a letter to the	registered nurse anesthetist (CRNA) and
		Centers for Medicare & Description (CMS)	anesthesiologist assistant.
		signed by the governor, following consultation with the	Note 3: The CoP at 42 CFR 485.639(e) for state
		state's Boards of Medicine and Nursing, requesting	exemption states: A critical access hospital may be
		exemption from doctor of medicine or osteopathy	exempted from the requirement for doctor of medicine
		supervision for CRNAs. The letter from the governor must	or osteopathy supervision of CRNAs if the state in
		attest that they have consulted with the state Boards of	which the critical access hospital is located submits a
		Medicine and Nursing about issues related to access to	letter to the Centers for Medicare & Dedicard
		and the quality of anesthesia services in the state and has	Services (CMS) signed by the governor, following
		concluded that it is in the best interests of the state's	consultation with the state's boards of medicine and
		citizens to opt out of the current doctor of medicine or	nursing, requesting exemption from doctor of medicine
		osteopathy supervision requirement, and that the opt-out	or osteopathy supervision for CRNAs. The letter from
		is consistent with state law. The request for exemption	the governor must attest that they have consulted with
		and recognition of state laws and the withdrawal of the	the state boards of medicine and nursing about issues
		request may be submitted at any time and are effective	related to access to and the quality of anesthesia
		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(e)(2)	(2) The request for exemption and	PC.03.01.01, EP 9	PC.13.01.01, EP 1
	recognition of State laws and the	In accordance with the critical access hospital's policy	Anesthesia is administered only by the following
	withdrawal of the request may be	and state scope of practice laws, anesthesia is	individuals:
	submitted at any time, and are	administered only by the following individuals:	- A qualified anesthesiologist
	effective upon submission.	- An anesthesiologist	- A doctor of medicine or osteopathy other than an
		- 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	recognized under section 1101(a)(7) of the Social
		- A doctor of dental surgery or dental medicine	Security Act
		- A doctor of podiatric medicine	- A doctor of dental surgery or dental medicine, who is
		- A certified registered nurse anesthetist (CRNA)	qualified to administer anesthesia under state law
		supervised by the operating practitioner except as	- A doctor of podiatric medicine, who is qualified to
		provided in 42 CFR 485.639(e) regarding the state	administer anesthesia under state law
		exemption for this supervision *	- A certified registered nurse anesthetist (CRNA), as
		- An anesthesiologist's assistant supervised by an	defined in 42 CFR 410.69(b) of this chapter, supervised
		anesthesiologist	by the operating practitioner, except as provided in 42
		- A supervised trainee in an approved educational	CFR 485.639(e) regarding the state exemption for this
		program	supervision
			- An anesthesiologist's assistant, as defined in 42 CFR
		Note: In accordance with 42 CFR 413.85(e), an approved	410.69(b), supervised by an anesthesiologist
		nursing and allied health education program is a planned	- A supervised trainee in an approved educational
		program of study that is licensed by state law, or if	program
		licensing is not required, is accredited by a recognized	Note 1: In accordance with 42 CFR 413.85(e), an
		national professional organization. Such national	approved nursing and allied health education program
		accrediting bodies include, but are not limited to, the	is a planned program of study that is licensed by state
		Commission on Accreditation of Allied Health Education	law, or if licensing is not required, is accredited by a
		Programs and the National League of Nursing Accrediting	recognized national professional organization. Such
		Commission.	national accrediting bodies include, but are not limited
		Footnote *: The CoP at 42 CFR 485.639(e) for state	to, the Commission on Accreditation of Allied Health
		exemption states: A critical access hospital may be	Education Programs and the National League of
		exempted from the requirement for doctor of medicine or	Nursing Accrediting Commission.
		osteopathy supervision of CRNAs if the state in which the	Note 2: See Glossary for the definition of certified
		critical access hospital is located submits a letter to the	registered nurse anesthetist (CRNA) and
		Centers for Medicare & Description (CMS)	anesthesiologist assistant.
		signed by the governor, following consultation with the	Note 3: The CoP at 42 CFR 485.639(e) for state
		state's Boards of Medicine and Nursing, requesting	exemption states: A critical access hospital may be
		exemption from doctor of medicine or osteopathy	exempted from the requirement for doctor of medicine
		supervision for CRNAs. The letter from the governor must	or osteopathy supervision of CRNAs if the state in
		attest that they have consulted with the state Boards of	which the critical access hospital is located submits a
		Medicine and Nursing about issues related to access to	letter to the Centers for Medicare & Dedicard

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		and the quality of anesthesia services in the state and has	Services (CMS) signed by the governor, following
		concluded that it is in the best interests of the state's	consultation with the state's boards of medicine and
		citizens to opt out of the current doctor of medicine or	nursing, requesting exemption from doctor of medicine
		osteopathy supervision requirement, and that the opt-out	or osteopathy supervision for CRNAs. The letter from
		is consistent with state law. The request for exemption	the governor must attest that they have consulted with
		and recognition of state laws and the withdrawal of the	the state boards of medicine and nursing about issues
		request may be submitted at any time and are effective	related to access to and the quality of anesthesia
		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.
§485.640	§485.640 Condition of	EC.02.05.01, EP 15	IC.04.01.01, EP 2
	participation: Infection prevention	In critical care areas designed to control airborne	The infection preventionist(s) or infection control
	and control and antibiotic	contaminants (such as biological agents, gases, fumes,	professional(s) is responsible for the following:
	stewardship programs. The CAH	dust), the ventilation system provides appropriate	- Development and implementation of hospitalwide
	must have active hospital-wide	pressure relationships, air-exchange rates, filtration	infection surveillance, prevention, and control policies
	programs for the surveillance,	efficiencies, temperature, and humidity. For new and	and procedures that adhere to law and regulation and
	prevention, and control of HAIs	existing health care facilities, or altered, renovated, or	nationally recognized guidelines
	and other infectious diseases, and	modernized portions of existing systems or individual	- Documentation of the infection prevention and control
	for the optimization of antibiotic	components (constructed or plans approved on or after	program and its surveillance, prevention, and control
	use through stewardship. The	July 5, 2016), heating, cooling, and ventilation are in	activities
	programs must demonstrate	accordance with NFPA 99-2012, which includes 2008	- Competency-based training and education of critical
	adherence to nationally	ASHRAE 170, or state design requirements if more	access hospital personnel and staff, including medical
	recognized infection prevention	stringent.	staff and, as applicable, personnel providing contracted
	and control guidelines, as well as	Note 1: Existing facilities may elect to implement a	services in the critical access hospital, on infection
	to best practices for improving	Centers for Medicare & Description (CMS)	prevention and control guidelines, policies and
	antibiotic use where applicable,	categorical waiver to reduce their relative humidity to 20%	procedures and their application

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		IC.05.01.01, EP 1	administrative leaders).
		The critical access hospital's governing body, or	
		responsible individual, is responsible for the	IC.06.01.01, EP 3
		implementation, performance, and sustainability of the	The critical access hospital implements activities for
		infection prevention and control program and provides	the surveillance, prevention, and control of health care–
		resources to support and track the implementation,	associated infections and other infectious diseases,
		success, and sustainability of the program's activities.	including maintaining a clean and sanitary environment
		Note: To make certain that systems are in place and	to avoid sources and transmission of infection, and
		operational to support the program, the governing body,	addresses any infection control issues identified by
		or responsible individual, provides access to information	public health authorities that could impact the critical
		technology; laboratory services; equipment and supplies;	access hospital.
		local, state, and federal public health authorities'	
		advisories and alerts, such as the CDC's Health Alert	MM.18.01.01, EP 1
		Network (HAN); FDA alerts; manufacturers' instructions	The antibiotic stewardship program reflects the scope
		for use; and guidelines used to inform policies.	and complexity of the critical access hospital services
			provided.
		IC.05.01.01, EP 2	
		The critical access hospital's governing body, or	MM.18.01.01, EP 3
		responsible individual, ensures that the problems	The leader(s) of the antibiotic stewardship program is
		identified by the infection prevention and control program	responsible for the following:
		are addressed in collaboration with critical access	- Development and implementation a critical access
		hospital quality assessment and performance	hospitalwide antibiotic stewardship program, based on
		improvement leaders and other leaders (for example, the	nationally recognized guidelines, to monitor and
		medical director, nurse executive, and administrative	improve the use of antibiotics.
		leaders).	- All documentation, written or electronic, of antibiotic
		10 00 04 04 FD 0	stewardship program activities.
		IC.06.01.01, EP 3	- Communication and collaboration with medical staff,
		The critical access hospital implements activities for the	nursing, and pharmacy leadership, as well as with the
		surveillance, prevention, and control of health care-	critical access hospital's infection prevention and
		associated infections and other infectious diseases,	control and QAPI programs, on antibiotic use issues.
		including maintaining a clean and sanitary environment	- Competency-based training and education of critical
		to avoid sources and transmission of infection, and	access hospital personnel and staff, including medical
		addresses any infection control issues identified by	staff, and, as applicable, personnel providing

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		public health authorities that could impact the critical	contracted services in the critical access hospital, on
		access hospital.	the practical applications of antibiotic stewardship
			guidelines, policies, and procedures.
		MM.09.01.01, EP 10	
		The critical access hospital allocates financial resources	PE.04.01.01, EP 1
		for staffing and information technology to support the	The critical access hospital meets the applicable
		antibiotic stewardship program.	provisions and proceeds in accordance with the Health
		MM 00 04 04 ED 40	Care Facilities Code (NFPA 99-2012 and Tentative
		MM.09.01.01, EP 12	Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and
		The leader(s) of the antibiotic stewardship program is	12-6).
		responsible for the following:	Note 1: Chapters 7, 8, 12, and 13 of the Health Care
		- Developing and implementing a hospitalwide antibiotic	Facilities Code do not apply.
		stewardship program that is based on nationally recognized guidelines to monitor and improve the use of	Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the critical
		antibiotics	access hospital, the Centers for Medicare & December 1975
		- Documenting antibiotic stewardship activities, including	Medicaid Services may waive specific provisions of the
		any new or sustained improvements	Health Care Facilities Code, but only if the waiver does
		- Communicating and collaborating with the medical	not adversely affect the health and safety of patients.
		staff, nursing leaders, and pharmacy leaders, as well as	Note 3: All inspecting activities are documented with
		with the critical access hospital's infection prevention	the name of the activity; date of the activity; inventory of
		and control and quality assessment and performance	devices, equipment, or other items; required frequency;
		improvement programs on antibiotic use issues	name and contact information of person who
		- Providing competency-based training and education for	performed the activity; NFPA standard(s) referenced for
		staff on the practical applications of antibiotic	the activity; and results of the activity.
		stewardship guidelines, policies, and procedures	
§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),	HR.01.01.01, EP 1	HR.11.02.01, EP 1
	who is qualified through	The critical access hospital defines staff qualifications	The critical access hospital defines staff qualifications
	education, training, experience, or	specific to their job responsibilities.	specific to their job responsibilities.
	certification in infection	Note 1: Qualifications for infection control may be met	Note 1: Qualifications for infection control may be met

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
CoP Requirement	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, speechlanguage 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, speechlanguage 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, speechlanguage 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
§485.640(a)(2)	(2) The infection prevention and	IC.04.01.01, EP 3	program. IC.04.01.01, EP 3
3403.040(a)(2)	control program, as documented	The critical access hospital's infection prevention and	The critical access hospital's infection prevention and

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		treatment systems, processing steps, control measures,	IC.06.01.01, EP 4
		and end-use points	The critical access hospital implements its policies and
		Note: An example would be a flow chart with symbols	procedures for infectious disease outbreaks, including
		showing sinks, showers, water fountains, ice machines,	the following:
		and so forth.	- Implementing infection prevention and control
		- A water risk management plan based on the diagram	activities when an outbreak is first recognized by
		that includes an evaluation of the physical and chemical	internal surveillance or public health authorities
		conditions of each step of the water flow diagram to	- Reporting an outbreak in accordance with state and
		identify any areas where potentially hazardous conditions	local public health authorities' requirements
		may occur (these conditions are most likely to occur in	- Investigating an outbreak
		areas with slow or stagnant water)	- Communicating information necessary to prevent
		Note: Refer to the Centers for Disease Control and	further transmission of the infection among patients,
		Prevention's "Water Infection Control Risk Assessment	visitors, and staff, as appropriate
		(WICRA) for Healthcare Settings" tool as an example for	
		conducting a water-related risk assessment.	IC.06.01.01, EP 5
		- A plan for addressing the use of water in areas of	The critical access hospital implements policies and
		buildings where water may have been stagnant for a	procedures to minimize the risk of communicable
		period of time (for example, unoccupied or temporarily	disease exposure and acquisition among its staff, in
		closed areas)	accordance with law and regulation. The policies and
		- An evaluation of the patient populations served to	procedures address the following:
		identify patients who are immunocompromised	- Screening and medical evaluations for infectious
		- Monitoring protocols and acceptable ranges for control	diseases
		measures	- Immunizations
		Note: Critical access hospitals should consider	- Staff education and training
		incorporating basic practices for water monitoring within	- Management of staff with potentially infectious
		their water management programs that include	exposures or communicable illnesses
		monitoring of water temperature, residual disinfectant,	DE 04 04 04 ED 4
		and pH. In addition, protocols should include specificity	PE.01.01.01, EP 1
		around the parameters measured, locations where	The critical access hospital's building is constructed,
		measurements are made, and appropriate corrective	arranged, and maintained to allow safe access and to
		actions taken when parameters are out of range.	protect the safety and well-being of patients.
		EC 02.06.05 ED 2	Note 1: Diagnostic and therapeutic facilities are located
		EC.02.06.05, EP 2	in areas appropriate for the services provided.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		When planning for demolition, construction, renovation,	Note 2: When planning for new, altered, or renovated
		or general maintenance, the critical access hospital	space, the critical access hospital uses state rules and
		conducts a preconstruction risk assessment for air	regulations or the current Guidelines for Design and
		quality requirements, infection control, utility	Construction of Hospitals published by the Facility
		requirements, noise, vibration, and other hazards that	Guidelines Institute. If the state rules and regulations or
		affect care, treatment, and services and mitigates the	the Guidelines do not address the design needs of the
		identified risks.	critical access hospital, then it uses other reputable
		Note: See LS.01.02.01 for information on fire safety	standards and guidelines that provide equivalent design
		procedures to implement during construction or	criteria.
		renovation.	DE 04 04 05 ED 4
		EC 02 06 05 ED 2	PE.04.01.05, EP 1
		EC.02.06.05, EP 3	The water management program has an individual or a
		The critical access hospital takes action based on its assessment to minimize risks during demolition,	team responsible for the oversight and implementation of the program, including but not limited to
		construction, renovation, or general maintenance.	development, management, and maintenance
		construction, renovation, or general maintenance.	activities.
		IC.06.01.01, EP 3	dottvittos.
		The critical access hospital implements activities for the	PE.04.01.05, EP 2
		surveillance, prevention, and control of health care–	The individual or team responsible for the water
		associated infections and other infectious diseases,	management program develops the following:
		including maintaining a clean and sanitary environment	- A basic diagram that maps all water supply sources,
		to avoid sources and transmission of infection, and	treatment systems, processing steps, control
		addresses any infection control issues identified by	measures, and end-use points
		public health authorities that could impact the critical	Note: An example would be a flow chart with symbols
		access hospital.	showing sinks, showers, water fountains, ice machines,
			and so forth.
		IC.06.01.01, EP 4	- A water risk management plan based on the diagram
		The critical access hospital implements its policies and	that includes an evaluation of the physical and
		procedures for infectious disease outbreaks, including	chemical conditions of each step of the water flow
		the following:	diagram to identify any areas where potentially
		- Implementing infection prevention and control activities	hazardous conditions may occur (these conditions are
		when an outbreak is first recognized by internal	most likely to occur in areas with slow or stagnant
		surveillance or public health authorities	water)

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	in infectious diseases and/or	or experience in infectious diseases and/or antibiotic	education, training, or experience in infectious diseases
	antibiotic stewardship, is	stewardship as the leader(s) of the antibiotic stewardship	and/or antibiotic stewardship, is appointed by the
	appointed by the governing body,	program.	governing body, or responsible individual, as the
	or responsible individual, as the	Note: The appointment(s) is based on recommendations	leader(s) of the antibiotic stewardship program and that
	leader(s) of the antibiotic	of medical staff leaders and pharmacy leaders.	the appointment is based on the recommendations of
	stewardship program and that the		medical staff leadership and pharmacy leadership.
	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	MM.09.01.01, EP 14	MM.18.01.01, EP 5
	among all components of the CAH	The antibiotic stewardship program demonstrates	The critical access hospitalwide antibiotic stewardship
	responsible for antibiotic use and	coordination among all components of the critical access	program:
	resistance, including, but not	hospital responsible for antibiotic use and resistance,	- Demonstrates coordination among all components of
	limited to, the infection prevention	including, but not limited to, the infection prevention and	the critical access hospital responsible for antibiotic
	and control program, the QAPI	control program, the quality assessment and	use and resistance, including, but not limited to, the
	program, the medical staff,	performance improvement program, the medical staff,	infection prevention and control program, the QAPI
	nursing services, and pharmacy	nursing services, and pharmacy services.	program, the medical staff, nursing services, and
	services;		pharmacy services.
			- Documents the evidence-based use of antibiotics in
			all departments and services of the critical access
			hospital Documents any improvements, including sustained
§485.640(b)(2)(ii)	(ii) Documents the evidence-	MM.09.01.01, EP 15	improvements, in proper antibiotic use. MM.18.01.01, EP 5
340J.040(D)(Z)(II)	based use of antibiotics in all	The antibiotic stewardship program documents the	The critical access hospitalwide antibiotic stewardship
	departments and services of the	evidence-based use of antibiotics in all departments and	program:
	CAH; and	services of the critical access hospital.	- Demonstrates coordination among all components of
	Orari, and	Solvioco of the offical access hospital.	the critical access hospital responsible for antibiotic
			use and resistance, including, but not limited to, the
			infection prevention and control program, the QAPI
			integration provention and control program, the QAFT

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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	MM.09.01.01, EP 12	MM.18.01.01, EP 5
	improvements, including sustained improvements, in proper antibiotic use;	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.	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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.640(b)(3)	(3) The antibiotic stewardship	MM.09.01.01, EP 21 The critical access hospital takes action on improvement opportunities identified by the antibiotic stewardship program. MM.09.01.01, EP 17	MM.18.01.01, EP 6
	program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use; and	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	The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.
		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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§485.640(b)(4)	(4) The antibiotic stewardship program reflects the scope and complexity of the CAH services provided.	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. 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	MM.18.01.01, EP 1 The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.
		The antibiotic stewardship program documents the	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		evidence-based use of antibiotics in all departments and services of the critical access hospital.	
§485.640(c)	(c) Standard: Leadership responsibilities.	services of the chilical access hospital.	
\$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	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.
		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	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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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).	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	MM.18.01.01, EP 4 The governing body, or responsible individual, ensures

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		responsible for the following:	all antibiotic use issues identified by the antibiotic
		- Developing and implementing a hospitalwide antibiotic	stewardship program are addressed in collaboration
		stewardship program that is based on nationally	with the critical access hospital's QAPI leadership.
		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.	
§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	IC.04.01.01, EP 2	IC.04.01.01, EP 2
	implementation of facility-wide	The infection preventionist(s) or infection control	The infection preventionist(s) or infection control
	infection surveillance, prevention,	professional(s) is responsible for the following:	professional(s) is responsible for the following:
	and control policies and	- Development and implementation of hospitalwide	- Development and implementation of hospitalwide
	procedures that adhere to	infection surveillance, prevention, and control policies	infection surveillance, prevention, and control policies
	nationally recognized guidelines.	and procedures that adhere to law and regulation and	and procedures that adhere to law and regulation and

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

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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- 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
§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	HR.11.04.01 EP 1). IC.04.01.01, EP 2 The infection preventionist(s) or infection control professional(s) is responsible for the following: - Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines - Documentation of the infection prevention and control program and its surveillance, prevention, and control activities - Competency-based training and education of 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	stewardship program that is based on nationally	hospitalwide antibiotic stewardship program, based on
programs, on antibiotic use issues.	recognized guidelines to monitor and improve the use of	nationally recognized guidelines, to monitor and
	antibiotics	improve the use of antibiotics.
	- Documenting antibiotic stewardship activities, including	- All documentation, written or electronic, of antibiotic
	any new or sustained improvements	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
	stewardship guidelines, policies, and procedures	contracted services in the critical access hospital, on
		the practical applications of antibiotic stewardship
1	NM 00 04 04 10	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
l		nationally recognized guidelines, to monitor and
		improve the use of antibiotics.
	-	- All documentation, written or electronic, of antibiotic stewardship program activities.
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
	prevention and control and QAPI	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 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

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

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

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

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

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

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

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

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	implement, and maintain an	- Improving the safety and quality of care, treatment, or	performance improvement program.
	effective, ongoing, CAH-wide,	services in order to achieve the goals of the performance	Note: For rehabilitation and psychiatric distinct part
	data-driven quality assessment	improvement program - Creating a culture of safety and quality	units in critical access hospitals: The critical access hospital maintains and demonstrates evidence of its
	and performance improvement (QAPI) program. The CAH must	- Decision making that supports the safety and quality of	QAPI program for review by CMS.
	maintain and demonstrate	care, treatment, and services	QAFT program for review by CP13.
	evidence of the effectiveness of its	- Identifying and responding to internal and external	
	QAPI program.	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	
		- 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:	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		see Standard LD.04.03.09)	related to improved health outcomes and the
		Note: For rehabilitation and psychiatric distinct part units	prevention and reduction of medical errors and
		in critical access hospitals: The critical access hospital is	objective measures to evaluate its organizational
		not required to participate in a quality improvement	processes, functions, and services. (For more
		organization (QIO) cooperative project, but its own	information on contracted services, see Standard
		projects are required to be of comparable effort.	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	LD.01.03.01, EP 21	LD.11.01.01, EP 8
3465.041(b)(5)	CAH and services (including those	The governing body is responsible for the performance	The governing body or designated individual is
	services furnished under contract	improvement program. The governing body makes sure	responsible and accountable for the quality
	or arrangement).	that performance improvement activities reflect the	assessment and performance improvement program.
	or arrangement).	complexity of the critical access hospital's organization	The governing body makes sure that performance
		and services; are ongoing and comprehensive; involve all	improvement activities reflect the complexity of the
		departments and services, including those services	critical access hospital's organization and services; are
		provided under contract; and use objective measures to	ongoing and comprehensive; involve all departments
		evaluate its organizational processes, functions, and	and services, including those services provided under
		services. (For more information on contracted services,	contract or arrangement; and focuses on indicators
		see Standard LD.04.03.09)	related to improved health outcomes and the
		Note: For rehabilitation and psychiatric distinct part units	prevention and reduction of medical errors and
		in critical access hospitals: The critical access hospital is	objective measures to evaluate its organizational
		not required to participate in a quality improvement	processes, functions, and services. (For more
		organization (QIO) cooperative project, but its own	information on contracted services, see Standard
		projects are required to be of comparable effort.	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	LD.01.03.01, EP 21	LD.11.01.01, EP 8
	evaluate its organizational	The governing body is responsible for the performance	The governing body or designated individual is
	processes, functions and services.	improvement program. The governing body makes sure	responsible and accountable for the quality

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	meets the requirements of	provided under contract; and use objective measures to	ongoing and comprehensive; involve all departments
	paragraph (b) of this section.	evaluate its organizational processes, functions, and	and services, including those services provided under
		services. (For more information on contracted services,	contract or arrangement; and focuses on indicators
		see Standard LD.04.03.09)	related to improved health outcomes and the
		Note: For rehabilitation and psychiatric distinct part units	prevention and reduction of medical errors and
		in critical access hospitals: The critical access hospital is	objective measures to evaluate its organizational
		not required to participate in a quality improvement	processes, functions, and services. (For more
		organization (QIO) cooperative project, but its own	information on contracted services, see Standard
		projects are required to be of comparable effort.	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	LD.03.07.01, EP 2	LD.12.01.01, EP 2
	improved health outcomes that	As part of performance improvement, leaders (including	As part of performance improvement, leaders
	are shown to be predictive of	the governing body) do the following:	(including the governing body) do the following:
	desired patient outcomes.	- Set priorities for performance improvement activities	- Set priorities for performance improvement activities
		and patient health outcomes	related to improved health outcomes that are shown to
		- Give priority to high-volume, high-risk, or problem-prone	be predictive of desired patient outcomes, patient
		processes for performance improvement activities	safety, and quality of care
		- Identify the frequency of data collection for performance	- Give priority to high-volume, high-risk, or problem-
		improvement activities	prone processes for performance improvement
		- Reprioritize performance improvement activities in	activities and consider the incidence, prevalence, and
		response to changes in the internal or external	severity of problems in those areas
		environment	- 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	PI.03.01.01, EP 3	LD.12.01.01, EP 2
	and track its performance.	The critical access hospital uses statistical tools and	As part of performance improvement, leaders

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		techniques to analyze and display data.	(including the governing body) do the following: - Set priorities for performance improvement activities
		PI.03.01.01, EP 4	related to improved health outcomes that are shown to
		The critical access hospital analyzes and compares	be predictive of desired patient outcomes, patient
		internal data over time to identify levels of performance,	safety, and quality of care
		patterns, trends, and variations.	- Give priority to high-volume, high-risk, or problem-
			prone processes for performance improvement
		PI.03.01.01, EP 8	activities and consider the incidence, prevalence, and
		The critical access hospital uses the results of data	severity of problems in those areas
		analysis to identify improvement opportunities.	- 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	LD.03.07.01, EP 2	LD.12.01.01, EP 2
	improvement, considering either	As part of performance improvement, leaders (including	As part of performance improvement, leaders
	high-volume, high-risk services, or	the governing body) do the following:	(including the governing body) do the following:
	problem-prone areas.	- Set priorities for performance improvement activities	- Set priorities for performance improvement activities
		and patient health outcomes	related to improved health outcomes that are shown to
		- Give priority to high-volume, high-risk, or problem-prone	be predictive of desired patient outcomes, patient
		processes for performance improvement activities	safety, and quality of care
		- Identify the frequency of data collection for performance	- Give priority to high-volume, high-risk, or problem-
		improvement activities	prone processes for performance improvement
		- Reprioritize performance improvement activities in	activities and consider the incidence, prevalence, and
		response to changes in the internal or external environment	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	LD.03.02.01, EP 1	PI.11.01.01, EP 2
3700.041(6)	collection and analysis. The	Leaders set expectations for using data and information,	The critical access hospital has an ongoing quality
	program must incorporate quality	including patient care data and other relevant data, for	assessment and performance improvement program
	indicator data including patient	the following:	that shows measurable improvement for indicators that
	care data, and other relevant data,	- Improving the safety and quality of care, treatment, or	are selected based on evidence that they will improve
	in order to achieve the goals of the	services in order to achieve the goals of the performance	health outcomes and aid in the identification and
	QAPI program.	improvement program	reduction of medical errors. The program incorporates

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	unified and integrated QAPI	state and local laws. The system governing body is	is in accordance with all applicable state and local
	program for all of its member	responsible and accountable for making certain that each	laws. Each separately certified critical access hospital
	facilities after determining that	of its separately certified critical access hospitals meets	subject to the system governing body demonstrates
	such a decision is in accordance	the requirements for quality assessment and	that the unified and integrated quality assessment and
	with all applicable State and local	performance improvement at 42 CFR 485.641.	performance improvement program does the following:
	laws. The system governing body is		- Accounts for each member critical access hospital's
	responsible and accountable for	Each separately certified critical access hospital subject	unique circumstances and any significant differences in
	ensuring that each of its separately	to the system governing body demonstrates that the	patient populations and services offered
	certified CAHs meets all of the	unified and integrated quality assessment and	- Establishes and implements policies and procedures
	requirements of this section. Each	performance improvement program does the following:	to make certain that the needs and concerns of each of
	separately certified CAH subject to	- Accounts for each member critical access hospital's	its separately certified hospitals, regardless of practice
	the system governing body must	unique circumstances and any significant differences in	or location, are given due consideration, and that the
	demonstrate that:	patient populations and services offered in each critical	unified and integrated program has mechanisms in
		access hospital	place to ensure that issues localized to particular
		- Establishes and implements policies and procedures to	critical access hospitals are duly considered and
		make certain that the needs and concerns of each of its	addressed
		separately certified hospitals, regardless of practice or	Note: The system governing body is responsible and
		location, are given due consideration, and that the unified	accountable for making certain that each of its
		and integrated program has mechanisms in place to	separately certified critical access hospitals meets the
		ensure that issues localized to particular hospitals are	requirements for quality assessment and performance
		duly considered and addressed	improvement at 42 CFR 485.641.
§485.641(f)(1)	(1) The unified and integrated	LD.01.03.01, EP 14	LD.11.01.01, EP 9
	QAPI program is established in a	If a critical access hospital is part of a system consisting	If a critical access hospital is part of a system
	manner that takes into account	of multiple separately accredited hospitals, critical	consisting of multiple separately accredited hospitals,
	each member CAH's unique	access hospitals, and/or rural emergency hospitals using	critical access hospitals, and/or rural emergency
	circumstances and any significant	a system governing body that is legally responsible for the	hospitals using a system governing body that is legally
	differences in patient populations	conduct of two or more hospitals, critical access	responsible for the conduct of two or more hospitals,
	and services offered in each CAH;	hospitals, and/or rural emergency hospitals, the system	critical access hospitals, and/or rural emergency
	and	governing body can elect to have a unified and integrated	hospitals, the system governing body can elect to have
		quality assessment and performance improvement	a unified and integrated quality assessment and
		program for all of its member facilities after determining	performance improvement program for all of its
		that such decision is in accordance with all applicable	member facilities after determining that such decision
		state and local laws. The system governing body is	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	laws. Each separately certified critical access hospital
		of its separately certified critical access hospitals meets	subject to the system governing body demonstrates
		the requirements for quality assessment and	that the unified and integrated quality assessment and
		performance improvement at 42 CFR 485.641.	performance improvement program does the following:
			- Accounts for each member critical access hospital's
		Each separately certified critical access hospital subject	unique circumstances and any significant differences in
		to the system governing body demonstrates that the	patient populations and services offered
		unified and integrated quality assessment and	- Establishes and implements policies and procedures
		performance improvement program does the following:	to make certain that the needs and concerns of each of
		- Accounts for each member critical access hospital's	its separately certified hospitals, regardless of practice
		unique circumstances and any significant differences in	or location, are given due consideration, and that the
		patient populations and services offered in each critical	unified and integrated program has mechanisms in
		access hospital	place to ensure that issues localized to particular
		- Establishes and implements policies and procedures to	critical access hospitals are duly considered and
		make certain that the needs and concerns of each of its	addressed
		separately certified hospitals, regardless of practice or	Note: The system governing body is responsible and
		location, are given due consideration, and that the unified	accountable for making certain that each of its
		and integrated program has mechanisms in place to	separately certified critical access hospitals meets the
		ensure that issues localized to particular hospitals are	requirements for quality assessment and performance
		duly considered and addressed	improvement at 42 CFR 485.641.
§485.641(f)(2)	(2) The unified and integrated QAPI	LD.01.03.01, EP 14	LD.11.01.01, EP 9
	program establishes and	If a critical access hospital is part of a system consisting	If a critical access hospital is part of a system
	implements policies and	of multiple separately accredited hospitals, critical	consisting of multiple separately accredited hospitals,
	procedures to ensure that the	access hospitals, and/or rural emergency hospitals using	critical access hospitals, and/or rural emergency
	needs and concerns of each of its	a system governing body that is legally responsible for the	hospitals using a system governing body that is legally
	separately certified CAHs,	conduct of two or more hospitals, critical access	responsible for the conduct of two or more hospitals,
	regardless of practice or location,	hospitals, and/or rural emergency hospitals, the system	critical access hospitals, and/or rural emergency
	are given due consideration, and	governing body can elect to have a unified and integrated	hospitals, the system governing body can elect to have
	that the unified and integrated	quality assessment and performance improvement	a unified and integrated quality assessment and
	QAPI program has mechanisms in	program for all of its member facilities after determining	performance improvement program for all of its
	place to ensure that issues	that such decision is in accordance with all applicable	member facilities after determining that such decision
	localized to particular CAHs are	state and local laws. The system governing body is	is in accordance with all applicable state and local
	duly considered and addressed.	responsible and accountable for making certain that each	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	subject to the system governing body demonstrates
		the requirements for quality assessment and	that the unified and integrated quality assessment and
		performance improvement at 42 CFR 485.641.	performance improvement program does the following:
			- Accounts for each member critical access hospital's
		Each separately certified critical access hospital subject	unique circumstances and any significant differences in
		to the system governing body demonstrates that the	patient populations and services offered
		unified and integrated quality assessment and	- Establishes and implements policies and procedures
		performance improvement program does the following:	to make certain that the needs and concerns of each of
		- Accounts for each member critical access hospital's	its separately certified hospitals, regardless of practice
		unique circumstances and any significant differences in	or location, are given due consideration, and that the
		patient populations and services offered in each critical	unified and integrated program has mechanisms in
		access hospital	place to ensure that issues localized to particular
		- Establishes and implements policies and procedures to	critical access hospitals are duly considered and
		make certain that the needs and concerns of each of its	addressed
		separately certified hospitals, regardless of practice or	Note: The system governing body is responsible and
		location, are given due consideration, and that the unified	accountable for making certain that each of its
		and integrated program has mechanisms in place to	separately certified critical access hospitals meets the
		ensure that issues localized to particular hospitals are	requirements for quality assessment and performance
		duly considered and addressed	improvement at 42 CFR 485.641.
§485.642	§ 485.642 Condition of	PC.04.01.03, EP 7	PC.14.01.01, EP 1
	participation: Discharge planning.	The critical access hospital has an effective discharge	The critical access hospital has an effective discharge
	A Critical Access Hospital (CAH)	planning process that focuses on the patient's goals and	planning process that focuses on, and is consistent
	must have an effective discharge	treatment preferences and includes the patient and the	with, the patient's goals and treatment preferences;
	planning process that focuses on	patient's caregiver or support person(s) as active partners	makes certain there is an effective transition of the
	the patient's goals and treatment	in the discharge planning for post-discharge care. The	patient from the critical access hospital to
	preferences and includes the	discharge planning process is consistent with the	postdischarge care; and reduces the factors leading to
	patient and his or her	patient's goals for care and their treatment preferences,	preventable critical access hospital and hospital
	caregivers/support person(s) as	makes certain that there is an effective transition of the	readmissions.
	active partners in the discharge	patient from the hospital to post-discharge care, and	Note: The critical access hospital's discharge planning
	planning for post-discharge care.	reduces the factors leading to preventable critical access	process requires regular reevaluation of the patient's
	The discharge planning process	hospital readmissions.	condition to identify changes that require modification
	and the discharge plan must be		of the discharge plan. The discharge plan is updated as
	consistent with the patient's goals		needed to reflect these changes.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	for care and his or her treatment		
	preferences, ensure an effective		PC.14.01.01, EP 4
	transition of the patient from the		The patient, the patient's caregiver(s) or support
	CAH to post-discharge care, and		person(s), physicians, other licensed practitioners,
	reduce the factors leading to		clinical psychologists, and staff who are involved in the
	preventable CAH and hospital		patient's care, treatment, and services participate in
	readmissions.		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 & Defication of the Medicare & Deficient & Deficient & Deficient & Deficient & Deficient & Deficient & De
			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
			ontioat access hospital senus a copy of the hotice to a

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			representative of the office of the state's long-term care
			ombudsman.
§485.642(a)	(a) Standard: Discharge planning	PC.04.01.03, EP 2	PC.14.01.01, EP 2
	process. The CAH's discharge	The critical access hospital identifies any needs the	The critical access hospital begins the discharge
	planning process must identify, at	patient may have for psychosocial or physical care,	planning process early in the patient's episode of care,
	an early stage of hospitalization,	treatment, and services after discharge or transfer.	treatment, and services.
	those patients who are likely to	DO 04 04 02 FD 4	DO 14 01 01 FD 5
	suffer adverse health	PC.04.01.03, EP 4	PC.14.01.01, EP 5
	consequences upon discharge in the absence of adequate	Prior to discharge, the critical access hospital arranges or assists in arranging the services required by the patient	The critical access hospital performs a discharge planning evaluation and creates a discharge plan for
	discharge planning and must	after discharge in order to meet the patient's ongoing	those patients it identifies at an early stage of
	provide a discharge planning	needs for care and services.	hospitalization are likely to suffer adverse health
	evaluation for those patients so		consequences upon discharge in the absence of
	identified as well as for other		adequate discharge planning or at the request of the
	patients upon the request of the		patient, patient's representative, or the patient's
	patient, patient's representative,		physician.
	or 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	PC.04.01.03, EP 1	PC.14.01.01, EP 5
0 10010 12(d)(1)	evaluation must be made on a	The critical access hospital begins the discharge planning	The critical access hospital performs a discharge
	timely basis to ensure that	process early in the patient's episode of care, treatment,	planning evaluation and creates a discharge plan for
	appropriate arrangements for	and services.	those patients it identifies at an early stage of
	post-CAH care will be made before		hospitalization are likely to suffer adverse health
	discharge and to avoid	PC.04.01.03, EP 2	consequences upon discharge in the absence of
	unnecessary delays in discharge.	The critical access hospital identifies any needs the	adequate discharge planning or at the request of the
		patient may have for psychosocial or physical care,	patient, patient's representative, or the patient's
		treatment, and services after discharge or transfer.	physician.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		procedures	- Medical history and physical examination, including
		- Any medications dispensed or prescribed on discharge	any conclusions or impressions drawn from the
		- Discharge diagnosis	information
		- Discharge plan and discharge planning evaluation	- Discharge plan and discharge planning evaluation
			- Discharge summary with outcome of hospitalization,
			disposition of case, and provisions for follow-up care,
			including any medications dispensed or prescribed on
			discharge
			- Any diagnoses or conditions established during the
			patient's course of care, treatment, and services
			Note: Medical records are completed within 30 days
			following discharge, including final diagnosis.
§485.642(a)(4)	(4) Upon the request of a patient's	PC.04.01.03, EP 1	PC.14.01.01, EP 5
	physician, the CAH must arrange	The critical access hospital begins the discharge planning	The critical access hospital performs a discharge
	for the development and initial	process early in the patient's episode of care, treatment,	planning evaluation and creates a discharge plan for
	implementation of a discharge	and services.	those patients it identifies at an early stage of
	plan for the patient.		hospitalization are likely to suffer adverse health
		PC.04.01.03, EP 2	consequences upon discharge in the absence of
		The critical access hospital identifies any needs the	adequate discharge planning or at the request of the
		patient may have for psychosocial or physical care,	patient, patient's representative, or the patient's
		treatment, and services after discharge or transfer.	physician.
		DO 04 04 00 FD 0	Note 1: The discharge planning evaluation is completed
		PC.04.01.03, EP 3	in a timely manner so that appropriate arrangements for
		The patient, the patient's family, physicians, other	post-hospital care are made before discharge and
		licensed practitioners, clinical psychologists, and staff	unnecessary delays in discharge are avoided.
		involved in the patient's care, treatment, and services	Note 2: The discharge planning evaluation is performed
		participate in planning the patient's discharge or transfer.	and subsequent discharge plan is created by, or under
		Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of	the supervision of, a registered nurse, social worker, or other qualified person.
		·	other qualified person.
		"physician" is the same as that used by the Centers for Medicare & Description (CMS) (refer to the	
		Glossary).	
		,	
		Note 2: For psychiatric distinct part units in critical	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	
§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, speechlanguage 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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		CFR 484.4) provide physical therapy, occupational	Medicare & mp; Medicaid Services (refer to the
		therapy, speech-language pathology, or audiology	Glossary).
		services, if these services are provided by the critical	Note 2: For psychiatric distinct part units in critical
		access hospital. The provision of care and staff	access hospitals: Social service staff responsibilities
		qualifications are in accordance with national acceptable	include but are not limited to participating in discharge
		standards of practice and also meet the requirements of	planning, arranging for follow-up care, and developing
		409.17. See Appendix B for 409.17 requirements.	mechanisms for exchange of information with sources
			outside the critical access hospital.
		PC.02.01.05, EP 1	Note 3: For swing beds in critical access hospitals: The
		Care, treatment, and services are provided to the patient	critical access hospital notifies the resident and, if
		in an interdisciplinary, collaborative manner.	known, a family member or legal representative of the
			resident of the transfer or discharge and reasons for the
		PC.02.02.01, EP 3	move. The notice is in writing, in a language and manner
		The critical access hospital coordinates the patient's	they understand, and includes the items described in
		care, treatment, and services within a time frame that	42 CFR 483.15(c)(5). The critical access hospital also
		meets the patient's needs.	provides sufficient preparation and orientation to
		Note: Coordination involves resolving scheduling	residents to make sure that transfer or discharge from
		conflicts and duplication of care, treatment, and services.	the critical access hospital is safe and orderly. The
		DO 04 04 00 ED 0	critical access hospital sends a copy of the notice to a
		PC.04.01.03, EP 3	representative of the office of the state's long-term care
		The patient, the patient's family, physicians, other	ombudsman.
		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 & Description (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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
\$485.642(a)(6)	(6) The CAH's discharge planning process must require regular reevaluation 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.	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.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 & Decial 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	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.
		diagnostic testing.	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	goals of care and treatment		
	preferences.		
§485.642(b)	(b) Standard: Discharge of the	IM.02.01.01, EP 4	PC.14.02.03, EP 1
	patient and provision and	The critical access hospital discloses health information	The critical access hospital provides or transmits
	transmission of the patient's	only as authorized by the patient or as otherwise	necessary medical information when discharging,
	necessary medical information.	consistent with law and regulation.	transferring, or referring the patient to post–acute care
	The CAH must discharge the		service providers and suppliers, facilities, agencies, and
	patient, and also transfer or refer	PC.02.02.01, EP 1	other outpatient service providers and practitioners
	the patient where applicable,	The critical access hospital follows a process to receive	who are responsible for the patient's follow-up or
	along with all necessary medical	or share patient information when the patient is referred	ancillary care. Necessary medical information includes,
	information pertaining to the	to other internal or external providers of care, treatment,	at a minimum, the following:
	patient's current course of illness	and services.	- Current course of illness and treatment
	and treatment, postdischarge	DO 04 00 04 FD 4	- Postdischarge goals of care
	goals of care, and treatment	PC.04.02.01, EP 1	- Treatment preferences at the time of discharge
	preferences, at the time of	At the time of the patient's discharge or transfer, the	Note: For swing beds in critical access hospitals: The
	discharge, to the appropriate post- acute care service providers and	critical access hospital informs other service providers who will provide care, treatment, and services to the	information sent to the receiving provider also includes the following:
	suppliers, facilities, agencies, and	patient about the following:	- Contact information of the physician or other licensed
	other outpatient service providers	- The reason for the patient's discharge or transfer	practitioner responsible for the care of the resident
	and practitioners responsible for	- The patient's physical and psychosocial status	- Resident representative information, including contact
	the patient's follow-up or ancillary	- A summary of care, treatment, and services it provided	information
	care.	to the patient	- Advance directive information
	our or	- The patient's progress toward goals	- All special instructions or precautions for ongoing
		- A list of community resources or referrals made or	care, when appropriate
		provided to the patient	- Comprehensive care plan goals
			- All other necessary information, including a copy of
		Note: For swing beds in critical access hospitals: The	the residents discharge summary, consistent with 42
		information sent to the receiving provider also includes	CFR 483.21(c)(2), and any other documentation, as
		the following:	applicable, to support a safe and effective transition of
		- Contact information of the physician or other licensed	care
		practitioner responsible for the care of the resident	
		- Resident representative information, including contact	
		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	
§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	TS.01.01.01, EP 1	TS.11.01.01, EP 1
	agreement with an OPO	The critical access hospital has a written agreement with	The critical access hospital develops and implements
	designated under part 486 of this	an organ procurement organization (OPO) and follows its	written policies and procedures for organ procurement
	chapter, under which it must	rules and regulations.	responsibilities that include the following:
	notify, in a timely manner, the OPO		- A written agreement with an organ procurement
	or a third party designated by the	TS.01.01.01, EP 9	organization (OPO) that requires the critical access
	OPO of individuals whose death is	The critical access hospital notifies the organ	hospital to notify, in a timely manner, the OPO or a third
	imminent or who have died in the	procurement organization (OPO) of patients who have	party designated by the OPO of individuals whose death
	CAH. The OPO determines	died and of mechanically ventilated patients whose death	is imminent or who have died in the critical access
	medical suitability for organ	is imminent, according to the following:	hospital, and that includes the OPO's responsibility to
	donation and, in the absence of	- Clinical triggers defined jointly with its medical staff and	determine medical suitability for organ donation
	alternative arrangements by the	the designated OPO	- A written agreement with at least one tissue bank and
	CAH, the OPO determines medical	- Within the time frames (ideally, within one hour of death	at least one eye bank to cooperate in retrieving,
	suitability for tissue and eye	for patients who have expired) jointly agreed on by the	processing, preserving, storing, and distributing tissues
	donation, using the definition of	critical access hospital and the designated OPO	and eyes to make certain that all usable tissues and
	potential tissue and eye donor and	- For mechanically ventilated patients, prior to the	eyes are obtained from potential donors, to the extent
	the notification protocol	withdrawal of life-sustaining therapies including medical	that the agreement does not interfere with organ
	developed in consultation with the	or pharmacological support	procurement
	tissue and eye banks identified by	Note: For additional information about criteria for the	- Designation of an individual, who is an organ
	the CAH for this purpose;	determination of brain death, please see the American	procurement representative, an organizational
		Academy of Neurology guidelines available at	representative of a tissue or eye bank, or a designated
		https://n.neurology.org/content/early/2023/09/13/WNL.0	requestor, to notify the family regarding the option to
		000000000207740 and the American Academy of	donate or decline to donate organs, tissues, or eyes
		Pediatrics guidelines available at	- Procedures for informing the family of each potential

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		https://www.aan.com/Guidelines/Home/GuidelineDetail/	donor about the option to donate or decline to donate
		1085 and the interactive tool that can be used alongside	organs, tissues, or eyes, in collaboration with the
		the new guidance to help walk clinicians through the	designated OPO
		BD/DNC evaluation process at	- Education and training of staff in the use of discretion
		https://www.aan.com/Guidelines/BDDNC.	and sensitivity to the circumstances, views, and beliefs
			of the family when discussing potential organ, tissue, or
		TS.01.01.01, EP 11	eye donations
		The organ procurement organization determines medical suitability of organs for organ donation and, in the	Note 1: The critical access hospital has an agreement with an OPO designated under 42 CFR part 486.
		absence of alternative arrangements by the critical	Note 2: The requirements for a written agreement with
		access hospital, it determines the medical suitability of	at least one tissue bank and at least one eye bank may
		tissue and eyes for donation.	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.
			000000000207740, the American Academy of
			Pediatrics guidelines available at
			https://www.aan.com/Guidelines/Home/GuidelineDeta
			il/1085, and the interactive tool that can be used
			in 1003, and the interactive toot that can be used

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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	TS.01.01.01, EP 3	TS.11.01.01, EP 1
§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
			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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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.
			000000000207740, the American Academy of
			Pediatrics guidelines available at
			https://www.aan.com/Guidelines/Home/GuidelineDeta
			il/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.
8495 642(0)	§485.643(c) Ensure, in	TS.01.01.01, EP 6	TS.11.01.01, EP 1
§485.643(c)	collaboration with the designated	The critical access hospital develops, in collaboration	The critical access hospital develops and implements
	OPO, that the family of each	with the designated organ procurement organization,	written policies and procedures for organ procurement

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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.
			000000000207740, the American Academy of
			Pediatrics guidelines available at
			https://www.aan.com/Guidelines/Home/GuidelineDeta
			il/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	TS.01.01.01, EP 5	TS.11.01.01, EP 1
	and sensitivity with respect to the	Staff education includes training in the use of discretion	The critical access hospital develops and implements
			written policies and procedures for organ procurement

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	circumstances, views, and beliefs	and sensitivity to the circumstances, beliefs, and desires	responsibilities that include the following:
	of the family of potential donors;	of the families of potential organ, tissue, or eye donors.	- 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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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.
			000000000207740, the American Academy of
			Pediatrics guidelines available at
			https://www.aan.com/Guidelines/Home/GuidelineDeta
			il/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	TS.01.01, EP 4	TS.11.01.01, EP 2
	works cooperatively with the	The critical access hospital works with the organ	The critical access hospital develops and implements
	designated OPO, tissue bank and	procurement organization (OPO) and tissue and eye	policies and procedures for working with the organ
	eye bank in educating staff on	banks to do the following:	procurement organization (OPO) and tissue and eye
	donation issues, reviewing death	- Review death records in order to improve identification	banks to do the following:
	records to improve identification	of potential donors.	- Review death records in order to improve identification
	of potential donors, and	- Maintain potential donors while the necessary testing	of potential donors
	maintaining potential donors while	and placement of potential donated organs, tissues, and	- Maintain potential donors while the necessary testing
	necessary testing and placement	eyes takes place in order to maximize the viability of	and placement of potential donated organs, tissues,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	of potential donated organs,	donor organs for transplant.	and eyes takes place in order to maximize the viability
	tissues, and eyes takes place.	- Educate staff about issues surrounding donation.	of donor organs for transplant
		- Develop a written donation policy that addresses	- Educate staff about issues surrounding donation
		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.	
§485.643(f)	§485.643(f) For purpose of these	asjetone receivery.	TS.11.01.01, EP 1
	standards, the term "organ"		The critical access hospital develops and implements
	means a human kidney, liver,		written policies and procedures for organ procurement
	heart, lung, pancreas, or intestines		responsibilities that include the following:
	(or multivisceral organs).		- 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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			0000000000207740, the American Academy of
			Pediatrics guidelines available at
			https://www.aan.com/Guidelines/Home/GuidelineDeta
			il/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	LD.04.01.01, EP 6	LD.13.01.01, EP 3
	than 25 inpatient beds. Any bed of	Except as permitted for critical access hospitals having	Except as permitted for critical access hospitals having
	a unit of the facility that is licensed	distinct part units under 42 CFR 485.647, the critical	distinct part units under 42 CFR 485.647, the critical
	as a distinct-part SNF at the time	access hospital maintains no more than 25 inpatient	access hospital maintains no more than 25 inpatient
	the facility applies to the State for	beds that can be used for either inpatient or swing bed	beds that can be used for either inpatient or swing bed
	designation as a CAH is not	services.	services.
	counted under paragraph (a) of	Note: Any bed in a unit of the facility that is licensed as a	Note: Any bed in a unit of the facility that is licensed as
	this section.	distinct-part skilled nursing facility at the time the facility	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	facility applies to the state for designation as a critical
		hospital is not counted in this 25-bed count.	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		
0.10-0.1-(1.)/0	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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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),	IM.02.01.01, EP 1	IM.12.01.01, EP 1
	(c)(1), (c)(2)(iii), (c)(6), (d), (e)(2)	The critical access hospital follows a written policy	The critical access hospital develops and implements
	and (4), (f)(4)(ii) and (iii), (g)(8) and	addressing the privacy and confidentiality of health	policies and procedures addressing the privacy and
	(17), (g)(18) introductory text, and	information.	confidentiality of health information.
	(h) of this chapter).		Note: For swing beds in critical access hospitals:
		IM.02.01.01, EP 3	Policies and procedures also address the resident's
		The critical access hospital uses health information only	personal records.
		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
		IM.02.01.01, EP 4	patient's written consent or as otherwise required by
		The critical access hospital discloses health information	law and regulation.
		only as authorized by the patient or as otherwise	Note: For swing beds in critical access hospitals: The
		consistent with law and regulation.	critical access hospital allows representatives of the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			Office of the State Long-Term Care Ombudsman to
		LD.04.02.03, EP 13	examine a resident's medical, social, and
		For swing beds in critical access hospitals: Each resident	administrative records in accordance with state law.
		who is entitled to Medicaid benefits is informed in writing,	
		either at the time of admission or when the resident	LD.13.02.01, EP 2
		becomes eligible for Medicaid, of the following:	For swing beds in critical access hospitals: Each
		- The items and services included in the state plan for	Medicaid-eligible resident is informed in writing, either
		which the resident may not be charged	at the time of admission or when the resident becomes
		- Those items and services that the facility offers and for	eligible for Medicaid, of the following:
		which the resident may be charged, and the amount of	- Items and services included in the state plan for which
		charges for those services	the resident may not be charged
		LD 04 00 00 FD 44	- Items and services that the critical access hospital
		LD.04.02.03, EP 14	offers, those for which the resident may be charged,
		For swing beds in critical access hospitals: Residents are informed when changes are made to the services that are	and the amount of charges for those services Note: The critical access hospital informs the resident
		specified in LD.04.02.03, EP 13.	when changes are made to the items and services.
		Specified in LD.04.02.03, LF 13.	when changes are made to the items and services.
		LD.04.02.03, EP 16	LD.13.02.01, EP 3
		For swing beds in critical access hospitals: Residents are	For swing beds in critical access hospitals: The critical
		informed before or at the time of admission, and	access hospital informs residents before or at the time
		periodically during the resident's stay, of services	of admission, and periodically during the resident's
		available in the facility and of charges for those services	stay, of services available in the critical access hospital
		not covered under Medicare or by the facility's per diem	and of charges for those services not covered under
		rate.	Medicare, Medicaid, or by the critical access hospital's
			per diem rate.
		MS.06.01.03, EP 6	
		The credentialing process requires that the critical access	PC.11.03.01, EP 2
		hospital verifies in writing and from the primary source	The critical access hospital involves the patient in the
		whenever feasible, or from a credentials verification	development and implementation of their plan of care.
		organization (CVO), the following information:	Note: For swing beds in critical access hospitals: The
		- The applicant's current licensure at the time of initial	resident has the right to be informed, in advance, of
		granting, renewal, and revision of privileges, and at the	changes to their plan of care.
		time of license expiration	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		and personal values, beliefs, and preferences.	
			RI.12.01.01, EP 1
		RI.01.01.01, EP 7	The patient or their representative (as allowed, in
		The critical access hospital respects the patient's right to	accordance with state law) has the right to make
		privacy.	informed decisions regarding their care. The patient's
		Note: This element of performance (EP) addresses a	rights include being informed of their health status,
		patient's personal privacy. For EPs addressing the privacy	being involved in care planning and treatment, and
		of a patient's health information, refer to Standard	being able to request or refuse treatment. This does not
		IM.02.01.01.	mean the patient has the right to demand the provision
			of treatment or services deemed medically
		RI.01.01.03, EP 1	unnecessary or inappropriate.
		The critical access hospital provides information in a	
		manner tailored to the patient's age, language, and ability	RI.12.01.01, EP 3
		to understand.	For swing beds in critical access hospitals: If a resident
			is adjudged incompetent under state law by a court of
		RI.01.01.03, EP 3	proper jurisdiction, the rights of the resident
		The critical access hospital communicates with the	automatically transfer to and are exercised by a
		patient who has vision, speech, hearing, or cognitive	resident representative appointed by the court under
		impairments in a manner that meets the patient's needs.	state law to act on the resident's behalf. The resident
			representative exercises the resident's rights to the
		RI.01.02.01, EP 1	extent allowed by the court in accordance with state
		The critical access hospital involves the patient in making	law.
		decisions about their care, treatment, and services,	Note 1: If a resident representative's decision-making
		including the right to have the patient's family and	authority is limited by state law or court appointment,
		physician or other licensed practitioner promptly notified	the resident retains the right to make those decisions
		of their admission to or discharge or transfer from the	outside the representative's authority.
		critical access hospital.	Note 2: The resident's wishes and preferences are
		Note 1: The patient is informed, prior to the notification	considered by the representative when exercising the
		occurring, of any process to automatically notify the	patient's rights.
		patient's established primary care practitioner, primary	Note 3: To the extent practicable, the resident is
		care practice group/entity, or other practitioner	provided with opportunities to participate in the care
		group/entity, as well as all applicable post–acute care	planning process.
		services providers and suppliers. The critical access	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospital has a process for documenting a patient's refusal	RI.12.01.01, EP 4
		to permit notification of registration to the emergency	For swing beds in critical access hospitals: The resident
		department, admission to an inpatient unit, or discharge	has the right to request, refuse, and/or discontinue
		or transfer from the emergency department or inpatient	treatment; to participate in or refuse to participate in
		unit. Notifications with primary care practitioners and	experimental research; and to formulate an advance
		entities are in accordance with all applicable federal and	directive.
		state laws and regulations.	
		Note 2: For swing beds in critical access hospitals: The	RI.12.01.01, EP 6
		resident has the right to be informed in advance of	For swing beds in critical access hospitals: The critical
		changes to their plan of care.	access hospital supports the residents right to choose
		DI OL OG OL ED O	a licensed attending physician.
		RI.01.02.01, EP 2	Note: If the physician chosen by the resident refuses to
		When a patient is unable to make decisions about their	or does not meet the requirements for attending
		care, treatment, and services, the critical access hospital	physicians at 42 CFR 483, the critical access hospital
		involves a surrogate decision-maker in making these decisions.	may seek alternative physician participation to assure
			provision of appropriate and adequate care and
		Note: For swing beds in critical access hospitals: The selection of the surrogate decision-maker is in	treatment. The critical access hospital informs the resident if it determines that the physician chosen by
		accordance with state law.	the resident is unlicensed or unable to serve as the
		accordance with state taw.	attending physician. The critical access hospital also
		RI.01.02.01, EP 3	discusses alternative physician participation with the
		The critical access hospital provides the patient or	resident and honors the resident's preferences, if any,
		surrogate decision-maker with written information about	among the options.
		the right to refuse care, treatment, and services.	among the options.
			RI.13.01.03, EP 1
		RI.01.02.01, EP 4	For swing beds in critical access hospitals: The critical
		The critical access hospital respects the right of the	access hospital allows the resident to keep and use
		patient or surrogate decision-maker to refuse care,	personal clothing and possessions, unless this infringes
		treatment, and services in accordance with law and	on others' rights or is medically or therapeutically
		regulation.	contraindicated, based on the setting or service.
		RI.01.03.05, EP 3	RI.13.01.03, EP 2
		The critical access hospital informs the patient that	For swing beds in critical access hospitals: The critical

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	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.01.05.01, EP 1 The critical access hospital follows written policies on advance directives, forgoing or withdrawing lifesustaining treatment, and withholding resuscitative services that address the following: - Providing patients with written information about advance directives, forgoing or withdrawing lifesustaining 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 right to formulate or review and revise the patient scare, 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.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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	PC.04.01.01, EP 14	PC.14.01.01, EP 4
	discharge rights (§483.5,	The critical access hospital transfers a patient upon order	The patient, the patient's caregiver(s) or support
	§483.15(c)(1), (c)(2), (c)(3), (c)(4),	of their attending physician.	person(s), physicians, other licensed practitioners,
	(c)(5), (c)(7), (c)(8), and (c)(9) of		clinical psychologists, and staff who are involved in the
	this chapter).	PC.04.01.03, EP 3	patient's care, treatment, and services participate in
		The patient, the patient's family, physicians, other	planning the patient's discharge or transfer. The patient
		licensed practitioners, clinical psychologists, and staff	and their caregiver(s) or support person(s) are included
		involved in the patient's care, treatment, and services	as active partners when planning for postdischarge
		participate in planning the patient's discharge or transfer.	care.
		Note 1: For rehabilitation and psychiatric distinct part	Note 1: For rehabilitation and psychiatric distinct part
		units in critical access hospitals: The definition of	units in critical access hospitals: The definition of
		"physician" is the same as that used by the Centers for	"physician" is the same as that used by the Centers for
		Medicare & mp; Medicaid Services (CMS) (refer to the	Medicare & mp; Medicaid Services (refer to the
		Glossary).	Glossary).
		Note 2: For psychiatric distinct part units in critical	Note 2: For psychiatric distinct part units in critical
		access hospitals: Social service staff responsibilities	access hospitals: Social service staff responsibilities
		include, but are not limited to, participating in discharge	include but are not limited to participating in discharge
		planning, arranging for follow-up care, and developing	planning, arranging for follow-up care, and developing
		mechanisms for exchange of information with sources	mechanisms for exchange of information with sources
		outside the critical access hospital.	outside the critical access hospital.
		Note 3: For swing beds in critical access hospitals: The	Note 3: For swing beds in critical access hospitals: The
		critical access hospital notifies the resident and, if	critical access hospital notifies the resident and, if
		known, a family member or legal representative of the	known, a family member or legal representative of the
		resident of the transfer or discharge and reasons for the	resident of the transfer or discharge and reasons for the
		move in writing. The hospital also provides sufficient	move. The notice is in writing, in a language and manner
		preparation and orientation to residents to make sure that	they understand, and includes the items described in
		transfer or discharge from the hospital is safe and orderly.	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	provides sufficient preparation and orientation to
		a representative of the office of the state's long-term care	residents to make sure that transfer or discharge from
		ombudsman.	the critical access hospital is safe and orderly. The
			critical access hospital sends a copy of the notice to a
		PC.04.01.03, EP 5	representative of the office of the state's long-term care
		For swing beds in critical access hospitals: Except when	ombudsman.
		specified in the CoP from 42 CFR 483.12(a)(5)(ii), the	
		written notice of transfer or discharge required under	PC.14.01.01, EP 12
		paragraph 42 CFR 483.12(a)(4) must be made by the	For swing beds in critical access hospitals: The critical
		critical access hospital at least 30 days before the	access hospital provides the written notice of transfer
		resident is transferred or discharged.	or discharge at least 30 days before the resident is
		Note: Notice may be made as soon as is practical before	transferred or discharged.
		transfer or discharge when the safety of the individuals in	Note: Notice may be made as soon as is practical
		the facility would be endangered; the health of the	before transfer or discharge when the safety of the
		individuals in the facility would be endangered; the	individuals in the facility would be endangered, the
		resident's health improves sufficiently to allow a more	health of the individuals in the facility would be
		immediate transfer or discharge, and immediate transfer	endangered, the resident's health improves sufficiently
		or discharge is required by the resident's urgent medical	to allow a more immediate transfer or discharge,
		needs; or a resident has not resided in the facility for 30	immediate transfer or discharge is required by the
		days.	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	PC.14.01.01, EP 13
		notice before transfer or discharge specified in the CoP	For swing beds in critical access hospitals: The written
		from 42 CFR 483.12(a)(4) includes the following:	notice before transfer or discharge specified in 42 CFR
		- The reason for transfer or discharge	483.15(c)(3) includes the following:
		- The effective date of transfer or discharge	- Reason for transfer or discharge
		- The location to which the resident is transferred or	- Effective date of transfer or discharge
		discharged	- Location to which the resident is transferred or
		- A statement of the resident's appeal rights, including the	discharged
		name, address (mailing and e-mail), and telephone	- Statement of the resident's appeal rights, including
		number of the entity which receives such requests;	the name, address (mailing and e-mail), and telephone
		information on how to obtain an appeal form; where to	number of the entity which receives appeal requests;

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		find assistance in completing the form; and how to	information on how to obtain an appeal form; where to
		submit the appeal hearing request	find assistance in completing the form; and how to
		- The name, address (mailing and e-mail), and telephone	submit the appeal hearing request
		number of the office of the state's long-term care	- Name, address (mailing and e-mail), and telephone
		ombudsman	number of the office of the state's long-term care
		- For a resident with intellectual and developmental	ombudsman
		disabilities, the mailing and e-mail address and telephone	- For a resident with intellectual and developmental
		number of the agency responsible for the protection and	disabilities, the mailing and e-mail address and
		advocacy of these individuals, established under Part C of	telephone number of the agency responsible for the
		the Developmental Disabilities Assistance and Bill of	protection and advocacy of these individuals,
		Rights Act of 2000	established under Part C of the Developmental
		- For a resident with a mental disorder or related	Disabilities Assistance and Bill of Rights Act of 2000
		disabilities, the mailing and e-mail address and telephone	- For a resident with a mental disorder or related
		number of the agency responsible for the protection and	disabilities, the mailing and e-mail address and
		advocacy of these individuals, established under the	telephone number of the agency responsible for the
		Protection and Advocacy for Mentally Ill Individuals Act	protection and advocacy of these individuals,
			established under the Protection and Advocacy for
		PC.04.01.05, EP 1	Mentally Ill Individuals Act
		When the critical access hospital determines the	
		patient's discharge or transfer needs, it promptly shares	PC.14.01.03, EP 1
		this information with the patient, and also with the	For swing beds in critical access hospitals: The critical
		patient's family when it is involved in decision making or	access hospital transfers or discharges residents only
		ongoing care.	under at least one of the following conditions:
		DO 04 04 05 ED 0	- The resident's health has improved to the point where
		PC.04.01.05, EP 2	they no longer need the critical access hospital's
		Before the patient is discharged, the critical access	services.
		hospital informs the patient, and also the patient's family	- The transfer or discharge is necessary for the
		when it is involved in decision making or ongoing care, of	resident's welfare, and the critical access hospital
		the kinds of continuing care, treatment, and services the	cannot meet the resident's needs.
		patient will need.	- The safety of the individuals in the critical access
		PC.04.01.07, EP 1	hospital is endangered due to the resident's clinical or behavioral status.
		•	
		For swing beds in critical access hospitals: The critical	- 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	would otherwise be endangered.
		when at least one of the following conditions is met:	- The resident has failed, after reasonable and
		- The resident's health has improved to the point where	appropriate notice, to pay for (or to have paid under
		they no longer need the critical access hospital's	Medicare or Medicaid) a stay at the critical access
		services.	hospital. Nonpayment applies if the resident does not
		- The transfer or discharge is necessary for the resident's	submit the necessary paperwork for third party
		welfare and the critical access hospital cannot meet the	payment or after the third party, including Medicare or
		resident's needs.	Medicaid, denies the claim and the resident refuses to
		- The safety of the individuals in the critical access	pay for their stay. For a resident who becomes eligible
		hospital is endangered due to the clinical or behavioral	for Medicaid after admission to a critical access
		status of the resident.	hospital, the critical access hospital may charge a
		- The health of individuals in the critical access hospital	resident only the allowable charges under Medicaid.
		would otherwise be endangered.	- The critical access hospital ceases operation.
		- The resident has failed, after reasonable and	Note: The critical access hospital cannot transfer or
		appropriate notice, to pay for (or to have paid under	discharge a resident while an appeal is pending
		Medicare or Medicaid) a stay at the critical access	pursuant to 42 CFR 431.230, unless the failure to
		hospital. Nonpayment applies if the resident does not	discharge or transfer would endanger the health or
		submit the necessary paperwork for third party payment	safety of the resident or other individuals in the critical
		or after the third party, including Medicare or Medicaid,	access hospital. The critical access hospital
		denies the claim and the resident refuses to pay for their	documents the danger that failure to transfer or
		stay. For a resident who becomes eligible for Medicaid	discharge would pose.
		after admission to a critical access hospital, the critical	
		access hospital may charge a resident only the allowable	PC.14.01.03, EP 2
		charges under Medicaid.	For critical access hospitals with swing beds: In the
		- The critical access hospital ceases operation.	case of critical access hospital closure, the
		Note: The critical access hospital cannot transfer or	administrator of the critical access hospital provides
		discharge a resident while an appeal is pending pursuant	written notification prior to the impending closure to the
		to 42 CFR 431.230, unless the failure to discharge or	state survey agency, the office of the state's long-term
		transfer would endanger the health or safety of the	care ombudsman, residents of the critical access
		resident or other individuals in the critical access	hospital, and the residents' representatives, as well as
		hospital. The critical access hospital documents the	the plan for the transfer and adequate relocation of the
		danger that failure to transfer or discharge would pose.	residents.

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		when appropriate	- Information needed to support the patient's diagnosis
		- Comprehensive care plan goals	and condition
			- Information about the patient's care, treatment, and
		RC.01.01.01, EP 5	services that promotes continuity of care among staff
		The medical record includes the following:	and providers
		- Information needed to support the patient's diagnosis	Note: For critical access hospitals that elect The Joint
		and condition	Commission Primary Care Medical Home option: This
		- Information needed to justify the patient's care,	requirement refers to care provided by both internal and
		treatment, and services	external providers.
		- Information that documents the course and result of the	DO 40 00 04 FD 4
		patient's care, treatment, and services	RC.12.03.01, EP 1
		- Information about the patient's care, treatment, and	For swing beds in critical access hospitals:
		services that promotes continuity of care among staff and	Documentation in the medical record includes
		providers	discharge information provided to the resident and/or to
		Note: For critical access hospitals that elect The Joint	the receiving organization. A physician document in the
		Commission Primary Care Medical Home option: This	resident's medical record when the resident is being
		requirement refers to care provided by both internal and	transferred or discharged because the safety of other
		external providers.	residents would otherwise be endangered. The resident's physician documents in the medical record
		RC.02.04.01, EP 1	when the transfer is due to the resident improving and
		For swing beds in critical access hospitals:	no longer needing long term care services or when the
		Documentation in the medical record includes discharge	transfer is due to the resident's welfare and resident's
		information provided to the resident and/or to the	needs cannot be met in the critical access hospital's
		receiving organization. There is documentation in the	swing bed.
		resident's medical record by the resident's physician	Swillg bed.
		when the resident is transferred or discharged, either	RC.12.03.01, EP 2
		when the transfer is due to the resident improving and no	For swing beds in critical access hospitals: The
		longer needing long term care services or when the	resident's discharge information includes the following:
		resident's needs cannot be met in the critical access	- Reason for transfer, discharge, or referral
		hospital's swing bed. There is documentation in the	- Treatment provided, diet, medication orders, and
		resident's medical record by a physician when the	orders for the resident's immediate care
		resident is being transferred or discharged because the	- Referrals provided to the resident, the referring
		safety of other residents would otherwise be endangered.	physician's or other licensed practitioner's name, and

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			the name of the physician or other licensed practitioner
		RC.02.04.01, EP 2	who has agreed to be responsible for the resident's
		For swing beds in critical access hospitals: The resident's	medical care and treatment, if this person is someone
		discharge information includes the following:	other than the referring physician or other licensed
		- The reason for transfer, discharge, or referral	practitioner
		- Treatment provided, diet, medication orders, and orders	- Medical findings and diagnoses; a summary of the
		for the resident's immediate care	care, treatment, and services provided; and progress
		- Referrals provided to the resident, the referring	reached toward goals
		physician's or other licensed practitioner's name, and the	- Information about the resident's behavior, ambulation,
		name of the physician or other licensed practitioner who	nutrition, physical status, psychosocial status, and
		has agreed to be responsible for the resident's medical	potential for rehabilitation
		care and treatment, if this person is someone other than	- Nursing information that is useful in the resident's
		the referring physician or other licensed practitioner	care
		- Medical findings and diagnoses; a summary of the care,	- Any advance directives
		treatment, and services provided; and progress reached	- Instructions given to the resident before discharge
		toward goals	- Attempts to meet the resident's needs
		- Information about the resident's behavior, ambulation,	
		nutrition, physical status, psychosocial status, and	RC.12.03.01, EP 3
		potential for rehabilitation	For swing beds in critical access hospitals: When the
		- Nursing information that is useful in the resident's care	resident is transferred or discharged because the
		- Any advance directives	critical access hospital cannot meet their needs, the
		- Instructions given to the resident before discharge	critical access hospital documents which needs could
		- Attempts to meet the resident's needs	not be met, the critical access hospital's attempts to
		DO 00 04 04 FD 0	meet the resident's needs, and the services available at
		RC.02.04.01, EP 3	the receiving organization that will meet the resident's
		In order to provide information to other caregivers and	needs.
		facilitate the patient's continuity of care, the medical	DO 10 03 01 FD 4
		record contains a discharge summary that includes the	RC.12.03.01, EP 4
		following:	For swing beds in critical access hospitals: The critical
		- The reason for hospitalization	access hospital records the reasons for the transfer or
		- The procedures performed	discharge in the resident's medical record in
		- The care, treatment, and services provided	accordance with 42 CFR 483.15(c)(2).
		- The patient's condition and disposition at discharge	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Information provided to the patient and family	RI.11.02.01, EP 1
		- Provisions for follow-up care	The critical access hospital provides information,
		- For critical access hospitals with swing beds: Where the	including but not limited to the patient's total health
		resident plans to reside	status, in a manner tailored to the patient's age,
		Note 1: A discharge summary is not required when a	language, and ability to understand.
		patient is seen for minor problems or interventions, as	Note: The critical access hospital communicates with
		defined by the medical staff. In this instance, a final	the patient during the provision of care, treatment, and
		progress note may be substituted for the discharge	services in a manner that meets the patient's oral and
		summary provided the note contains the outcome of	written communication needs.
		hospitalization, disposition of the case, and provisions for	DI 12 01 02 ED 1
		follow-up care.	RI.13.01.03, EP 4
		Note 2: When a patient is transferred to a different level of care within the critical access hospital, and caregivers	For swing beds in critical access hospitals: Room changes in an organization that is a composite distinct
		change, a transfer summary may be substituted for the	part (a distinct part consisting of two or more
		discharge summary. If the caregivers do not change, a	noncontiguous components that are not located within
		progress note may be used.	the same campus, as defined in 42 CFR 413.65(a)(2))
		progress note may be deed.	are limited to moves within the particular building in
		RI.01.01.01, EP 5	which the resident resides, unless the resident
		The critical access hospital respects the patient's right to	voluntarily agrees to move to another of the composite
		and need for effective communication.	distinct part's locations.
		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	

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	HR.01.01.01, EP 18	HR.11.02.01, EP 4
	and exploitation (§483.12(a)(1),	For swing beds in critical access hospitals: The facility	For swing beds in critical access hospitals: The critical
	(a)(2), (a)(3)(i), (a)(3)(ii), (a)(4),	does not employ individuals who have been found guilty	access hospital does not employ individuals who have
	(b)(1), (b)(2), (c)(1), (c)(2), (c)(3),	by a court of law of abusing, neglecting, exploiting,	been found guilty by a court of law of abusing,
	and (c)(4) of this chapter).	misappropriating property, or mistreating residents or	neglecting, exploiting, misappropriating property, or
		who have had a finding entered into the state nurse aide	mistreating residents or who have had a finding entered
		registry concerning abuse, neglect, exploitation,	into the state nurse aide registry concerning abuse,
		mistreatment of residents, or misappropriation of	neglect, exploitation, mistreatment of residents, or
		residents' property.	misappropriation of residents' property.
		PC.01.02.09, EP 7	PC.13.02.01, EP 1
		The critical access hospital reports cases of possible	The critical access hospital does not use restraint or
		abuse and neglect to external agencies, in accordance	seclusion of any form as a means of coercion,
		with law and regulation.	discipline, convenience, or staff retaliation. Restraint or
			seclusion is only used to protect the immediate
		PC.01.02.09, EP 8	physical safety of the patient, staff, or others when less
		For swing beds in critical access hospitals: The critical	restrictive interventions have been ineffective and is
		access hospital reports to the state nurse aide registry or	discontinued at the earliest possible time, regardless of
		licensing authorities any knowledge it has of any actions	the length of time specified in the order.
		taken by a court of law against an employee that would	
		indicate unfitness for service as a nurse aide or other	PC.13.02.01, EP 2
		facility staff.	The critical access hospital uses the least restrictive
			form of restraint or seclusion that will be effective to
		PC.03.05.01, EP 1	protect the patient, a staff member, or others from
		The critical access hospital uses restraint or seclusion	harm.
		only to protect the immediate physical safety of the	DI 42 04 04 ED 4
		patient, staff, or others.	RI.13.01.01, EP 1
		PC.03.05.01, EP 2	The critical access hospital protects the patient from
		The critical access hospital does not use restraint or	harassment, neglect, exploitation, corporal punishment, involuntary seclusion, and verbal, mental,
		The childal access hospital does not use restraint or	punishment, involuntary sectusion, and verbal, mental,

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

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

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, speechlanguage 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	HR.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, speechlanguage pathologists, or audiologists (as defined in 42	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.
	§413.343(b) of this chapter).	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 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	assessment within 14 calendar days after it determines
		qualifications are in accordance with national acceptable	that there has been a significant change in the
		standards of practice and also meet the requirements of	resident's physical or mental condition.
		409.17. See Appendix B for 409.17 requirements.	Note: For this element of performance, the term
			"significant change" means a major decline or
		HR.01.01.01, EP 3	improvement in the resident's status that will not
		The critical access hospital verifies and documents that	resolve itself without further intervention by staff or by
		the applicant has the education and experience required	implementing standard disease-related clinical
		by the job responsibilities.	interventions, that has an impact on more than one
			area of the resident's health status, and that requires
		LD.03.06.01, EP 2	interdisciplinary review or revision of the care plan, or
		Leaders provide for a sufficient number and mix of	both.
		individuals to support safe, quality care, treatment, and	
		services.	PC.11.02.01, EP 8
		Note: The number and mix of individuals is appropriate to	For swing beds in critical access hospitals: Each
		the scope and complexity of the services offered.	resident receives a comprehensive assessment no less
			often than every 12 months.
		LD.03.06.01, EP 3	
		Those who work in the critical access hospital are	PC.11.02.01, EP 11
		competent to complete their assigned responsibilities.	For swing beds in critical access hospitals: The
			comprehensive assessment of the resident includes
		LD.03.08.01, EP 1	the following:
		The critical access hospital's design of new or modified	- Identifying and demographic information
		services or processes incorporates the following:	- Customary routines
		- The needs of patients, staff, and others	- Cognitive patterns
		- The results of performance improvement activities	- Communication needs
		- Information about potential risks to patients	- Vision needs
		- Evidence-based information in the decision-making	- Psychosocial well-being
		process	- Mood and behavior patterns
		- Information about sentinel events	- Physical functioning and structural problems
		Note 1: A proactive risk assessment is one of several ways	- Continence
		to assess potential risks to patients. For suggested	- Disease(s), diagnoses, and health conditions
		components, refer to the "Proactive Risk Assessment"	- Dental status

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		section at the beginning of this chapter.	- Nutritional status (such as usual body weight or
		Note 2: Evidence-based information could include	desirable body weight range, electrolyte balance)
		practice guidelines, successful practices, information	- Skin
		from current literature, and clinical standards.	- Pursuit of activity
			- Medications
		PC.01.02.01, EP 26	- Need for special treatment(s) and procedure(s)
		For swing beds in critical access hospitals: The	- Discharge planning
		comprehensive assessment of the resident includes the	Note: The critical access hospital maintains the
		following:	resident's acceptable nutritional status parameters
		- Identifying and demographic information	unless the resident's clinical condition demonstrates
		- Customary routines	that this is not possible or the resident's preferences
		- Cognitive patterns	indicate otherwise.
		- Communication needs	
		- Vision needs	PC.11.02.01, EP 12
		- Psychosocial well-being	For swing beds in critical access hospitals: The
		- Mood and behavior patterns	comprehensive assessment of the resident includes
		- Physical functioning and structural problems	documentation of summary information about the
		- Continence	additional assessment(s) performed through the
		- Disease(s), diagnoses, and health conditions	resident assessment protocols.
		- Dental and nutritional status	
		- Skin	PC.11.02.01, EP 13
		- Pursuit of activity	For swing beds in critical access hospitals: The
		- Medications	comprehensive assessment includes direct
		- Need for special treatment(s) and procedure(s)	observation and communication with the resident and
		- Discharge planning	communication with staff members on all shifts.
		PC.01.02.01, EP 27	PC.11.03.01, EP 1
		For swing beds in critical access hospitals: The	The critical access hospital develops, implements, and
		comprehensive assessment of the resident includes	revises a written individualized plan of care based on
		documentation of summary information about the	the following:
		additional assessment(s) performed through the resident	- Needs identified by the patient's assessment,
		assessment protocols.	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	services required to meet those goals
		For swing beds in critical access hospitals: The	Note 1: Nursing staff develops and keeps current a
		comprehensive assessment of the resident includes	nursing plan of care, which may be a part of an
		documentation of the resident's participation in the	interdisciplinary plan of care, for each inpatient.
		assessment.	Note 2: The hospital evaluates the patient's progress
			and revises the plan of care based on the patient's
		PC.01.02.03, EP 14	progress.
		For swing beds in critical access hospitals: The critical	Note 3: For rehabilitation distinct part units in critical
		access hospital specifies that each resident's	access hospitals: The plan is reviewed and revised as
		comprehensive assessment is completed within 14	needed by a physician in consultation with other
		calendar days after admission.	professional staff who provide services to the patient.
		PC.01.02.03, EP 15	PC.11.03.01, EP 6
		For swing beds in critical access hospitals: A	For swing beds in critical access hospitals: The
		comprehensive assessment is conducted within 14	interdisciplinary team involves the resident and the
		calendar days after the critical access hospital	resident's representative in developing the person-
		determines that there has been a significant change in	centered, comprehensive treatment plan.
		the resident's physical or mental condition.	Note 1: The treatment plan includes documentation of
			the following:
		PC.01.02.03, EP 16	- Any specialized or rehabilitation services the critical
		For swing beds in critical access hospitals: Each resident	access hospital will provide as a result of preadmission
		receives a comprehensive assessment no less often than	screening and resident review (PASARR)
		every 12 months.	recommendations and any disagreement with PASARR
			recommendations
		PC.01.03.01, EP 1	- Resident's goals for admission and desired outcomes
		The critical access hospital plans the patient's care,	- Resident's preferences and potential for future
		treatment, and services based on needs identified by the	discharge, including whether the resident's desire to
		patient's assessment, reassessment, and results of	return to the community was assessed and any referrals
		diagnostic testing.	to local contact agencies and/or other appropriate
		DO 04 00 04 FD 0	entities for this purpose
		PC.01.03.01, EP 2	- Discharge plans
		For swing beds in critical access hospitals: The resident's	- Measurable objectives and time frames to meet a
		written plan of care is developed by an interdisciplinary	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	psychosocial needs
		the resident's care, treatment, and services. At a	Note 2: If not feasible for the resident and the resident's
		minimum, the team includes the following individuals:	representative to participate in the development of the
		the attending physician, registered nurse with	treatment plan, an explanation is included in the
		responsibility for the resident, nurse aide with	resident's medical record.
		responsibility for the resident, and a member of the food	
		and nutrition services staff.	PC.11.03.01, EP 8
			For swing beds in critical access hospitals: The critical
		PC.01.03.01, EP 4	access hospital develops the resident's written
		For swing beds in critical access hospitals: The critical	comprehensive plan of care as soon as possible after
		access hospital develops the resident's written plan of	admission, but no later than seven calendar days after
		care as soon as possible after admission, but no later	the resident's comprehensive assessments are
		than seven calendar days after the resident's	completed.
		comprehensive assessments are completed.	
			PC.11.03.01, EP 9
		PC.01.03.01, EP 22	For swing beds in critical access hospitals: The
		Based on the goals established in the patient's plan of	resident's written plan of care is developed by an
		care, staff evaluate the patient's progress.	interdisciplinary team comprised of health care
			professionals involved in the resident's care, treatment,
		PC.01.03.01, EP 23	and services. At a minimum, the team includes the
		The critical access hospital revises plans and goals for	attending physician, registered nurse with responsibility
		care, treatment, and services based on the patient's	for the resident, nurse aide with responsibility for the
		needs.	resident, a member of the food and nutrition services
			staff, and other appropriate staff as determined by the
		PC.02.01.01, EP 1	resident's needs or as requested by the resident.
		The critical access hospital provides the patient with	Note: The plan of care is reviewed and revised by the
		care, treatment, and services according to the patient's	interdisciplinary team after each assessment.
		individualized plan of care.	
			RC.12.03.01, EP 5
		PC.02.04.06, EP 1	For swing beds in critical access hospitals: When the
		For critical access hospitals with swing beds: The	critical access hospital anticipates the discharge of a
		interdisciplinary team works in partnership with the	resident, the discharge summary includes but is not
		resident to achieve planned outcomes.	limited to the following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			- A summary of the resident's stay that includes at a
		PC.02.04.06, EP 2	minimum the resident's diagnosis, course of
		For critical access hospitals with swing beds: The	illness/treatment or therapy, and pertinent laboratory,
		interdisciplinary team involves the resident and the	radiology, and consultation results
		resident's representative in the development of the	- A final summary of the resident's status to include
		treatment plan.	items in 42 CFR 483.20 (b)(1) at the time of the
		Note: The treatment plan includes the following:	discharge that is available for release to authorized
		- Any specialized or rehabilitation services the critical	persons and agencies, with the consent of the resident
		access hospital will provide as a result of preadmission	or resident's representative.
		screening and resident review (PASARR)	- Reconciliation of all predischarge medications with
		recommendations. Disagreement with PASARR	the resident's postdischarge medications (both
		recommendations is documented in the resident's	prescribed and over-the-counter).
		record.	- A postdischarge plan of care, which will assist the
		- The resident's goals for admission and desired	resident to adjust to his or her new living environment,
		outcomes.	that is developed with the participation of the resident
		- The resident's preferences and potential for future	and, with the resident's consent, the resident
		discharge.	representative(s). The postdischarge plan of care
		- Discharge plans.	indicates where the individual plans to reside, any
		- Measurable objectives and time frames to meet a	arrangements that have been made for the resident's
		resident's medical, nursing, and mental and psychosocial	follow up care, and any postdischarge medical and
		needs.	nonmedical services
		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	

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		access hospital provides services (directly or through	occupational therapy, respiratory therapy, and
		referral) to facilitate family support, social work, nursing	rehabilitative services for a mental disorder and
		care, dental care, rehabilitation, primary physician care,	intellectual disability or services of a lesser intensity,
		or discharge.	the critical access hospital provides or obtains the
			required services from a provider of specialized
		PC.02.02.01, EP 10	rehabilitative services and is not excluded from
		When the critical access hospital uses external resources	participating in any federal or state health care
		to meet the patient's needs, it coordinates the patient's	programs pursuant to section 1128 and 1156 of the
		care, treatment, and services.	Social Security Act.
§485.645(d)(7)	(7) Dental services (§483.55(a)(2),	PC.02.02.01, EP 9	PC.14.02.01, EP 3
	(3), (4), and (5) and (b) of this	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	chapter).	access hospital provides services (directly or through	access hospital assists residents who are eligible and
		referral) to facilitate family support, social work, nursing	wish to apply for reimbursement of dental services as
		care, dental care, rehabilitation, primary physician care,	an incurred medical expense under the state plan. The
		or discharge.	critical access hospital may charge a Medicare resident
			an additional amount for routine and emergency dental
		PC.02.02.01, EP 10	services.
		When the critical access hospital uses external resources	
		to meet the patient's needs, it coordinates the patient's	PC.14.02.01, EP 4
		care, treatment, and services.	For swing beds in critical access hospitals: The critical
			access hospital develops and implements a policy
		PC.02.02.01, EP 12	identifying circumstances when loss of or damage to a
		For swing beds in critical access hospitals: The critical	resident's dentures is the critical access hospital's
		access hospital assists residents who are eligible and	responsibility, and it may not charge a resident for the
		wish to apply for reimbursement of dental services as an	loss or damage of dentures.
		incurred medical expense under the state plan. The	
		critical access hospital may charge a Medicare resident	PC.14.02.01, EP 5
		an additional amount for routine and emergency dental	For swing beds in critical access hospitals: If necessary
		services.	or requested, the critical access hospital assists
		DO 00 00 04 FD 00	residents in making dental appointments and arranging
		PC.02.01, EP 29	for transportation to and from the dental services
		For critical access hospitals with swing beds: The critical	location.
		access hospital follows its policy identifying	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
Cor Requirement	COP Text	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	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
		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.	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.
		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.	
§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	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- Medications
			- Need for special treatment(s) and procedure(s)
		PC.01.02.03, EP 3	- Discharge planning
		Each patient is reassessed as necessary based on their	Note: The critical access hospital maintains the
		plan for care or changes in their condition.	resident's acceptable nutritional status parameters
		Note 1: Reassessments may also be based on the	unless the resident's clinical condition demonstrates
		patient's diagnosis; desire for care, treatment, and	that this is not possible or the resident's preferences
		services; response to previous care, treatment, and	indicate otherwise.
		services; discharge planning needs; and/or their setting	
		requirements.	PC.12.01.09, EP 3
		Note 2: For rehabilitation distinct part units in critical	For swing beds in critical access hospitals: The critical
		access hospitals: The Centers for Medicare & Description (1997)	access hospital offers the resident sufficient fluid
		Medicaid Services requires that a physician with	intake to maintain proper hydration and health.
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
Cor noquironicine		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	
§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.	care.	
§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, 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
CoP Requirement	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.	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.
		Note 2: For swing beds in critical access hospitals: The resident has the right to be informed in advance of	

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	RI.01.01.01, EP 1	RI.12.01.01, EP 3
	representative whose decision-	The critical access hospital has written policies on	For swing beds in critical access hospitals: If a resident
	making authority is limited by	patient rights.	is adjudged incompetent under state law by a court of
	State law or court appointment,	Note: The critical access hospital's written policies	proper jurisdiction, the rights of the resident
	the resident retains the right to	address procedures regarding patient visitation rights,	automatically transfer to and are exercised by a
	make those decision outside the	including any clinically necessary or reasonable	resident representative appointed by the court under
	representative's authority.	restrictions or limitations.	state law to act on the resident's behalf. The resident
			representative exercises the resident's rights to the
		RI.01.02.01, EP 1	extent allowed by the court in accordance with state
		The critical access hospital involves the patient in making	law.
		decisions about their care, treatment, and services,	Note 1: If a resident representative's decision-making
		including the right to have the patient's family and	authority is limited by state law or court appointment,
		physician or other licensed practitioner promptly notified	the resident retains the right to make those decisions
		of their admission to or discharge or transfer from the	outside the representative's authority.
		critical access hospital.	Note 2: The resident's wishes and preferences are
		Note 1: The patient is informed, prior to the notification	considered by the representative when exercising the
		occurring, of any process to automatically notify the	patient's rights.
		patient's established primary care practitioner, primary	Note 3: To the extent practicable, the resident is
		care practice group/entity, or other practitioner	provided with opportunities to participate in the care
		group/entity, as well as all applicable post–acute care	planning process.
		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	

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	RI.01.01.01, EP 1	RI.12.01.01, EP 3
	preferences must be considered in	The critical access hospital has written policies on	For swing beds in critical access hospitals: If a resident
	the exercise of rights by the	patient rights.	is adjudged incompetent under state law by a court of
	representative.	Note: The critical access hospital's written policies	proper jurisdiction, the rights of the resident
		address procedures regarding patient visitation rights,	automatically transfer to and are exercised by a
		including any clinically necessary or reasonable	resident representative appointed by the court under
		restrictions or limitations.	state law to act on the resident's behalf. The resident
		DI OLOLOLO ED O	representative exercises the resident's rights to the
		RI.01.01.01, EP 6	extent allowed by the court in accordance with state
		The critical access hospital respects the patient's cultural	law.
		and personal values, beliefs, and preferences.	Note 1: If a resident representative's decision-making authority is limited by state law or court appointment,
		RI.01.02.01, EP 1	the resident retains the right to make those decisions
		The critical access hospital involves the patient in making	outside the representative's authority.
		decisions about their care, treatment, and services,	Note 2: The resident's wishes and preferences are
		including the right to have the patient's family and	considered by the representative when exercising the
		physician or other licensed practitioner promptly notified	patient's rights.
		of their admission to or discharge or transfer from the	Note 3: To the extent practicable, the resident is
		critical access hospital.	provided with opportunities to participate in the care
		Note 1: The patient is informed, prior to the notification	planning process.
		occurring, of any process to automatically notify the	
		patient's established primary care practitioner, primary	
		care practice group/entity, or other practitioner	

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	RI.01.02.01, EP 1	RI.12.01.01, EP 3
	resident must be provided with	The critical access hospital involves the patient in making	For swing beds in critical access hospitals: If a resident
	opportunities to participate in the	decisions about their care, treatment, and services,	is adjudged incompetent under state law by a court of
	care planning process.	including the right to have the patient's family and	proper jurisdiction, the rights of the resident
		physician or other licensed practitioner promptly notified	automatically transfer to and are exercised by a
		of their admission to or discharge or transfer from the	resident representative appointed by the court under
		critical access hospital.	state law to act on the resident's behalf. The resident
		Note 1: The patient is informed, prior to the notification	representative exercises the resident's rights to the
		occurring, of any process to automatically notify the	extent allowed by the court in accordance with state
		patient's established primary care practitioner, primary	law.
		care practice group/entity, or other practitioner	Note 1: If a resident representative's decision-making
		group/entity, as well as all applicable post–acute care	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.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		(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
§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	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.	
	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,	RI.01.02.01, EP 1	RI.12.01.01, EP 4
	and/ or discontinue treatment, to	The critical access hospital involves the patient in making	For swing beds in critical access hospitals: The resident
	participate in or refuse to	decisions about their care, treatment, and services,	has the right to request, refuse, and/or discontinue
	participate in experimental	including the right to have the patient's family and	treatment; to participate in or refuse to participate in
	research, and to formulate an	physician or other licensed practitioner promptly notified	experimental research; and to formulate an advance
	advance directive.	of their admission to or discharge or transfer from the	directive.
		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	

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.	
		DI 04 05 04 ED 4	
		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,	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
\$483.10(d)	(d) Choice of attending physician. The resident has the right to choose his or her attending physician.	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.01.06.09, 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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	alternate physician participation	unlicensed or unable to serve as the attending physician.	physicians at 42 CFR 483, the critical access hospital
	to assure provision of appropriate	The critical access hospital also discusses alternative	may seek alternative physician participation to assure
	and adequate care and treatment.	physician participation with the resident and honors the	provision of appropriate and adequate care and
	The facility must discuss the	resident's preferences, if any, among the options.	treatment. The critical access hospital informs the
	alternative physician participation		resident if it determines that the physician chosen by
	with the resident and honor the		the resident is unlicensed or unable to serve as the
	resident's preferences, if any,		attending physician. The critical access hospital also
	among options.		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	RI.01.06.09, EP 1	RI.12.01.01, EP 6
	selects another attending	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	physician who meets the	access hospital supports the resident's right to choose an	access hospital supports the residents right to choose
	requirements specified in this	attending physician, dentist, and other care providers.	a licensed attending physician.
	part, the facility must honor that	Note: The critical access hospital informs the resident if it	Note: If the physician chosen by the resident refuses to
	choice.	determines that the physician chosen by the resident is	or does not meet the requirements for attending
		unlicensed or unable to serve as the attending physician.	physicians at 42 CFR 483, the critical access hospital
		The critical access hospital also discusses alternative	may seek alternative physician participation to assure
		physician participation with the resident and honors the	provision of appropriate and adequate care and
		resident's preferences, if any, among the options.	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,
0.400, 404, 1			among the options.
§483.10(e)	(e) Respect and dignity. The		
	resident has a right to be treated		
\$400.40(-)(0)	with respect and dignity, including:	DI 04 00 05 FD 4	DI 40 04 00 FD 4
§483.10(e)(2)	(2) The right to retain and use	RI.01.06.05, EP 4	RI.13.01.03, EP 1
	personal possession, including	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	furnishings, and clothing, as space	access hospital allows the resident to keep and use	access hospital allows the resident to keep and use
	permits, unless to do so would	personal clothing and possessions, unless this infringes	personal clothing and possessions, unless this infringes

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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, 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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
			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
§483.10(g)(17)	(17) The facility must—		expense.
\$483.10(g)(17)(i)	(i) Inform each Medicaid-eligible		
0.000.0(8)(1.7)(.)	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	LD.04.02.03, EP 13	LD.13.02.01, EP 2
	included in nursing facility	For swing beds in critical access hospitals: Each resident	For swing beds in critical access hospitals: Each
	services under the State plan and	who is entitled to Medicaid benefits is informed in writing,	Medicaid-eligible resident is informed in writing, either
	for which the resident may not be	either at the time of admission or when the resident	at the time of admission or when the resident becomes
	charged;	becomes eligible for Medicaid, of the following:	eligible for Medicaid, of the following:
		- The items and services included in the state plan for	- Items and services included in the state plan for which
		which the resident may not be charged	the resident may not be charged
		- Those items and services that the facility offers and for	- Items and services that the critical access hospital
		which the resident may be charged, and the amount of	offers, those for which the resident may be charged,
		charges for those services	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	LD.04.02.03, EP 13	LD.13.02.01, EP 2
	that the facility offers and for	For swing beds in critical access hospitals: Each resident	For swing beds in critical access hospitals: Each
	which the resident may be	who is entitled to Medicaid benefits is informed in writing,	Medicaid-eligible resident is informed in writing, either
	charged, and the amount of	either at the time of admission or when the resident	at the time of admission or when the resident becomes
	charges for those services; and	becomes eligible for Medicaid, of the following:	eligible for Medicaid, of the following:
		- The items and services included in the state plan for	- Items and services included in the state plan for which
		which the resident may not be charged	the resident may not be charged
		- Those items and services that the facility offers and for	- Items and services that the critical access hospital

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		which the resident may be charged, and the amount of	offers, those for which the resident may be charged,
		charges for those services	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	LD.04.02.03, EP 14	LD.13.02.01, EP 2
	resident when changes are made	For swing beds in critical access hospitals: Residents are	For swing beds in critical access hospitals: Each
	to the items and services specified	informed when changes are made to the services that are	Medicaid-eligible resident is informed in writing, either
	in §483.10(g)(17)(i)(A) and (B) of	specified in LD.04.02.03, EP 13.	at the time of admission or when the resident becomes
	this section.		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	LD.04.02.03, EP 16	LD.13.02.01, EP 3
3.331.3(8)(13)	resident before, or at the time of	For swing beds in critical access hospitals: Residents are	For swing beds in critical access hospitals: The critical
	admission, and periodically during	informed before or at the time of admission, and	access hospital informs residents before or at the time
	the resident's stay, of services	periodically during the resident's stay, of services	of admission, and periodically during the resident's
	available in the facility and of	available in the facility and of charges for those services	stay, of services available in the critical access hospital
	charges for those services,	not covered under Medicare or by the facility's per diem	and of charges for those services not covered under
	including any charges for services	rate.	Medicare, Medicaid, or by the critical access hospital's
	not covered under Medicare/		per diem rate.
	Medicaid or by the facility's per		
	diem rate.		
§483.10(h)	(h) Privacy and confidentiality.	IM.02.01.01, EP 1	IM.12.01.01, EP 1
	The resident has a right to	The critical access hospital follows a written policy	The critical access hospital develops and implements
	personal privacy and	addressing the privacy and confidentiality of health	policies and procedures addressing the privacy and
	confidentiality of his or her	information.	confidentiality of health information.
	personal and medical records.	W 00 04 04 FD 0	Note: For swing beds in critical access hospitals:
		IM.02.01.01, EP 3	Policies and procedures also address the resident's
		The critical access hospital uses health information only	personal records.

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	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	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.
	private room for each resident.	for purposes permitted by law and regulation or as further limited by its policy on privacy.	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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		IM.02.01.01, EP 4	resident groups, but this does not require the facility to
		The critical access hospital discloses health information	provide a private room for each resident.
		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.	
		117.02.01.01.	
		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	
\$400 40(L)(0)	(0) The facility was a second of	visitors in comfort and privacy.	DI 44 04 04 ED 5
§483.10(h)(2)	(2) The facility must respect the	RI.01.01.01, EP 7	RI.11.01.01, EP 5
	residents right to personal privacy,	The critical access hospital respects the patient's right to	The critical access hospital respects the patient's right
	including the right to privacy in his	privacy.	to personal privacy.
	or her oral (that is, spoken), written, and electronic	Note: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the privacy	Note 1: This element of performance (EP) addresses a patient's personal privacy. For EPs addressing the
	willen, and electronic	patient's personal privacy, For Er's addressing the privacy	patient 5 personal privacy. For EFS addressing the

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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.	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.
		RI.01.01.01, EP 1 The critical access hospital has written policies on	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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		

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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	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.
		PC.03.05.01, EP 4 The critical access hospital uses the least restrictive form	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		of restraint or seclusion that protects the physical safety	
		of the patient, staff, or others.	
		DO 02 05 04 FD 5	
		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.	
		Some dated 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	
0.400.40(.)(0)	(0) 11	Care, Treatment, and Services" (PC) chapter.	
§483.12(a)(3)	(3) Not employ or otherwise		
§483.12(a)(3)(i)	engage individuals who— (i) Have been found guilty of	HR.01.01.01, EP 18	HR.11.02.01, EP 4
8465.12(a)(5)(1)	abuse, neglect, exploitation,	For swing beds in critical access hospitals: The facility	For swing beds in critical access hospitals: The critical
	misappropriation of property, or	does not employ individuals who have been found guilty	access hospital does not employ individuals who have
	mistreatment by a court of law;	by a court of law of abusing, neglecting, exploiting,	been found guilty by a court of law of abusing,
	,	misappropriating property, or mistreating residents or	neglecting, exploiting, misappropriating property, or
		who have had a finding entered into the state nurse aide	mistreating residents or who have had a finding entered
		registry concerning abuse, neglect, exploitation,	into the state nurse aide registry concerning abuse,
		mistreatment of residents, or misappropriation of	neglect, exploitation, mistreatment of residents, or
		residents' property.	misappropriation of residents' property.
§483.12(a)(3)(ii)	(ii) Have had a finding entered into	HR.01.01.01, EP 18	HR.11.02.01, EP 4
	the State nurse aide registry	For swing beds in critical access hospitals: The facility	For swing beds in critical access hospitals: The critical
	concerning abuse, neglect,	does not employ individuals who have been found guilty	access hospital does not employ individuals who have
	exploitation, mistreatment of	by a court of law of abusing, neglecting, exploiting,	been found guilty by a court of law of abusing,
	residents or misappropriation of	misappropriating property, or mistreating residents or	neglecting, exploiting, misappropriating property, or
	their property; or	who have had a finding entered into the state nurse aide	mistreating residents or who have had a finding entered

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	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	RI.01.06.03, EP 4	RI.13.01.01, EP 3
	procedures to investigate any such allegations, and	For critical access hospitals with swing beds: The critical access hospital develops and implements written	For critical access hospitals with swing beds: The critical access hospital develops and implements

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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.	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.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.	
§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	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.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
	cause the allegation do not involve abuse and do not result in serious	RI.01.06.03, EP 1	based on its evaluation of the suspected events or as required by law.

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		Note: For critical access hospitals with swing beds: The	prevents further abuse, neglect, exploitation, or
		critical access hospital protects residents from	mistreatment while the investigation is in progress. The
		involuntary seclusion.	results of all investigations are reported to the
			administrator or their designated representative and to
		RI.01.06.03, EP 5	other officials in accordance with state law, including
		For critical access hospitals with swing beds: The critical	the state survey agency, within five working days of the
		access hospital has evidence that all alleged violations	incident. If the alleged violation is verified, appropriate
		are thoroughly investigated and that it prevents further	corrective actions is taken.
		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.	
§483.12(c)(3)	(3) Prevent further potential abuse,	RI.01.06.03, EP 1	RI.13.01.01, EP 5
	neglect, exploitation, or	The critical access hospital protects the patient from	For critical access hospitals with swing beds: The
	mistreatment while the	harassment, neglect, exploitation, corporal punishment,	critical access hospital has evidence that all alleged
	investigation is in progress.	and abuse that could occur while the patient is receiving	violations of abuse, neglect, exploitation, or
		care, treatment, and services.	mistreatment are thoroughly investigated and that it
		Note: For critical access hospitals with swing beds: The	prevents further abuse, neglect, exploitation, or
		critical access hospital protects residents from	mistreatment while the investigation is in progress. The
		involuntary seclusion.	results of all investigations are reported to the
		DI 04 00 00 FD 5	administrator or their designated representative and to
		RI.01.06.03, EP 5	other officials in accordance with state law, including
		For critical access hospitals with swing beds: The critical	the state survey agency, within five working days of the
		access hospital has evidence that all alleged violations	incident. If the alleged violation is verified, appropriate
		are thoroughly investigated and that it prevents further	corrective actions is taken.
		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.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	PC.04.01.07, EP 1	PC.14.01.03, EP 1
	necessary for the resident's	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	welfare and the resident's needs	access hospital transfers or discharges residents only	access hospital transfers or discharges residents only
	cannot be met in the facility;	when at least one of the following conditions is met:	under at least one of the following conditions:
		- The resident's health has improved to the point where	- The resident's health has improved to the point where
		they no longer need the critical access hospital's	they no longer need the critical access hospital's
		services.	services.
		- The transfer or discharge is necessary for the resident's	- The transfer or discharge is necessary for the
		welfare and the critical access hospital cannot meet the	resident's welfare, and the critical access hospital
		resident's needs.	cannot meet the resident's needs.
		- The safety of the individuals in the critical access	- The safety of the individuals in the critical access

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		resident's needs.	cannot meet the resident's needs.
		- The safety of the individuals in the critical access	- The safety of the individuals in the critical access
		hospital is endangered due to the clinical or behavioral	hospital is endangered due to the resident's clinical or
		status of the resident.	behavioral status.
		- The health of individuals in the critical access hospital	- The health of individuals in the critical access hospital
		would otherwise be endangered.	would otherwise be endangered.
		- The resident has failed, after reasonable and	- The resident has failed, after reasonable and
		appropriate notice, to pay for (or to have paid under	appropriate notice, to pay for (or to have paid under
		Medicare or Medicaid) a stay at the critical access	Medicare or Medicaid) a stay at the critical access
		hospital. Nonpayment applies if the resident does not	hospital. Nonpayment applies if the resident does not
		submit the necessary paperwork for third party payment	submit the necessary paperwork for third party
		or after the third party, including Medicare or Medicaid,	payment or after the third party, including Medicare or
		denies the claim and the resident refuses to pay for their	Medicaid, denies the claim and the resident refuses to
		stay. For a resident who becomes eligible for Medicaid	pay for their stay. For a resident who becomes eligible
		after admission to a critical access hospital, the critical	for Medicaid after admission to a critical access
		access hospital may charge a resident only the allowable	hospital, the critical access hospital may charge a
		charges under Medicaid.	resident only the allowable charges under Medicaid.
		- The critical access hospital ceases operation.	- The critical access hospital ceases operation.
		Note: The critical access hospital cannot transfer or	Note: The critical access hospital cannot transfer or
		discharge a resident while an appeal is pending pursuant	discharge a resident while an appeal is pending
		to 42 CFR 431.230, unless the failure to discharge or	pursuant to 42 CFR 431.230, unless the failure to
		transfer would endanger the health or safety of the	discharge or transfer would endanger the health or
		resident or other individuals in the critical access	safety of the resident or other individuals in the critical
		hospital. The critical access hospital documents the	access hospital. The critical access hospital
		danger that failure to transfer or discharge would pose.	documents the danger that failure to transfer or
2422 457 \(\d\dagger)(2)(2)	(O) TI () () () () ()	DO 04 04 07 FD 4	discharge would pose.
§483.15(c)(1)(i)(C)	(C) The safety of individuals in the	PC.04.01.07, EP 1	PC.14.01.03, EP 1
	facility is endangered due to the	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	clinical or behavioral status of the	access hospital transfers or discharges residents only	access hospital transfers or discharges residents only
	resident;	when at least one of the following conditions is met:	under at least one of the following conditions:
		- The resident's health has improved to the point where	- The resident's health has improved to the point where
		they no longer need the critical access hospital's	they no longer need the critical access hospital's
		services.	services.

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

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

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

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		hospital. The critical access hospital documents the	documents the danger that failure to transfer or
		danger that failure to transfer or discharge would pose.	discharge would pose.
§483.15(c)(1)(ii)	(ii) The facility may not transfer or	PC.04.01.07, EP 1	PC.14.01.03, EP 1
	discharge the resident while the	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	appeal is pending, pursuant to §	access hospital transfers or discharges residents only	access hospital transfers or discharges residents only
	431.230 of this chapter, when a	when at least one of the following conditions is met:	under at least one of the following conditions:
	resident exercises his or her right	- The resident's health has improved to the point where	- The resident's health has improved to the point where
	to appeal a transfer or discharge	they no longer need the critical access hospital's	they no longer need the critical access hospital's
	notice from the facility pursuant to	services.	services.
	§ 431.220(a)(3) of this chapter,	- The transfer or discharge is necessary for the resident's	- The transfer or discharge is necessary for the
	unless the failure to discharge or	welfare and the critical access hospital cannot meet the	resident's welfare, and the critical access hospital
	transfer would endanger the	resident's needs.	cannot meet the resident's needs.
	health or safety of the resident or	- The safety of the individuals in the critical access	- The safety of the individuals in the critical access
	other individuals in the facility. The	hospital is endangered due to the clinical or behavioral	hospital is endangered due to the resident's clinical or
	facility must document the danger	status of the resident.	behavioral status.
	that failure to transfer or discharge	- The health of individuals in the critical access hospital	- The health of individuals in the critical access hospital
	would pose.	would otherwise be endangered.	would otherwise be endangered.
		- The resident has failed, after reasonable and	- The resident has failed, after reasonable and
		appropriate notice, to pay for (or to have paid under	appropriate notice, to pay for (or to have paid under
		Medicare or Medicaid) a stay at the critical access	Medicare or Medicaid) a stay at the critical access
		hospital. Nonpayment applies if the resident does not	hospital. Nonpayment applies if the resident does not
		submit the necessary paperwork for third party payment	submit the necessary paperwork for third party
		or after the third party, including Medicare or Medicaid,	payment or after the third party, including Medicare or
		denies the claim and the resident refuses to pay for their	Medicaid, denies the claim and the resident refuses to
		stay. For a resident who becomes eligible for Medicaid	pay for their stay. For a resident who becomes eligible
		after admission to a critical access hospital, the critical	for Medicaid after admission to a critical access
		access hospital may charge a resident only the allowable	hospital, the critical access hospital may charge a
		charges under Medicaid.	resident only the allowable charges under Medicaid.
		- The critical access hospital ceases operation.	- The critical access hospital ceases operation.
		Note: The critical access hospital cannot transfer or	Note: The critical access hospital cannot transfer or
		discharge a resident while an appeal is pending pursuant	discharge a resident while an appeal is pending
		to 42 CFR 431.230, unless the failure to discharge or	pursuant to 42 CFR 431.230, unless the failure to
		transfer would endanger the health or safety of the	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	safety of the resident or other individuals in the critical
		hospital. The critical access hospital documents the	access hospital. The critical access hospital
		danger that failure to transfer or discharge would pose.	documents the danger that failure to transfer or
			discharge would pose.
§483.15(c)(2)	(2) Documentation. When the	RC.02.04.01, EP 1	RC.12.03.01, EP 1
	facility transfers or discharges a	For swing beds in critical access hospitals:	For swing beds in critical access hospitals:
	resident under any of the	Documentation in the medical record includes discharge	Documentation in the medical record includes
	circumstances specified in	information provided to the resident and/or to the	discharge information provided to the resident and/or to
	paragraphs (c)(1)(i)(A) through (F)	receiving organization. There is documentation in the	the receiving organization. A physician document in the
	of this section, the facility must	resident's medical record by the resident's physician	resident's medical record when the resident is being
	ensure that the transfer or	when the resident is transferred or discharged, either	transferred or discharged because the safety of other
	discharge is documented in the	when the transfer is due to the resident improving and no	residents would otherwise be endangered. The
	resident's medical record and	longer needing long term care services or when the	resident's physician documents in the medical record
	appropriate information is	resident's needs cannot be met in the critical access	when the transfer is due to the resident improving and
	communicated to the receiving	hospital's swing bed. There is documentation in the	no longer needing long term care services or when the
	health care institution or provider.	resident's medical record by a physician when the	transfer is due to the resident's welfare and resident's
		resident is being transferred or discharged because the	needs cannot be met in the critical access hospital's
		safety of other residents would otherwise be endangered.	swing bed.
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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	FC.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	RC.02.04.01, EP 2	RC.12.03.01, EP 3
	(c)(1)(i)(A) of this section, the	For swing beds in critical access hospitals: The resident's	For swing beds in critical access hospitals: When the
	specific resident need(s) that	discharge information includes the following:	resident is transferred or discharged because the
	cannot be met, facility attempts to	- The reason for transfer, discharge, or referral	critical access hospital cannot meet their needs, the
	meet the resident needs, and the	- Treatment provided, diet, medication orders, and orders	critical access hospital documents which needs could
	service available at the receiving	for the resident's immediate care	not be met, the critical access hospital's attempts to
	facility to meet the need(s).	- Referrals provided to the resident, the referring	meet the resident's needs, and the services available at
		physician's or other licensed practitioner's name, and the	the receiving organization that will meet the resident's
		name of the physician or other licensed practitioner who	needs.
		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)(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	PC.04.01.01, EP 14	RC.12.03.01, EP 1
	transfer or discharge is necessary	The critical access hospital transfers a patient upon order	For swing beds in critical access hospitals:
	under paragraph (c)(1)(A) or (B) of	of their attending physician.	Documentation in the medical record includes
	this section; and		discharge information provided to the resident and/or to
		RC.02.04.01, EP 1	the receiving organization. A physician document in the
		For swing beds in critical access hospitals:	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 is being transferred or discharged because the	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 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:	and, and and real and an	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.15(c)(2)(iii)(A)	(A) Contact information of the	PC.04.02.01, EP 1	PC.14.02.03, EP 1
	practitioner responsible for the	At the time of the patient's discharge or transfer, the	The critical access hospital provides or transmits
	care of the resident	critical access hospital informs other service providers	necessary medical information when discharging,
		who will provide care, treatment, and services to the	transferring, or referring the patient to post–acute care
		patient about the following:	service providers and suppliers, facilities, agencies, and
		- The reason for the patient's discharge or transfer	other outpatient service providers and practitioners
		- The patient's physical and psychosocial status	who are responsible for the patient's follow-up or
		- A summary of care, treatment, and services it provided	ancillary care. Necessary medical information includes,
		to the patient	at a minimum, the following:
		- The patient's progress toward goals	- Current course of illness and treatment
		- A list of community resources or referrals made or	- Postdischarge goals of care
		provided to the patient	- Treatment preferences at the time of discharge
			Note: For swing beds in critical access hospitals: The
		Note: For swing beds in critical access hospitals: The	information sent to the receiving provider also includes
		information sent to the receiving provider also includes	the following:
		the following:	- Contact information of the physician or other licensed
		- Contact information of the physician or other licensed	practitioner responsible for the care of the resident
		practitioner responsible for the care of the resident	- Resident representative information, including contact
		- Resident representative information, including contact	information
		information	- Advance directive information
		- Advance directive information	- All special instructions or precautions for ongoing
		- All special instructions or precautions for ongoing care,	care, when appropriate
		when appropriate	- Comprehensive care plan goals
		- Comprehensive care plan goals	- All other necessary information, including a copy of the residents discharge summary, consistent with 42
		RC.02.04.01, EP 1	CFR 483.21(c)(2), and any other documentation, as
		For swing beds in critical access hospitals:	applicable, to support a safe and effective transition of
		Documentation in the medical record includes discharge	care
		information provided to the resident and/or to the	33.3
		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	

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	PC.04.02.01, EP 1	PC.14.02.03, EP 1
	information including contact	At the time of the patient's discharge or transfer, the	The critical access hospital provides or transmits
	information.	critical access hospital informs other service providers	necessary medical information when discharging,
		who will provide care, treatment, and services to the	transferring, or referring the patient to post–acute care

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

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	
0.400.45(.)(0)("")(0)	(0) 4 1	- Attempts to meet the resident's needs	DO 44.00.00 ED 4
§483.15(c)(2)(iii)(C)	(C) Advance Directive information.	PC.04.02.01, EP 1	PC.14.02.03, EP 1
		At the time of the patient's discharge or transfer, the	The critical access hospital provides or transmits
		critical access hospital informs other service providers	necessary medical information when discharging,
		who will provide care, treatment, and services to the	transferring, or referring the patient to post-acute care
		patient about the following:	service providers and suppliers, facilities, agencies, and
		- The reason for the patient's discharge or transfer	other outpatient service providers and practitioners
		- The patient's physical and psychosocial status	who are responsible for the patient's follow-up or
		- A summary of care, treatment, and services it provided	ancillary care. Necessary medical information includes,

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

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	
§483.15(c)(2)(iii)(D)	(D) All special instructions or precautions for ongoing care, as appropriate.	- Attempts to meet the resident's needs 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
		Note: For swing beds in critical access hospitals: The	information sent to the receiving provider also includes
		information sent to the receiving provider also includes	the following:
		the following:	- Contact information of the physician or other licensed
		- Contact information of the physician or other licensed	practitioner responsible for the care of the resident
		practitioner responsible for the care of the resident	- Resident representative information, including contact
		- Resident representative information, including contact	information
		information	- Advance directive information
		- Advance directive information	- All special instructions or precautions for ongoing
		- All special instructions or precautions for ongoing care,	care, when appropriate
		when appropriate	- Comprehensive care plan goals
		- Comprehensive care plan goals	- All other necessary information, including a copy of
			the residents discharge summary, consistent with 42
		RC.02.04.01, EP 1	CFR 483.21(c)(2), and any other documentation, as
		For swing beds in critical access hospitals:	applicable, to support a safe and effective transition of
		Documentation in the medical record includes discharge	care
		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	

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
		practitioner responsible for the care of the resident	- Resident representative information, including contact
		- Resident representative information, including contact	information
		information	- Advance directive information
		- Advance directive information	- All special instructions or precautions for ongoing
		- All special instructions or precautions for ongoing care,	care, when appropriate
		when appropriate	- Comprehensive care plan goals
		- Comprehensive care plan goals	- All other necessary information, including a copy of
			the residents discharge summary, consistent with 42
		RC.02.04.01, EP 1	CFR 483.21(c)(2), and any other documentation, as
		For swing beds in critical access hospitals:	applicable, to support a safe and effective transition of
		Documentation in the medical record includes discharge	care
		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	

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	
§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
		- All special instructions or precautions for ongoing care,	care, when appropriate
		when appropriate	- Comprehensive care plan goals
		- Comprehensive care plan goals	- All other necessary information, including a copy of
			the residents discharge summary, consistent with 42
		RC.02.04.01, EP 1	CFR 483.21(c)(2), and any other documentation, as
		For swing beds in critical access hospitals:	applicable, to support a safe and effective transition of
		Documentation in the medical record includes discharge	care
		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,	

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	PC.04.01.03, EP 3	PC.14.01.01, EP 4
	resident's representative(s) of the	The patient, the patient's family, physicians, other	The patient, the patient's caregiver(s) or support
	transfer or discharge and the	licensed practitioners, clinical psychologists, and staff	person(s), physicians, other licensed practitioners,
	reasons for the move in writing and	involved in the patient's care, treatment, and services	clinical psychologists, and staff who are involved in the
	in a language and manner they	participate in planning the patient's discharge or transfer.	patient's care, treatment, and services participate in
	understand. The facility must send	Note 1: For rehabilitation and psychiatric distinct part	planning the patient's discharge or transfer. The patient
	a copy of the notice to a	units in critical access hospitals: The definition of	and their caregiver(s) or support person(s) are included
	representative of the Office of the	"physician" is the same as that used by the Centers for	as active partners when planning for postdischarge
	State Long-Term Care	Medicare & Defication of the Medicare & Defic	care.
	Ombudsman.	Glossary).	Note 1: For rehabilitation and psychiatric distinct part
		Note 2: For psychiatric distinct part units in critical	units in critical access hospitals: The definition of
		access hospitals: Social service staff responsibilities	"physician" is the same as that used by the Centers for
		include, but are not limited to, participating in discharge	Medicare & Description of the Medica
		planning, arranging for follow-up care, and developing	Glossary).
		mechanisms for exchange of information with sources	Note 2: For psychiatric distinct part units in critical
		outside the critical access hospital.	access hospitals: Social service staff responsibilities
		Note 3: For swing beds in critical access hospitals: The	include but are not limited to participating in discharge
		critical access hospital notifies the resident and, if	planning, arranging for follow-up care, and developing
		known, a family member or legal representative of the	mechanisms for exchange of information with sources
		resident of the transfer or discharge and reasons for the	outside the critical access hospital.
		move in writing. The hospital also provides sufficient	Note 3: For swing beds in critical access hospitals: The
		preparation and orientation to residents to make sure that	critical access hospital notifies the resident and, if
		transfer or discharge from the hospital is safe and orderly.	known, a family member or legal representative of the
		The critical access hospital sends a copy of the notice to	resident of the transfer or discharge and reasons for the
		a representative of the office of the state's long-term care	move. The notice is in writing, in a language and manner
		ombudsman.	they understand, and includes the items described in
		DI 04 04 04 ED 5	42 CFR 483.15(c)(5). The critical access hospital also
		RI.01.01.01, EP 5	provides sufficient preparation and orientation to

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
Got moquiroment		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
\$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.	written communication 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).
§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	clinical psychologists, and staff who are involved in the
		participate in planning the patient's discharge or transfer.	patient's care, treatment, and services participate in
		Note 1: For rehabilitation and psychiatric distinct part	planning the patient's discharge or transfer. The patient
		units in critical access hospitals: The definition of	and their caregiver(s) or support person(s) are included
		"physician" is the same as that used by the Centers for	as active partners when planning for postdischarge
		Medicare & mp; Medicaid Services (CMS) (refer to the	care.
		Glossary).	Note 1: For rehabilitation and psychiatric distinct part
		Note 2: For psychiatric distinct part units in critical	units in critical access hospitals: The definition of
		access hospitals: Social service staff responsibilities	"physician" is the same as that used by the Centers for
		include, but are not limited to, participating in discharge	Medicare & mp; Medicaid Services (refer to the
		planning, arranging for follow-up care, and developing	Glossary).
		mechanisms for exchange of information with sources	Note 2: For psychiatric distinct part units in critical
		outside the critical access hospital.	access hospitals: Social service staff responsibilities
		Note 3: For swing beds in critical access hospitals: The	include but are not limited to participating in discharge
		critical access hospital notifies the resident and, if	planning, arranging for follow-up care, and developing
		known, a family member or legal representative of the	mechanisms for exchange of information with sources
		resident of the transfer or discharge and reasons for the	outside the critical access hospital.
		move in writing. The hospital also provides sufficient	Note 3: For swing beds in critical access hospitals: The
		preparation and orientation to residents to make sure that	critical access hospital notifies the resident and, if
		transfer or discharge from the hospital is safe and orderly.	known, a family member or legal representative of the
		The critical access hospital sends a copy of the notice to	resident of the transfer or discharge and reasons for the
		a representative of the office of the state's long-term care	move. The notice is in writing, in a language and manner
		ombudsman.	they understand, and includes the items described in
			42 CFR 483.15(c)(5). The critical access hospital also
		RC.01.01.01, EP 5	provides sufficient preparation and orientation to
		The medical record includes the following:	residents to make sure that transfer or discharge from
		- Information needed to support the patient's diagnosis	the critical access hospital is safe and orderly. The
		and condition	critical access hospital sends a copy of the notice to a
		- Information needed to justify the patient's care,	representative of the office of the state's long-term care
		treatment, and services	ombudsman.
		- Information that documents the course and result of the	
		patient's care, treatment, and services	RI.11.02.01, EP 1
		- Information about the patient's care, treatment, and	The critical access hospital provides information,

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		services that promotes continuity of care among staff and	including but not limited to the patient's total health
		providers	status, in a manner tailored to the patient's age,
		Note: For critical access hospitals that elect The Joint	language, and ability to understand.
		Commission Primary Care Medical Home option: This	Note: The critical access hospital communicates with
		requirement refers to care provided by both internal and	the patient during the provision of care, treatment, and
		external providers.	services in a manner that meets the patient's oral and
			written communication needs.
		RI.01.01, EP 5	
		The critical access hospital respects the patient's right to	
		and need for effective communication.	
		DI OLOGO ED A	
		RI.01.03, EP 1	
		The critical access hospital provides information in a	
		manner tailored to the patient's age, language, and ability to understand.	
§483.15(c)(4)	(4) Timing of the notice.	to understand.	
\$483.15(c)(4)(i)	(i) Except as specified in	PC.04.01.03, EP 5	PC.14.01.01, EP 12
3400.10(0)(4)(1)	paragraphs (b)(4)(ii) and (b)(8) of	For swing beds in critical access hospitals: Except when	For swing beds in critical access hospitals: The critical
	this section, the notice of transfer	specified in the CoP from 42 CFR 483.12(a)(5)(ii), the	access hospital provides the written notice of transfer
	or discharge required under this	written notice of transfer or discharge required under	or discharge at least 30 days before the resident is
	section must be made by the	paragraph 42 CFR 483.12(a)(4) must be made by the	transferred or discharged.
	facility at least 30 days before the	critical access hospital at least 30 days before the	Note: Notice may be made as soon as is practical
	resident is transferred or	resident is transferred or discharged.	before transfer or discharge when the safety of the
	discharged.	Note: Notice may be made as soon as is practical before	individuals in the facility would be endangered, the
		transfer or discharge when the safety of the individuals in	health of the individuals in the facility would be
		the facility would be endangered; the health of the	endangered, the resident's health improves sufficiently
		individuals in the facility would be endangered; the	to allow a more immediate transfer or discharge,
		resident's health improves sufficiently to allow a more	immediate transfer or discharge is required by the
		immediate transfer or discharge, and immediate transfer	resident's urgent medical needs, or a resident has not
		or discharge is required by the resident's urgent medical	resided in the facility for 30 days.
		needs; or a resident has not resided in the facility for 30	
		days.	

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

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	PC.04.01.03, EP 5	PC.14.01.01, EP 12
	facility would be endangered,	For swing beds in critical access hospitals: Except when	For swing beds in critical access hospitals: The critical
	under paragraph (b)(1)(ii)(D) of this	specified in the CoP from 42 CFR 483.12(a)(5)(ii), the	access hospital provides the written notice of transfer
	section;	written notice of transfer or discharge required under	or discharge at least 30 days before the resident is
		paragraph 42 CFR 483.12(a)(4) must be made by the	transferred or discharged.
		critical access hospital at least 30 days before the	Note: Notice may be made as soon as is practical
		resident is transferred or discharged.	before transfer or discharge when the safety of the
		Note: Notice may be made as soon as is practical before	individuals in the facility would be endangered, the
		transfer or discharge when the safety of the individuals in	health of the individuals in the facility would be
		the facility would be endangered; the health of the	endangered, the resident's health improves sufficiently
		individuals in the facility would be endangered; the	to allow a more immediate transfer or discharge,
		resident's health improves sufficiently to allow a more	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	resident's urgent medical needs, or a resident has not
		or discharge is required by the resident's urgent medical	resided in the facility for 30 days.
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.15(c)(4)(ii)(C)	(C) The resident's health improves	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.04.01.03, EP 5	PC.14.01.01, EP 12
	sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section;	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.	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	PC.04.01.03, EP 5	PC.14.01.01, EP 12
	discharge is required by the	For swing beds in critical access hospitals: Except when	For swing beds in critical access hospitals: The critical
	resident's urgent medical needs,	specified in the CoP from 42 CFR 483.12(a)(5)(ii), the	access hospital provides the written notice of transfer
	under paragraph (b)(1)(ii)(A) of this	written notice of transfer or discharge required under	or discharge at least 30 days before the resident is
	section; or	paragraph 42 CFR 483.12(a)(4) must be made by the	transferred or discharged.
		critical access hospital at least 30 days before the	Note: Notice may be made as soon as is practical
		resident is transferred or discharged.	before transfer or discharge when the safety of the
		Note: Notice may be made as soon as is practical before	individuals in the facility would be endangered, the
		transfer or discharge when the safety of the individuals in	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	endangered, the resident's health improves sufficiently
		individuals in the facility would be endangered; the	to allow a more immediate transfer or discharge,
		resident's health improves sufficiently to allow a more	immediate transfer or discharge is required by the
		immediate transfer or discharge, and immediate transfer	resident's urgent medical needs, or a resident has not
		or discharge is required by the resident's urgent medical	resided in the facility for 30 days.
		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	

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	PC.04.01.03, EP 6	PC.14.01.01, EP 13
	discharge;	For swing beds in critical access hospitals: The written	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	notice before transfer or discharge specified in 42 CFR
		from 42 CFR 483.12(a)(4) includes the following:	483.15(c)(3) includes the following:
		- The reason for transfer or discharge	- Reason for transfer or discharge
		- The effective date of transfer or discharge	- Effective date of transfer or discharge
		- The location to which the resident is transferred or	- Location to which the resident is transferred or
		discharged	discharged
		- A statement of the resident's appeal rights, including the	- Statement of the resident's appeal rights, including
		name, address (mailing and e-mail), and telephone	the name, address (mailing and e-mail), and telephone
		number of the entity which receives such requests;	number of the entity which receives appeal requests;
		information on how to obtain an appeal form; where to	information on how to obtain an appeal form; where to
		find assistance in completing the form; and how to	find assistance in completing the form; and how to
		submit the appeal hearing request	submit the appeal hearing request
		- The name, address (mailing and e-mail), and telephone	- Name, address (mailing and e-mail), and telephone
		number of the office of the state's long-term care	number of the office of the state's long-term care
		ombudsman	ombudsman
		- For a resident with intellectual and developmental	- For a resident with intellectual and developmental
		disabilities, the mailing and e-mail address and telephone	disabilities, the mailing and e-mail address and
		number of the agency responsible for the protection and	telephone number of the agency responsible for the
		advocacy of these individuals, established under Part C of	protection and advocacy of these individuals,
		the Developmental Disabilities Assistance and Bill of	established under Part C of the Developmental
		Rights Act of 2000	Disabilities Assistance and Bill of Rights Act of 2000
		- For a resident with a mental disorder or related	- For a resident with a mental disorder or related
		disabilities, the mailing and e-mail address and telephone	disabilities, the mailing and e-mail address and
		number of the agency responsible for the protection and	telephone number of the agency responsible for the
		advocacy of these individuals, established under the	protection and advocacy of these individuals,
		Protection and Advocacy for Mentally Ill Individuals Act	established under the Protection and Advocacy for
			Mentally Ill Individuals Act
§483.15(c)(5)(ii)	(ii) The effective date of transfer or	PC.04.01.03, EP 6	PC.14.01.01, EP 13
	discharge;	For swing beds in critical access hospitals: The written	For swing beds in critical access hospitals: The written
		notice before transfer or discharge specified in the CoP	notice before transfer or discharge specified in 42 CFR
		from 42 CFR 483.12(a)(4) includes the following:	483.15(c)(3) includes the following:
		- The reason for transfer or discharge	- Reason for transfer or discharge
		- The effective date of 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	- Location to which the resident is transferred or
		discharged - A statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives such requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - The name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act	- Statement of the resident's appeal rights, including the name, address (mailing and e-mail), and telephone number of the entity which receives appeal requests; information on how to obtain an appeal form; where to find assistance in completing the form; and how to submit the appeal hearing request - Name, address (mailing and e-mail), and telephone number of the office of the state's long-term care ombudsman - For a resident with intellectual and developmental disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 - For a resident with a mental disorder or related disabilities, the mailing and e-mail address and telephone number of the agency responsible for the protection and advocacy of these individuals, established under the Protection and Advocacy for
§483.15(c)(5)(iii)	(iii) The location to which the	PC.04.01.03, EP 6	Mentally Ill Individuals Act PC.14.01.01, EP 13
	resident is transferred or discharged;	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	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
§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	- Name, address (mailing and e-mail), and telephone
		number of the office of the state's long-term care	number of the office of the state's long-term care
		ombudsman	ombudsman
		- For a resident with intellectual and developmental	- For a resident with intellectual and developmental
		disabilities, the mailing and e-mail address and telephone	disabilities, the mailing and e-mail address and
		number of the agency responsible for the protection and	telephone number of the agency responsible for the
		advocacy of these individuals, established under Part C of	protection and advocacy of these individuals,
		the Developmental Disabilities Assistance and Bill of	established under Part C of the Developmental
		Rights Act of 2000	Disabilities Assistance and Bill of Rights Act of 2000
		- For a resident with a mental disorder or related	- For a resident with a mental disorder or related
		disabilities, the mailing and e-mail address and telephone	disabilities, the mailing and e-mail address and
		number of the agency responsible for the protection and	telephone number of the agency responsible for the
		advocacy of these individuals, established under the	protection and advocacy of these individuals,
		Protection and Advocacy for Mentally Ill Individuals Act	established under the Protection and Advocacy for
			Mentally Ill Individuals Act
§483.15(c)(5)(v)	(v) The name, address (mailing and	PC.04.01.03, EP 6	PC.14.01.01, EP 13
	email) and telephone number of	For swing beds in critical access hospitals: The written	For swing beds in critical access hospitals: The written
	the Office of the State Long-Term	notice before transfer or discharge specified in the CoP	notice before transfer or discharge specified in 42 CFR
	Care Ombudsman;	from 42 CFR 483.12(a)(4) includes the following:	483.15(c)(3) includes the following:
		- The reason for transfer or discharge	- Reason for transfer or discharge
		- The effective date of transfer or discharge	- Effective date of transfer or discharge
		- The location to which the resident is transferred or	- Location to which the resident is transferred or
		discharged	discharged
		- A statement of the resident's appeal rights, including the	- Statement of the resident's appeal rights, including
		name, address (mailing and e-mail), and telephone	the name, address (mailing and e-mail), and telephone
		number of the entity which receives such requests;	number of the entity which receives appeal requests;
		information on how to obtain an appeal form; where to	information on how to obtain an appeal form; where to
		find assistance in completing the form; and how to	find assistance in completing the form; and how to
		submit the appeal hearing request	submit the appeal hearing request
		- The name, address (mailing and e-mail), and telephone	- Name, address (mailing and e-mail), and telephone
		number of the office of the state's long-term care	number of the office of the state's long-term care
		ombudsman	ombudsman
		- For a resident with intellectual and developmental	- 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	Disabilities Assistance and Bill of Rights Act of 2000
		- For a resident with a mental disorder or related	- For a resident with a mental disorder or related
		disabilities, the mailing and e-mail address and telephone	disabilities, the mailing and e-mail address and
		number of the agency responsible for the protection and	telephone number of the agency responsible for the
		advocacy of these individuals, established under the	protection and advocacy of these individuals,
		Protection and Advocacy for Mentally Ill Individuals Act	established under the Protection and Advocacy for
			Mentally Ill Individuals Act
§483.15(c)(5)(vii)	(vii) For nursing facility residents	PC.04.01.03, EP 6	PC.14.01.01, EP 13
	with a mental disorder or related	For swing beds in critical access hospitals: The written	For swing beds in critical access hospitals: The written
	disabilities, the mailing and email	notice before transfer or discharge specified in the CoP	notice before transfer or discharge specified in 42 CFR
	address and telephone number of	from 42 CFR 483.12(a)(4) includes the following:	483.15(c)(3) includes the following:
	the agency responsible for the	- The reason for transfer or discharge	- Reason for transfer or discharge
	protection and advocacy of	- The effective date of transfer or discharge	- Effective date of transfer or discharge
	individuals with a mental disorder	- The location to which the resident is transferred or	- Location to which the resident is transferred or
	established under the Protection	discharged	discharged
	and Advocacy for Mentally Ill	- A statement of the resident's appeal rights, including the	- Statement of the resident's appeal rights, including
	Individuals Act.	name, address (mailing and e-mail), and telephone	the name, address (mailing and e-mail), and telephone
		number of the entity which receives such requests;	number of the entity which receives appeal requests;
		information on how to obtain an appeal form; where to	information on how to obtain an appeal form; where to
		find assistance in completing the form; and how to	find assistance in completing the form; and how to
		submit the appeal hearing request	submit the appeal hearing request
		- The name, address (mailing and e-mail), and telephone	- Name, address (mailing and e-mail), and telephone
		number of the office of the state's long-term care	number of the office of the state's long-term care
		ombudsman	ombudsman
		- For a resident with intellectual and developmental	- For a resident with intellectual and developmental
		disabilities, the mailing and e-mail address and telephone	disabilities, the mailing and e-mail address and
		number of the agency responsible for the protection and	telephone number of the agency responsible for the
		advocacy of these individuals, established under Part C of	protection and advocacy of these individuals,
		the Developmental Disabilities Assistance and Bill of	established under Part C of the Developmental
		Rights Act of 2000	Disabilities Assistance and Bill of Rights Act of 2000
		- For a resident with a mental disorder or related	- For a resident with a mental disorder or related
		disabilities, the mailing and e-mail address and telephone	disabilities, the mailing and e-mail address and
		number of the agency responsible for the protection 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 of these individuals,
		Protection and Advocacy for Mentally Ill Individuals Act	established under the Protection and Advocacy for
			Mentally Ill Individuals Act
§483.15(c)(7)	(7) Orientation for transfer or	PC.04.01.03, EP 3	PC.14.01.01, EP 4
	discharge. A facility must provide	The patient, the patient's family, physicians, other	The patient, the patient's caregiver(s) or support
	and document sufficient	licensed practitioners, clinical psychologists, and staff	person(s), physicians, other licensed practitioners,
	preparation and orientation to	involved in the patient's care, treatment, and services	clinical psychologists, and staff who are involved in the
	residents to ensure safe and	participate in planning the patient's discharge or transfer.	patient's care, treatment, and services participate in
	orderly transfer or discharge from	Note 1: For rehabilitation and psychiatric distinct part	planning the patient's discharge or transfer. The patient
	the facility. This orientation must	units in critical access hospitals: The definition of	and their caregiver(s) or support person(s) are included
	be provided in a form and manner	"physician" is the same as that used by the Centers for	as active partners when planning for postdischarge
	that the resident can understand.	Medicare & Defication of the Medicare & Defic	care.
		Glossary).	Note 1: For rehabilitation and psychiatric distinct part
		Note 2: For psychiatric distinct part units in critical	units in critical access hospitals: The definition of
		access hospitals: Social service staff responsibilities	"physician" is the same as that used by the Centers for
		include, but are not limited to, participating in discharge	Medicare & Defication of the Medicare & Defic
		planning, arranging for follow-up care, and developing	Glossary).
		mechanisms for exchange of information with sources	Note 2: For psychiatric distinct part units in critical
		outside the critical access hospital.	access hospitals: Social service staff responsibilities
		Note 3: For swing beds in critical access hospitals: The	include but are not limited to participating in discharge
		critical access hospital notifies the resident and, if	planning, arranging for follow-up care, and developing
		known, a family member or legal representative of the	mechanisms for exchange of information with sources
		resident of the transfer or discharge and reasons for the	outside the critical access hospital.
		move in writing. The hospital also provides sufficient	Note 3: For swing beds in critical access hospitals: The
		preparation and orientation to residents to make sure that	critical access hospital notifies the resident and, if
		transfer or discharge from the hospital is safe and orderly.	known, a family member or legal representative of the
		The critical access hospital sends a copy of the notice to	resident of the transfer or discharge and reasons for the
		a representative of the office of the state's long-term care	move. The notice is in writing, in a language and manner
		ombudsman.	they understand, and includes the items described in
			42 CFR 483.15(c)(5). The critical access hospital also
		PC.04.01.05, EP 1	provides sufficient preparation and orientation to
		When the critical access hospital determines the	residents to make sure that transfer or discharge from
		patient's discharge or transfer needs, it promptly shares	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.	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 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.	
§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	agrees to move to another of the composite distinct part's	voluntarily agrees to move to another of the composite
	another of the composite distinct	locations.	distinct part's locations.
	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	PC.01.02.01, EP 26	PC.11.02.01, EP 11
	instrument. A facility must make a	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
	comprehensive assessment of a	comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
	resident's needs, strengths, goals,	following:	the following:
	life history and preferences, using	- Identifying and demographic information	- Identifying and demographic information
	the resident assessment	- Customary routines	- Customary routines
	instrument (RAI) specified by CMS.	- Cognitive patterns	- Cognitive patterns
	The assessment must include at	- Communication needs	- Communication needs
	least the following:	- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.01.02.01, EP 26	PC.11.02.01, EP 11
	information.	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	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	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		 Need for special treatment(s) and procedure(s) 	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.01.02.01, EP 26	PC.11.02.01, EP 11
	structural problems.	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		 Need for special treatment(s) and procedure(s) 	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.01.02.01, EP 26	PC.11.02.01, EP 11
	conditions.	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		 Need for special treatment(s) and procedure(s) 	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		 Need for special treatment(s) and procedure(s) 	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		 Need for special treatment(s) and procedure(s) 	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.01.02.01, EP 26	PC.11.02.01, EP 11
	procedures.	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		 Need for special treatment(s) and procedure(s) 	- Pursuit of activity
		- Discharge planning	- 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	PC.11.02.01, EP 11
		For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
		comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
		following:	the following:
		- Identifying and demographic information	- Identifying and demographic information
		- Customary routines	- Customary routines
		- Cognitive patterns	- Cognitive patterns
		- Communication needs	- Communication needs
		- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Need for special treatment(s) and procedure(s)	- Pursuit of activity
		- Discharge planning	- 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	PC.01.02.01, EP 27	PC.11.02.01, EP 12
	information regarding the	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
	additional assessment performed	comprehensive assessment of the resident includes	comprehensive assessment of the resident includes
	on the care areas triggered by the	documentation of summary information about the	documentation of summary information about the
	completion of the Minimum Data	additional assessment(s) performed through the resident	additional assessment(s) performed through the
	Set (MDS).	assessment protocols.	resident assessment protocols.
§483.20(b)(1)(xviii)	(xviii) Documentation of	PC.01.02.01, EP 28	PC.11.02.01, EP 13
	participation in assessment. The	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
	assessment process must include	comprehensive assessment of the resident includes	comprehensive assessment includes direct
	direct observation and	documentation of the resident's participation in the	observation and communication with the resident and
	communication with the resident,	assessment.	communication with staff members on all shifts.
	as well as communication with		
	licensed and nonlicensed direct		
\$400,00(1-)(0)	care staff members on all shifts.	DO 04 00 00 FD 44	DO 44 00 04 ED 0
§483.20(b)(2)	(2) When required. Subject to the	PC.01.02.03, EP 14	PC.11.02.01, EP 6
	timeframes prescribed in §	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	413.343(b) of this chapter, a	access hospital specifies that each resident's	access hospital completes the resident's
	facility must conduct a	comprehensive assessment is completed within 14	comprehensive assessment within 14 calendar days
	comprehensive assessment of a resident in accordance with the	calendar days after admission.	after admission, excluding readmissions in which there
		PC.01.02.03, EP 15	is no significant change in the resident's physical or mental condition.
	timeframes specified in	For swing beds in critical access hospitals: A	Note: For this element of performance, the term
	paragraphs (b)(2)(i) through (iii) of this section. The timeframes	comprehensive assessment is conducted within 14	"readmission" means a return to the critical access
	uns section. The unienames	•	
		calendar days after the critical access hospital	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.	hospitalization or for therapeutic leave.
			PC.11.02.01, EP 7
		PC.01.02.03, EP 16	For swing beds in critical access hospitals: The critical
		For swing beds in critical access hospitals: Each resident	access hospital conducts a comprehensive
		receives a comprehensive assessment no less often than	assessment within 14 calendar days after it determines
		every 12 months.	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	PC.01.02.03, EP 14	PC.11.02.01, EP 6
	admission, excluding readmissions in which there is no	For swing beds in critical access hospitals: The critical access hospital specifies that each resident's	For swing beds in critical access hospitals: The critical access hospital completes the resident's
	significant change in the resident's	comprehensive assessment is completed within 14	comprehensive assessment within 14 calendar days
	physical or mental condition. (For	calendar days after admission.	after admission, excluding readmissions in which there
	purposes of this section,		is no significant change in the resident's physical or
	"readmission" means a return to		mental condition.
	the facility following a temporary		Note: For this element of performance, the term
	absence for hospitalization or for		"readmission" means a return to the critical access
	therapeutic leave.)		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	PC.01.02.03, EP 15	PC.11.02.01, EP 7
	the facility determines, or should	For swing beds in critical access hospitals: A	For swing beds in critical access hospitals: The critical
	have determined, that there has	comprehensive assessment is conducted within 14	access hospital conducts a comprehensive
	been a significant change in the	calendar days after the critical access hospital	assessment within 14 calendar days after it determines
	resident's physical or mental	determines that there has been a significant change in	that there has been a significant change in the
	condition. (For purposes of this	the resident's physical or mental condition.	resident's physical or mental condition.
	section, a "significant change"		Note: For this element of performance, the term
	means a major decline or		"significant change" means a major decline or
	improvement in the resident's		improvement in the resident's status that will not
	status that will not normally		resolve itself without further intervention by staff or by
	resolve itself without further		implementing standard disease-related clinical
	intervention by staff or by		interventions, that has an impact on more than one
	implementing standard disease-		area of the resident's health status, and that requires
	related clinical interventions, that		interdisciplinary review or revision of the care plan, or
	has an impact on more than one		both.
	area of the resident's health		
	status, and requires		
	interdisciplinary review or revision		
0.100.000	of the care plan, or both.)		
§483.20(b)(2)(iii)	(iii) Not less often than once every	PC.01.02.03, EP 16	PC.11.02.01, EP 8
	12 months.	For swing beds in critical access hospitals: Each resident	For swing beds in critical access hospitals: Each
		receives a comprehensive assessment no less often than	resident receives a comprehensive assessment no less
\$400.04	\$400.04.0	every 12 months.	often than every 12 months.
§483.21	§483.21 Comprehensive person-		
\$400.04/b)	centered care planning.		
§483.21(b)	(b) Comprehensive care plans.	DC 00 04 00 FD 4	DO 44 02 04 FD C
§483.21(b)(1)	(1) The facility must develop and	PC.02.04.06, EP 1	PC.11.03.01, EP 6
	implement a comprehensive person-centered care plan for	For critical access hospitals with swing beds: The interdisciplinary team works in partnership with the	For swing beds in critical access hospitals: The interdisciplinary team involves the resident and the
	each resident, consistent with the		resident's representative in developing the person-
	resident rights set forth at \$	resident to achieve planned outcomes.	centered, comprehensive treatment plan.
	483.10(c)(2) and § 483.10(c)(3),	PC.02.04.06, EP 2	Note 1: The treatment plan includes documentation of
	that includes measurable		•
	mat includes measurable	For critical access hospitals with swing beds: The	the following:

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

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

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		PC.11.03.01, EP 6
	resident and the resident's		For swing beds in critical access hospitals: The
	representative(s)—		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	PC.02.04.06, EP 2	PC.11.03.01, EP 6
5-50.2 ((S)(1)((V)(A)	admission and desired outcomes.	For critical access hospitals with swing beds: The	For swing beds in critical access hospitals: The
	administration and addition outcomes.	interdisciplinary team involves the resident and the	interdisciplinary team involves the resident and the
		resident's representative in the development of the	resident's representative in developing the person-
		treatment plan.	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 personcentered, 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 personcentered, 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	- Measurable objectives and time frames to meet a
		needs.	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	PC.01.03.01, EP 4	PC.11.03.01, EP 8
	completion of the comprehensive	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: The critical
	assessment.	access hospital develops the resident's written plan of	access hospital develops the resident's written
		care as soon as possible after admission, but no later	comprehensive plan of care as soon as possible after
		than seven calendar days after the resident's	admission, but no later than seven calendar days after
		comprehensive assessments are completed.	the resident's comprehensive assessments are
2422 24 (1) (2) (2)	(") D	DO 04 00 04 FD 4	completed.
§483.21(b)(2)(ii)	(ii) Prepared by an interdisciplinary	PC.01.03.01, EP 1	
	team, that includes but is not limited to—	The critical access hospital plans the patient's care,	
	umited to—	treatment, and services based on needs identified by the patient's assessment, reassessment, and results of	
		diagnostic testing.	
		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	PC.11.03.01, EP 9
		The critical access hospital plans the patient's care,	For swing beds in critical access hospitals: The
		treatment, and services based on needs identified by the	resident's written plan of care is developed by an
		patient's assessment, reassessment, and results of	interdisciplinary team comprised of health care
		diagnostic testing.	professionals involved in the resident's care, treatment,
			and services. At a minimum, the team includes the
		PC.01.03.01, EP 2	attending physician, registered nurse with responsibility
		For swing beds in critical access hospitals: The resident's	for the resident, nurse aide with responsibility for the
		written plan of care is developed by an interdisciplinary	resident, a member of the food and nutrition services
		team comprised of health care professionals involved in	staff, and other appropriate staff as determined by the
		the resident's care, treatment, and services. At a	resident's needs or as requested by the resident.
		minimum, the team includes the following individuals:	Note: The plan of care is reviewed and revised by the
		the attending physician, registered nurse with	interdisciplinary team after each assessment.
		responsibility for the resident, nurse aide with	
		responsibility for the resident, and a member of the food	
0.400 0.4 (1.) (0) (11) (12)	(5) 4	and nutrition services staff.	DO 44 00 04 FD 0
§483.21(b)(2)(ii)(B)	(B) A registered nurse with	PC.01.03.01, EP 1	PC.11.03.01, EP 9
	responsibility for the resident.	The critical access hospital plans the patient's care,	For swing beds in critical access hospitals: The
		treatment, and services based on needs identified by the	resident's written plan of care is developed by an
		patient's assessment, reassessment, and results of	interdisciplinary team comprised of health care
		diagnostic testing.	professionals involved in the resident's care, treatment, and services. At a minimum, the team includes the
		PC.01.03.01, EP 2	attending physician, registered nurse with responsibility
		For swing beds in critical access hospitals: The resident's	for the resident, nurse aide with responsibility for the
		written plan of care is developed by an interdisciplinary	resident, a member of the food and nutrition services
		team comprised of health care professionals involved in	staff, and other appropriate staff as determined by the
		the resident's care, treatment, and services. At a	resident's needs or as requested by the resident.
		minimum, the team includes the following individuals:	Note: The plan of care is reviewed and revised by the
		the attending physician, registered nurse with	interdisciplinary team after each assessment.
		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)(C)	(C) A nurse aide with responsibility	PC.01.03.01, EP 1	PC.11.03.01, EP 9
	for the resident.	The critical access hospital plans the patient's care,	For swing beds in critical access hospitals: The
		treatment, and services based on needs identified by the	resident's written plan of care is developed by an
		patient's assessment, reassessment, and results of	interdisciplinary team comprised of health care
		diagnostic testing.	professionals involved in the resident's care, treatment,
			and services. At a minimum, the team includes the
		PC.01.03.01, EP 2	attending physician, registered nurse with responsibility
		For swing beds in critical access hospitals: The resident's	for the resident, nurse aide with responsibility for the
		written plan of care is developed by an interdisciplinary	resident, a member of the food and nutrition services
		team comprised of health care professionals involved in	staff, and other appropriate staff as determined by the
		the resident's care, treatment, and services. At a	resident's needs or as requested by the resident.
		minimum, the team includes the following individuals:	Note: The plan of care is reviewed and revised by the
		the attending physician, registered nurse with	interdisciplinary team after each assessment.
		responsibility for the resident, nurse aide with	
		responsibility for the resident, and a member of the food	
		and nutrition services staff.	
§483.21(b)(2)(ii)(D)	(D) A member of food and nutrition	PC.01.03.01, EP 1	PC.11.03.01, EP 9
	services staff.	The critical access hospital plans the patient's care,	For swing beds in critical access hospitals: The
		treatment, and services based on needs identified by the	resident's written plan of care is developed by an
		patient's assessment, reassessment, and results of	interdisciplinary team comprised of health care
		diagnostic testing.	professionals involved in the resident's care, treatment,
		DO 04 00 04 FD 0	and services. At a minimum, the team includes the
		PC.01.03.01, EP 2	attending physician, registered nurse with responsibility
		For swing beds in critical access hospitals: The resident's	for the resident, nurse aide with responsibility for the
		written plan of care is developed by an interdisciplinary	resident, a member of the food and nutrition services
		team comprised of health care professionals involved in	staff, and other appropriate staff as determined by the
		the resident's care, treatment, and services. At a	resident's needs or as requested by the resident.
		minimum, the team includes the following individuals:	Note: The plan of care is reviewed and revised by the
		the attending physician, registered nurse with	interdisciplinary team after each assessment.
		responsibility for the resident, nurse aide with responsibility for the resident, and a member of the food	
		and nutrition services staff.	
		and natifition services stail.	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
§483.21(b)(2)(ii)(E)	(E) To the extent practicable, the	PC.02.04.06, EP 1	PC.11.03.01, EP 6
	participation of the resident and	For critical access hospitals with swing beds: The	For swing beds in critical access hospitals: The
	the resident's representative(s). An	interdisciplinary team works in partnership with the	interdisciplinary team involves the resident and the
	explanation must be included in a	resident to achieve planned outcomes.	resident's representative in developing the person-
	resident's medical record if the		centered, comprehensive treatment plan.
	participation of the resident and	PC.02.04.06, EP 2	Note 1: The treatment plan includes documentation of
	their resident representative is	For critical access hospitals with swing beds: The	the following:
	determined not practicable for the	interdisciplinary team involves the resident and the	- Any specialized or rehabilitation services the critical
	development of the resident's care	resident's representative in the development of the	access hospital will provide as a result of preadmission
	plan.	treatment plan.	screening and resident review (PASARR)
		Note: The treatment plan includes the following:	recommendations and any disagreement with PASARR
		- Any specialized or rehabilitation services the critical	recommendations
		access hospital will provide as a result of preadmission	- Resident's goals for admission and desired outcomes
		screening and resident review (PASARR)	- Resident's preferences and potential for future
		recommendations. Disagreement with PASARR	discharge, including whether the resident's desire to
		recommendations is documented in the resident's	return to the community was assessed and any referrals
		record.	to local contact agencies and/or other appropriate
		- The resident's goals for admission and desired	entities for this purpose
		outcomes.	- Discharge plans
		- The resident's preferences and potential for future	- Measurable objectives and time frames to meet a
		discharge.	resident's medical, nursing, and mental and
		- Discharge plans.	psychosocial needs
		- Measurable objectives and time frames to meet a	Note 2: If not feasible for the resident and the resident's
		resident's medical, nursing, and mental and psychosocial	representative to participate in the development of the
		needs.	treatment plan, an explanation is included in the
			resident's medical record.
§483.21(b)(2)(ii)(F)	(F) Other appropriate staff or	PC.01.03.01, EP 1	PC.11.03.01, EP 9
	professionals in disciplines as	The critical access hospital plans the patient's care,	For swing beds in critical access hospitals: The
	determined by the resident's	treatment, and services based on needs identified by the	resident's written plan of care is developed by an
	needs or as requested by the	patient's assessment, reassessment, and results of	interdisciplinary team comprised of health care
	resident.	diagnostic testing.	professionals involved in the resident's care, treatment,
			and services. At a minimum, the team includes the
		PC.01.03.01, EP 2	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	for the resident, nurse aide with responsibility for the
		written plan of care is developed by an interdisciplinary	resident, a member of the food and nutrition services
		team comprised of health care professionals involved in	staff, and other appropriate staff as determined by the
		the resident's care, treatment, and services. At a	resident's needs or as requested by the resident.
		minimum, the team includes the following individuals:	Note: The plan of care is reviewed and revised by the
		the attending physician, registered nurse with	interdisciplinary team after each assessment.
		responsibility for the resident, nurse aide with	
		responsibility for the resident, and a member of the food	
		and nutrition services staff.	
§483.21(b)(2)(iii)	(iii) Reviewed and revised by the	PC.01.03.01, EP 1	PC.11.03.01, EP 9
	interdisciplinary team after each	The critical access hospital plans the patient's care,	For swing beds in critical access hospitals: The
	assessment, including both the	treatment, and services based on needs identified by the	resident's written plan of care is developed by an
	comprehensive and quarterly	patient's assessment, reassessment, and results of	interdisciplinary team comprised of health care
	review assessments.	diagnostic testing.	professionals involved in the resident's care, treatment,
			and services. At a minimum, the team includes the
		PC.01.03.01, EP 2	attending physician, registered nurse with responsibility
		For swing beds in critical access hospitals: The resident's	for the resident, nurse aide with responsibility for the
		written plan of care is developed by an interdisciplinary	resident, a member of the food and nutrition services
		team comprised of health care professionals involved in	staff, and other appropriate staff as determined by the
		the resident's care, treatment, and services. At a	resident's needs or as requested by the resident.
		minimum, the team includes the following individuals:	Note: The plan of care is reviewed and revised by the
		the attending physician, registered nurse with	interdisciplinary team after each assessment.
		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.	
		PO 04 00 04 FP 00	
		PC.01.03.01, EP 23	
		The critical access hospital revises plans and goals for	

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.	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-	ED.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	
8492 21/b\/2\/;;;\	(iii) Be culturally competent and	individualized plan of care. HR.01.04.01, EP 3	LD.13.03.01, EP 19
§483.21(b)(3)(iii)	(iii) Be culturally-competent and trauma-informed.	The critical access hospital orients staff on the following:	For swing beds in critical access hospitals: The critical
	Gauma-imonneu.	- Relevant critical access hospital wide and unit-specific	access hospital provides or arranges for culturally
		policies and procedures	competent and trauma-informed services, as outlined
		ροποισό απα μισσσααίσό	competent and trauma-imormed services, as outlined

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		- Their specific job duties, including those related to	by the comprehensive care plan, that meet professional
		infection prevention and control and assessing and	standards of quality and are provided by qualified staff
		managing pain	in accordance with each resident's written plan of care.
		- 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.	
		Completion of this offentation 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.	
§483.21(c)	(c) Discharge planning—	priviteges.	
\$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	RC.02.04.01, EP 1	RC.12.03.01, EP 5
	stay that includes, but is not	For swing beds in critical access hospitals:	For swing beds in critical access hospitals: When the
	limited to, diagnoses, course of	Documentation in the medical record includes discharge	critical access hospital anticipates the discharge of a
	illness/treatment or therapy, and	information provided to the resident and/or to the	resident, the discharge summary includes but is not

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	pertinent lab, radiology, and	receiving organization. There is documentation in the	limited to the following:
	consultation results.	resident's medical record by the resident's physician	- A summary of the resident's stay that includes at a
		when the resident is transferred or discharged, either	minimum the resident's diagnosis, course of
		when the transfer is due to the resident improving and no	illness/treatment or therapy, and pertinent laboratory,
		longer needing long term care services or when the	radiology, and consultation results
		resident's needs cannot be met in the critical access	- A final summary of the resident's status to include
		hospital's swing bed. There is documentation in the	items in 42 CFR 483.20 (b)(1) at the time of the
		resident's medical record by a physician when the	discharge that is available for release to authorized
		resident is being transferred or discharged because the	persons and agencies, with the consent of the resident
		safety of other residents would otherwise be endangered.	or resident's representative.
			- Reconciliation of all predischarge medications with
		RC.02.04.01, EP 2	the resident's postdischarge medications (both
		For swing beds in critical access hospitals: The resident's	prescribed and over-the-counter).
		discharge information includes the following:	- A postdischarge plan of care, which will assist the
		- The reason for transfer, discharge, or referral	resident to adjust to his or her new living environment,
		- Treatment provided, diet, medication orders, and orders	that is developed with the participation of the resident
		for the resident's immediate care	and, with the resident's consent, the resident
		- Referrals provided to the resident, the referring	representative(s). The postdischarge plan of care
		physician's or other licensed practitioner's name, and the	indicates where the individual plans to reside, any
		name of the physician or other licensed practitioner who	arrangements that have been made for the resident's
		has agreed to be responsible for the resident's medical	follow up care, and any postdischarge medical and
		care and treatment, if this person is someone other than	nonmedical services
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
CoP Requirement	CoP Text	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	Future EP Mapping
		- 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	when the transfer is due to the resident improving and no	illness/treatment or therapy, and pertinent laboratory,
	resident's representative.	longer needing long term care services or when the	radiology, and consultation results
		resident's needs cannot be met in the critical access	- A final summary of the resident's status to include
		hospital's swing bed. There is documentation in the	items in 42 CFR 483.20 (b)(1) at the time of the
		resident's medical record by a physician when the	discharge that is available for release to authorized
		resident is being transferred or discharged because the	persons and agencies, with the consent of the resident
		safety of other residents would otherwise be endangered.	or resident's representative.
			- Reconciliation of all predischarge medications with
		RC.02.04.01, EP 2	the resident's postdischarge medications (both
		For swing beds in critical access hospitals: The resident's	prescribed and over-the-counter).
		discharge information includes the following:	- A postdischarge plan of care, which will assist the
		- The reason for transfer, discharge, or referral	resident to adjust to his or her new living environment,
		- Treatment provided, diet, medication orders, and orders	that is developed with the participation of the resident
		for the resident's immediate care	and, with the resident's consent, the resident
		- Referrals provided to the resident, the referring	representative(s). The postdischarge plan of care
		physician's or other licensed practitioner's name, and the	indicates where the individual plans to reside, any
		name of the physician or other licensed practitioner who	arrangements that have been made for the resident's
		has agreed to be responsible for the resident's medical	follow up care, and any postdischarge medical and
		care and treatment, if this person is someone other than	nonmedical services
		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	
		- Attempts to meet the resident's needs	
		RC.02.04.01, EP 3	
		In order to provide information to other caregivers and	

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-	RC.02.04.01, EP 1	RC.12.03.01, EP 5
	discharge medications with the	For swing beds in critical access hospitals:	For swing beds in critical access hospitals: When the
	resident's post-discharge	Documentation in the medical record includes discharge	critical access hospital anticipates the discharge of a
	medications (both prescribed and	information provided to the resident and/or to the	resident, the discharge summary includes but is not
	over-the-counter).	receiving organization. There is documentation in the	limited to the following:
		resident's medical record by the resident's physician	- A summary of the resident's stay that includes at a
		when the resident is transferred or discharged, either	minimum the resident's diagnosis, course of
		when the transfer is due to the resident improving and no	illness/treatment or therapy, and pertinent laboratory,
		longer needing long term care services or when the	radiology, and consultation results
		resident's needs cannot be met in the critical access	- 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	items in 42 CFR 483.20 (b)(1) at the time of the
		resident's medical record by a physician when the	discharge that is available for release to authorized
		resident is being transferred or discharged because the	persons and agencies, with the consent of the resident
		safety of other residents would otherwise be endangered.	or resident's representative.
			- Reconciliation of all predischarge medications with
		RC.02.04.01, EP 2	the resident's postdischarge medications (both
		For swing beds in critical access hospitals: The resident's	prescribed and over-the-counter).
		discharge information includes the following:	- A postdischarge plan of care, which will assist the
		- The reason for transfer, discharge, or referral	resident to adjust to his or her new living environment,
		- Treatment provided, diet, medication orders, and orders	that is developed with the participation of the resident
		for the resident's immediate care	and, with the resident's consent, the resident
		- Referrals provided to the resident, the referring	representative(s). The postdischarge plan of care
		physician's or other licensed practitioner's name, and the	indicates where the individual plans to reside, any
		name of the physician or other licensed practitioner who	arrangements that have been made for the resident's
		has agreed to be responsible for the resident's medical	follow up care, and any postdischarge medical and
		care and treatment, if this person is someone other than	nonmedical services
		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	
		PC 02 04 01 ED 2	
		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:	

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-	safety of other residents would otherwise be endangered.	or resident's representative.
	medical services.		- Reconciliation of all predischarge medications with
		RC.02.04.01, EP 2	the resident's postdischarge medications (both
		For swing beds in critical access hospitals: The resident's	prescribed and over-the-counter).
		discharge information includes the following:	- A postdischarge plan of care, which will assist the
		- The reason for transfer, discharge, or referral	resident to adjust to his or her new living environment,
		- Treatment provided, diet, medication orders, and orders	that is developed with the participation of the resident
		for the resident's immediate care	and, with the resident's consent, the resident
		- Referrals provided to the resident, the referring	representative(s). The postdischarge plan of care
		physician's or other licensed practitioner's name, and the	indicates where the individual plans to reside, any
		name of the physician or other licensed practitioner who	arrangements that have been made for the resident's
		has agreed to be responsible for the resident's medical	follow up care, and any postdischarge medical and
		care and treatment, if this person is someone other than	nonmedical services
		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	
		, teample to most the resident of house	
		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	

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	PC.01.02.01, EP 26	PC.11.02.01, EP 11
	parameters of nutritional status,	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The
	such as usual body weight or	comprehensive assessment of the resident includes the	comprehensive assessment of the resident includes
	desirable body weight range and	following:	the following:
	electrolyte balance, unless the	- Identifying and demographic information	- Identifying and demographic information
	resident's clinical condition	- Customary routines	- Customary routines
	demonstrates that this is not	- Cognitive patterns	- Cognitive patterns
	possible or resident preferences	- Communication needs	- Communication needs
	indicate otherwise;	- Vision needs	- Vision needs
		- Psychosocial well-being	- Psychosocial well-being
		- Mood and behavior patterns	- Mood and behavior patterns
		- Physical functioning and structural problems	- Physical functioning and structural problems
		- Continence	- Continence
		- Disease(s), diagnoses, and health conditions	- Disease(s), diagnoses, and health conditions
		- Dental and nutritional status	- Dental status
		- Skin	- Nutritional status (such as usual body weight or
		- Pursuit of activity	desirable body weight range, electrolyte balance)
		- Medications	- Skin
		 Need for special treatment(s) and procedure(s) 	- Pursuit of activity
		- Discharge planning	- Medications
			- Need for special treatment(s) and procedure(s)
		PC.01.02.03, EP 3	- Discharge planning
		Each patient is reassessed as necessary based on their	Note: The critical access hospital maintains the
		plan for care or changes in their condition.	resident's acceptable nutritional status parameters
		Note 1: Reassessments may also be based on the	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	that this is not possible or the resident's preferences
		services; response to previous care, treatment, and	indicate otherwise.
		services; discharge planning needs; and/or their setting	
		requirements.	
		Note 2: For rehabilitation distinct part units in critical	
		access hospitals: The Centers for Medicare & Description (1997)	
		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.	
		DC 02 02 02 ED 7	
		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	

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	PC.01.02.01, EP 26	PC.12.01.09, EP 3
	to maintain proper hydration and	For swing beds in critical access hospitals: The	For swing beds in critical access hospitals: The critical
	health; and	comprehensive assessment of the resident includes the	access hospital offers the resident sufficient fluid
		following:	intake to maintain proper hydration and health.
		- 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 & Description (1997)	

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.	
		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.02.01, 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	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	critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental
		services.	services.
§483.55(a)(3)	(3) Must have a policy identifying	PC.02.02.01, EP 29	PC.14.02.01, EP 4
	those circumstances when the	For critical access hospitals with swing beds: The critical	For swing beds in critical access hospitals: The critical
	loss or damage of dentures is the	access hospital follows its policy identifying	access hospital develops and implements a policy
	facility's responsibility and may	circumstances when loss of or damage to a resident's	identifying circumstances when loss of or damage to a
	not charge a resident for the loss	dentures is the critical access hospital's responsibility	resident's dentures is the critical access hospital's
	or damage of dentures determined	and it may not charge a resident for the loss or damage of	responsibility, and it may not charge a resident for the
	in accordance with facility policy	dentures.	loss or damage of dentures.
	to be the facility's responsibility;		
§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	PC.14.02.01, EP 5
		For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: If necessary
		access hospital provides services (directly or through	or requested, the critical access hospital assists
		referral) to facilitate family support, social work, nursing	residents in making dental appointments and arranging
		care, dental care, rehabilitation, primary physician care,	for transportation to and from the dental services
		or discharge.	location.
		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	
			1

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	PC.02.02.01, EP 9	PC.14.02.01, EP 5
	to and from the dental services	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: If necessary
	location; and	access hospital provides services (directly or through	or requested, the critical access hospital assists
		referral) to facilitate family support, social work, nursing	residents in making dental appointments and arranging
		care, dental care, rehabilitation, primary physician care,	for transportation to and from the dental services
		or discharge.	location.
		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.	
§483.55(a)(5)	(5) Must promptly, within 3 days,	PC.02.02.01, EP 30	PC.14.02.01, EP 6
	refer residents with lost or	For critical access hospitals with swing beds: The critical	For critical access hospitals with swing beds: The
	damaged dentures for dental	access hospital refers residents with lost or damaged	critical access hospital refers residents with lost or
	services. If a referral does not	dentures for dental services within three days. If referral	damaged dentures for dental services within three
	occur within 3 days, the facility	does not occur within three days, the critical access	days. If referral does not occur within three days, the
	must provide documentation of	hospital documents what was done to make sure that the	critical access hospital documents what was done to

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
\$402 EE(b)	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) §483.55(b)(1)	(b) Nursing facilities. The facility (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,	for transportation to and from the dental services
		or discharge.	location.
		DC 00 00 04 FD 40	
		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.	
§483.55(b)(2)(ii)	(ii) By arranging for transportation	PC.02.02.01, EP 9	PC.14.02.01, EP 5
	to and from the dental services	For swing beds in critical access hospitals: The critical	For swing beds in critical access hospitals: If necessary
	locations;	access hospital provides services (directly or through	or requested, the critical access hospital assists
		referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care,	residents in making dental appointments and arranging for transportation to and from the dental services
		or discharge.	location.
		of discharge.	todatom
		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	

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
	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	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
§483.65	§483.65 Specialized rehabilitative services.	services.	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

CoP Requirement C	CoP Text	Current EP Mapping	Future EP Mapping
		care, treatment, and services within a time frame that	programs pursuant to section 1128 and 1156 of the
		meets the patient's needs.	Social Security Act.
		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.	
	2) In accordance with § 483.70(g),	LD.04.03.01, EP 8	PC.14.02.01, EP 8
	btain the required services from	The critical access hospital furnishes services that	For swing beds in critical access hospitals: If a
	n outside resource that is a	include medical history, physical examination, specimen	resident's comprehensive plan of care requires
1	rovider of specialized	collection, assessment of health status, and treatment	specialized rehabilitative services, including but not
re	ehabilitative services and is not	for a variety of medical conditions.	limited to physical therapy, speech-language pathology,
	xcluded from participating in any		occupational therapy, respiratory therapy, and
fe	ederal or state health care	PC.02.01.01, EP 1	rehabilitative services for a mental disorder and
p	rograms pursuant to section	The critical access hospital provides the patient with	intellectual disability or services of a lesser intensity,
1	128 and 1156 of the Act.	care, treatment, and services according to the patient's	the critical access hospital provides or obtains the
		individualized plan of care.	required services from a provider of specialized
			rehabilitative services and is not excluded from
		PC.02.02.01, EP 3	participating in any federal or state health care
		The critical access hospital coordinates the patient's	programs pursuant to section 1128 and 1156 of the
		care, treatment, and services within a time frame that	Social Security Act.
		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.	
§483.65(b) (b	b) Qualifications. Specialized	LD.03.06.01, EP 2	PC.12.01.01, EP 1
	ehabilitative services must be	Leaders provide for a sufficient number and mix of	Prior to providing care, treatment, and services, the

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

CoP Requirement	CoP Text	Current EP Mapping	Future EP Mapping
		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		

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

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