

# State Operations Manual

## Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

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### Transmittals for Appendix W

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##### Regulations and Interpretive Guidelines for CAHs

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# Survey Protocol

## Introduction

Critical Access Hospitals (CAHs) are required to be in compliance with the Federal requirements set forth in the Medicare Conditions of Participation (CoP) in order to receive Medicare/Medicaid payment. The goal of a CAH survey is to determine if the CAH is in compliance with the CoP set forth at 42 CFR Part 485 Subpart F.

Certification of CAH compliance with the CoP is accomplished through observations, interviews, and document/record reviews. The survey process focuses on a CAH's performance of organizational and patient-focused functions and processes. The CAH survey is the means used to assess compliance with Federal health, safety, and quality standards that will assure that the beneficiary receives safe, quality care and services.

## Regulatory and Policy Reference

- The Medicare Conditions of Participation for CAHs are found at 42 CFR Part 485 Subpart F.
- Survey authority and compliance regulations can be found at 42 CFR Part 488 Subpart A.
- If an individual or entity (CAH) refuses to allow immediate access to either a State Agency or CMS surveyor, the Office of Inspector General (OIG) may terminate the CAH from participation in the Medicare/Medicaid programs in accordance with 42 CFR 1001.1301.
- The regulatory authority for the photocopying of records and information during the survey is found at 42 CFR 489.53.
- The CMS State Operations Manual (SOM) provides CMS policy regarding survey and certification activities.

Surveyors assess the CAH's compliance with the CoP for all services, areas and locations in which the provider receives reimbursement for patient care services billed under its provider number.

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct the survey at other times. These survey hours may include weekends and times outside of daytime (Monday through Friday) working hours. When the survey begins at times outside of normal work times, the survey team modifies the survey, if needed, in recognition of patients' activities and the staff available.

All routine CAH surveys are unannounced. Do not provide CAHs with advance notice of the survey.

## **Tasks in the Survey Protocol**

Listed below, and discussed in this document, are the tasks that comprise the survey protocol for CAHs.

- Task 1      Off-Site Survey Preparation
- Task 2      Entrance Activities
- Task 3      Information Gathering/ Investigation
- Task 4      Preliminary Decision Making and Analysis of Findings
- Task 5      Exit Conference
- Task 6      Post-Survey Activities

## **Survey Modules for Specialized CAH services**

The modules for CAH distinct part psychiatric units and rehabilitation units and CAH swing beds are attached to this document. The survey team is expected to use all the modules that apply to the CAH being surveyed. For example if the CAH has swing beds, a distinct part rehabilitation unit, and a distinct part psychiatric unit, the team will use all three modules to conduct the survey of those activities.

## **Survey Team**

### **Size and Composition**

The SA (or the RO for Federal teams) decides the composition and size of the team. In general, a suggested survey team for a full survey of a CAH would include 1-4 surveyors who will be at the facility for one or more days. Each survey team should include at least one RN with hospital/CAH survey experience, as well as other surveyors who have the expertise needed to determine whether the facility is in compliance. Survey team size and composition are normally based on the following factors:

- Size of the facility to be surveyed, based on average daily census;
- Complexity of services offered, including outpatient services;
- Type of survey to be conducted;
- Whether the facility has special care units or off-site clinics or locations;
- Whether the facility has a historical pattern of serious deficiencies or complaints; and
- Whether new surveyors are to accompany a team as part of their training.

## **Team Coordinator**

Surveyors conduct the survey under the leadership of a team coordinator. The SA (or the RO for Federal teams) should designate this individual. The team coordinator is responsible for assuring that all survey preparation and survey activities are completed within the specified time frames and in a manner consistent with this protocol, SOM, and SA procedures.

Responsibilities of the team coordinator include:

- Scheduling the date and time of survey activities;
- Acting as the spokesperson for the team;
- Assigning staff to areas of the CAH or tasks for the survey;
- Facilitating time management;
- Encouraging on-going communication among team members;
- Evaluating team progress;
- Coordinating daily team meetings;
- Coordinating any ongoing conferences with CAH leadership (as determined appropriate by the circumstances and SA/RO policy) and providing on-going feedback, as appropriate, to CAH leadership on the status of the survey;
- Coordinating Task 2 Entrance Conference;
- Facilitating Task 4 Preliminary Decision Making;
- Coordinating Task 5 Exit Conference; and
- Coordinating the preparation of the Form CMS-2567.

## **Task 1 - Off-Site Survey Preparation**

### **General Objective**

The objective of this task is to analyze information about the provider in order to identify areas of potential concern to be investigated during the survey and to determine if those areas, or any special features of the provider (e.g., provider-based clinics, specialty units, services offered, etc.) require the addition of any specialty surveyors to the team.

Information obtained about the provider will also allow the SA (or the RO for Federal

teams) to determine survey team size and composition, and to develop a preliminary survey plan. The type of provider information needed includes:

- Information from the provider file (to be updated on the survey using the Hospital/CAH Medicare Database Worksheet, Exhibit 286), such as the facility's ownership, the type(s) of services offered, whether the facility is a provider of swing-bed services, any distinct part units, the number, type and location of any off-site locations; and the number and categories of personnel.
- Previous Federal and state survey results for patterns, number, and nature of deficiencies, as well as the number, frequency, and types of complaint investigations and the findings;
- Information from CMS databases available to the SA and CMS. Note the exit date of the most recent survey;
- Waivers and variances, if they exist. Determine if there are any applicable survey directive(s) from the SA or the CMS Regional Office (RO); and
- Any additional information available about the facility (e.g. the CAH's Web site, any media reports about the CAH, etc.).

### **Off-Site Survey Preparation Team Meeting**

The team should prepare for the survey off site so they are ready to begin the survey immediately upon entering the facility. The team coordinator should arrange an off-site preparation meeting with as many team members as possible, including specialty surveyors. This meeting may be a conference call if necessary.

During the meeting, discuss at least the following:

- Information gathered by the team coordinator;
- Significant information from the CMS databases that are reviewed;
- Update and clarify information from the provider file (a surveyor can update the Medicare data base on survey using the Hospital/CAH Medicare Database Worksheet, Exhibit 286);
- Layout of the facility (if available);
- Preliminary team member assignments;
- Date, location and time team members will meet to enter the facility;
- The time for the daily team meetings; and

- Potential date and time of the exit conference.

Gather copies of resources that may be needed. These may include:

- CAH Regulations and Interpretive Guidelines (Appendix W);
- Survey protocol and modules;
- Immediate Jeopardy (Appendix Q);
- Responsibilities of Medicare Participating Hospitals in Emergency Cases (Appendix V);
- Hospital/CAH Medicare Database Worksheet, Exhibit 286;
- Letter of authorization to obtain facilities most recent accreditation survey, Exhibit 287; and
- Worksheets for swing bed and CAH distinct part rehabilitation and psychiatric units, Exhibit 288.

## **Task 2 - Entrance Activities**

### **General Objectives**

The objectives of this task are to explain the survey process to the provider and obtain the information needed to conduct the survey.

### **General Procedures**

#### **Arrival**

The entire survey team should enter the facility together. Upon arrival, surveyors should present their identification. The team coordinator should announce to the Administrator, or whoever is in charge, that a survey is being conducted. If the Administrator (or person in charge) is not on site or available (e.g., if the survey begins outside normal daytime, Monday – Friday working hours), ask that they be notified that a survey is being conducted. Do not delay the survey because the Administrator or other staff is/are not on site or available.

#### **Entrance Conference**

The entrance conference sets the tone for the entire survey. Be prepared and courteous, and make requests, not demands. The entrance conference should be informative, concise, and brief; it should not utilize a significant amount of time. Conduct the entrance

conference with administrative staff available at the time of entrance. During the entrance conference, the Team Coordinator should address the following:

- Explain the purpose and scope of the survey;
- Briefly explain the survey process;
- Introduce survey team members, including any additional surveyors who may join the team at a later time. Discuss the general area that each will be responsible for, and the various documents that they may request;
- Clarify that all CAH areas and locations, departments, and patient care settings under the CAH provider number may be surveyed, including any contracted patient care activities or patient services;
- Explain that all interviews will be conducted privately with patients, staff, and visitors, unless requested otherwise by the interviewee;
- Discuss and determine how the facility will ensure that surveyors are able to obtain the photocopies of material, records, and other information as they are needed;
- Obtain the names, locations, and telephone numbers of key staff to whom questions should be addressed;
- Discuss the approximate time, location, and possible attendees of any meetings to be held during the survey. The team coordinator should coordinate any meetings with facility leadership; and
- Propose a date and time for the exit conference.

During the entrance conference, the Team Coordinator will arrange with the CAH administrator, or available CAH administrative/supervisory staff if he/she is unavailable, to obtain the following:

- A location (e.g., conference room) where the team may meet privately during the survey;
- A telephone for team communications, preferably in the team meeting location;
- A list of inpatients, providing each patient's name, room number, diagnosis (es), admission date, age, attending physician, and other significant information as it applies to that patient. The team coordinator will explain to the CAH representative that in order to complete the survey within the allotted time it is important the survey team is given this information as soon as possible, and

request that it be no later than 3 hours after the request is made. SAs may develop a worksheet to give to the facility for obtaining this information;

- A list of department heads with their locations and telephone numbers;
- A copy of the facility's organizational chart;
- The names and addresses of all off-site locations operating under the same provider number;
- The CAH'S infection control plan;
- A list of employees;
- The medical staff bylaws and rules and regulations;
- A list of contracted services; and
- A copy of the facility's floor plan, indicating the location of patient care and treatment areas.

Arrange an interview with a member of the administrative staff to update and clarify information from the provider file.

### **Facility Tours**

Guided tours of the facility are not encouraged and should be avoided. A tour of a facility could consume several man-hours of allocated survey time and resources that are needed to conduct the survey.

### **Initial On-Site Team Meeting**

After the conclusion of the Entrance Conference, the team will meet in order to evaluate information gathered and modify surveyor assignments, as necessary. The team should not delay the continuation of the survey process waiting for information from the provider, and should adjust survey activities as necessary. During the on-site team meeting, team members should:

- Review the scope of services;
- Identify all locations to be surveyed, including all off-site locations;
- Adjust surveyor assignments, as necessary, based on new information;
- Discuss issues such as change of ownership, sentinel events, construction activities, and disasters, if they have been reported;

- Make an initial patient sample selection (the patient list may not be available immediately after the entrance conference, therefore the team may delay patients completing the initial patient sample selection a few hours as meets the needs of the survey team); and
- Set the next meeting time and date.

### **Sample Size and Selection**

To select the patient sample, review the patient list provided by the facility and select patients who represent a cross section of the patient population and services provided. The sample should include inpatients, outpatients and closed records of discharged patients. Inpatients should have a length of stay sufficient to assure knowledge of the various services they received. Their open record should include information about care already provided by all services and departments. The anticipated discharge date should be used to assist in determining which patients will be in the CAH long enough for the surveyor to contact the patient during the course of the survey. Patient logs (ED, OB, OR, etc.) in conjunction with the patient list provided by the facility, provide a good source to use when selecting patients for the sample. If the team finds it necessary during the survey to remove a patient from the sample (e.g., the patient refused to participate in an interview), replace this patient with another who fits a similar profile. Make the substitution as early in the survey as possible.

Whenever possible and appropriate, surveyors should interview patients that are in the facility during the time of the survey to assess the facility's compliance with the CoP. Therefore, open patient records should be selected whenever possible. Open records allow the surveyor to conduct a patient-focused survey and allow the surveyor to compare the medical record with patient observations and interviews. There are situations where closed records will be needed to assess compliance and there may be other situations where there are not adequate numbers of open records to assess compliance. The selected patient records should reflect the scope of services provided by the facility. The sample needs to be no fewer than 20 inpatient records, provided that number is adequate to determine compliance. Additionally, select a sample of outpatients in order to determine compliance in outpatient and emergency services.

Give each patient in the sample a unique identifier. Appropriate identifiable information should be kept on a separate identifier list. Do not use medical record numbers, Social security numbers, care unit or billing record numbers to identify patients.

To conduct an initial survey of a CAH there must be enough inpatients currently in the CAH and patient records (open and closed) for surveyors to determine whether the CAH can demonstrate compliance with all the applicable CoPs. The number of current and discharged inpatients and outpatients in relation to the complexity of care provided to patients and the length of stay of those patients needs to be large enough for surveyors to

evaluate the manner and degree to which the CAH satisfies all the standards within each CoP. Utilize the same sample size and selection methods as previously discussed.

If a complaint is being investigated during the survey, patients who have been identified as part of a complaint should be added to the sample. Issues or concerns identified in complaints may be a focus of concern when selecting sample patients.

### **Task 3 - Information Gathering/Investigation**

#### **General Objective**

The objective of this task is to determine the provider's compliance with the Medicare Conditions of Participation through observations, interviews, and documentation review.

#### **Guiding Principles**

- Focus attention on actual and potential patient outcomes, as well as required processes.
- Assess the care and services provided, including the appropriateness of the care and services within the context of the regulations.
- Visit patient care settings, including inpatient units, outpatient clinics, anesthetizing locations, emergency departments, imaging, rehabilitation, etc.
- Observe the actual provision of care and services to patients and the effects of that care, in order to assess whether the care provided meets the needs of the individual patient.
- Use the interpretive guidelines and other published CMS policy statements to guide the survey.
- Use Appendix Q for guidance if Immediate Jeopardy is suspected.

#### **General Procedures**

##### **During the Survey**

- Visit as many patient care settings as possible, including all on campus and off-campus patient care locations that bill for services under the CAH'S provider number and are considered a part of the CAH. Because the CAH'S compliance with the requirements is being assessed, all patient care locations should be part of the total CAH survey. A surveyor should observe what activities are taking place and assess the CoP that represent the scope and complexity of the patient care services located at each location, as well as, any other CoP that apply to those locations. The depth of assessment of the CoP will be determined by what the

surveyor observes at each location. The surveyor expands the survey activities as necessary.

- On any Medicare survey, contracted patient care activities or patient services (such as dietary services, treatment services, diagnostic services, etc.) located on the CAH campus or at CAH provider based locations should be included in the survey.
- The SA and surveyors have discretion whether to allow, or to refuse to allow, facility personnel to accompany the surveyors during a survey. Sometimes facility personnel may be helpful and may answer questions or point out concerns to the survey team. Conversely, facility personnel may sometimes hinder the surveyor, and argue about observed problems. Surveyors should make a decision whether to allow facility personnel to accompany them based on the circumstances at the time of the survey.
- The team should meet at least daily in order to assess the status of the survey, progress of completion of assigned tasks, areas of concern, and to identify areas for additional investigations. The team meetings should include an update by each surveyor that addresses findings and areas of concern that have been identified. If areas of concern are identified in the discussion, the team should coordinate efforts to obtain additional information. Additional team meetings can be called at any time during the survey to discuss crucial problems or issues.
- All significant issues or significant adverse events must be brought to the team coordinator's attention immediately.
- Maintain open and ongoing dialogue with the facility staff throughout the survey process. Conferences with facility staff may be held in order to inform them of survey findings. This affords facility staff the opportunity to present additional information or to offer explanations concerning identified issues. Survey information must not be discussed unless the investigation process and data collection for the specific concerns is completed.
- Surveyors should always maintain a professional working relationship with facility staff.
- Surveyors need to respect patient privacy and maintain patient confidentiality at all times during the survey.
- Surveyors should maintain their role as representatives of a regulatory agency. Although non-consultative information may be provided upon request, the surveyor is not a consultant.

## **Patient Review**

A comprehensive review of care and services received by each patient in the sample should be part of the survey. A comprehensive review includes observations of care/services provided to the patient, patient and/or family interview(s), staff interview(s), and medical record review. After obtaining the patient's permission, observe each sample patient receiving treatments (e.g., intravenous therapy, tube feedings, wound dressing changes) and observe the care provided in a variety of treatment settings, as necessary, to determine if patient needs are met.

## **Observations**

Observations provide first-hand knowledge of CAH practice. The regulations and interpretive guidelines offer guidance for conducting observations. Observation of the care environment provides valuable information about how the care delivery system works and how CAH departments work together to provide care. Surveyors are encouraged to make observations, complete interviews, and review records and policies/procedures by stationing themselves as physically close to patient care as possible. While completing a chart review, for instance, it may be possible to also observe the environment and the patients, staff interactions with patients, safety hazards, and infection control practices. When conducting observations, particular attention should be given to the following:

- Patient care, including treatments and therapies in all patient care settings;
- Staff member activities, equipment, documentation, building structure, sounds and smells;
- People, care, activities, processes, documentation, policies, equipment, etc., that are present that should not be present, as well as, those that are not present that should be present;
- Integration of all services, such that the facility is functioning as one integrated whole;
- Whether quality assurance (QA) is a facility-wide activity, incorporating every service and activity of the provider and whether every facility department and activity reports to, and receives reports from, the facility's central organized body managing the facility-wide QA program; and
- Storage, security, and confidentiality of medical records.

A surveyor should take complete notes of all observations and should document: the date and time of the observation(s); location; patient identifiers, individuals present during the observation, and the activity being observed (e.g., therapy, treatment modality, etc.).

A surveyor should have observations verified by the patient, family, facility staff, other survey team member(s), or by another mechanism. For example, when finding an out-dated medication in the pharmacy, ask the pharmacist to verify that the drug is out-dated. In addition, a surveyor should integrate the data from observations with data gathered through interviews and document reviews.

A surveyor must not examine patients by themselves, although in certain circumstances, in order to determine a patient's health status and whether safe and appropriate health care is being provided, especially to ensure a patient's welfare where he/she appears to be in immediate jeopardy, it is permissible and necessary to examine the patient. After obtaining permission from the patient, the surveyor should request that a staff member of the facility examine the patient in the surveyor's presence. The health and dignity of the patient is always of paramount concern. A surveyor must respect the patient's right to refuse to be examined.

## **Interviews**

Interviews provide a method to collect information, and to verify and validate information obtained through observations. Informal interviews should be conducted throughout the duration of the survey. Use the information obtained from interviews to determine what additional observations, interviews, and record reviews are necessary. When conducting interviews, observe the following:

- Maintain detailed documentation of each interview conducted. Document the interview date, time, and location; the full name and title of the person interviewed; and key points made and/or topics discussed. To the extent possible, document quotes from the interviewee.
- Interviews with facility staff should be brief. Use a few well-phrased questions to elicit the desired information. For example, to determine if a staff member is aware of disaster procedures and his/her role in such events, simply ask, "If you smelled smoke, what would you do?"
- When interviewing staff, begin your interviews with staff that work most closely with the patient.
- Conduct patient interviews regarding their knowledge of their plan of care, the implementation of the plan, and the quality of the services received. Other topics for patient or family interview may include advanced directives and the facility's grievance/complaint procedure.
- Interviews with patients must be conducted in privacy and with the patient's prior permission.
- Use open-ended questions during your interview.

- Validate all information obtained.
- Telephone interviews may be conducted if necessary, but a preference should be made for in-person interviews.
- Integrate the data from interviews with data gathered through observations and document reviews.

Staff interviews should gather information about the staff's knowledge of the patient's needs, plan of care, and progress toward goals. Problems or concerns identified during a patient or family interview should be addressed in the staff interview in order to validate the patient's perception, or to gather additional information.

Patient interviews should include questions specific to the patient's condition, reason for admission, quality of care received, and the patient's knowledge of their plan of care. For instance, a surgical patient should be questioned about the process for preparation for surgery, the patient's knowledge of and consent for the procedure, pre-operative patient teaching, post-operative patient goals and discharge plan.

### **Document Review**

Document review focuses on a facility's compliance with the CoP. When conducting a document review, document the source and date of the information obtained. When making document copies identify the original date of the document and indicate the date and time the copies were made. Once a document review is completed, integrate the data obtained with data gathered through observations and interviews to decide if the CAH is in compliance with the CoP. Documents reviewed may be both written and electronic and include the following:

- Patient's clinical records, to validate information gained during the interviews, as well as for evidence of advanced directives, discharge planning instructions, and patient teaching. This review will provide a broad picture of the patient's care. Plans of care and discharge plans should be initiated immediately upon admission, and be modified, as patient care needs change. The record review for that patient who has undergone surgery would include a review of the pre-surgical assessment, informed consent, operative report, and pre-, inter-, and post-operative anesthesia notes. Although team members may have a specific area assigned during the survey, the team should avoid duplication of efforts during review of medical records and each surveyor should review the record as a whole instead of targeting the assigned area of concern. Surveyors should use open patient records rather than closed records, whenever practical.
- Closed medical records may be used to determine past practice, and the scope or frequency of a deficient practice. Closed records should also be reviewed to provide information about services that are not being provided by the CAH at the time of the survey. For example, if there are no obstetrical patients in the facility

at the time of the survey, review closed OB records to determine care practices, or to evaluate past activities that cannot be evaluated using open records. In the review of closed clinical records, review all selected medical records for an integrated plan of care, timelines of implementation of the plan of care, and the patient responses to the interventions.

- Personnel files to determine if staff members have the appropriate educational requirements, have had the necessary training required, and are licensed, if it is required;
- Credential files to determine if the facility complies with CMS requirements and State law, as well as, follows its own written policies for medical staff privileges and credentialing;
- Maintenance records to determine if equipment is periodically examined and to determine if it is in good working order and if environmental requirements have been met;
- Staffing documents to determine if adequate numbers of staff are provided according to the number and acuity of patients;
- Policy and procedure manuals. When reviewing policy and procedure manuals, verify with the person in charge of an area that the policy and procedure manuals are current;
- Contracts, if applicable, to what requirements are provided under arrangements or agreements.
- Diet menus to ensure they meet the needs of the sample patients.

### **Photocopies**

Surveyors should make photocopies of all documents needed to support survey findings. The surveyor needs access to a photocopier where he/she can make his/her own photocopies of needed documents. If requested by the hospital, the surveyor should make the hospital a copy of all items photocopied. All photocopies need to be dated and timed as to when photocopied, and identified such as “CAH IV management policy- 2/27/04 page 3” or “Patient # 6, progress note –2/17/04.”

### **Completion of Hospital/CAH Medicare Database Worksheet**

Interview a member of the administrative staff to update and clarify information from the provider file.

The Hospital/CAH Medicare Database worksheet will be used to collect information about the CAH services, locations, and staffing by the Medicare CAH surveyors during the CAH survey. The worksheet will be completed by the surveyors using observation, staff interviews, and document review. The worksheet will not be given to the CAH staff to complete. The worksheet is used to collect information that will later be entered into the Medicare Database.

Clarify any inconsistencies from prior information or information gathered during the survey.

## **Task 4 - Preliminary Decision Making and Analysis of Findings**

### **General Objectives**

The general objectives of this task are to integrate findings, review and analyze all information collected from observations, interviews, and record reviews, and to determine whether or not the CAH meets the Conditions of Participation found at 42 CFR Part 485. The team's preliminary decision-making and analysis of findings assist it in preparing the exit conference report. Based on the team's decisions, additional activities may need to be initiated.

### **General Procedures**

#### **Preparation**

Prior to beginning this Task, each team member should review his/her notes, worksheets, records, observations, interviews, and document reviews to assure that all investigations are complete and organized for presentation to the team.

#### **Discussion Meeting**

At this meeting, the surveyors will share their findings with the team, evaluate the evidence, and make team decisions regarding compliance with each requirement. Proceed sequentially through the requirements for each condition appropriate to the facility as they appear in regulation. For any issues of noncompliance, the team needs to reach a consensus. Decisions about deficiencies are to be team decisions, with each member having input. The team should document their decisions, the substance of the evidence, and the numbers of patients impacted, in order to identify the extent of facility noncompliance. The team should document their decisions, the substance of the evidence, and the numbers of patients impacted, in order to identify the extent of facility noncompliance. The team must ensure that their findings are supported by adequate documentation of observations, interviews, and document reviews, and includes any needed evidence such as photocopies. Any additional documentation or evidence needed to support identified noncompliance should be gathered prior to the exit conference but at a minimum prior to exiting the hospital.

## **Determining the Severity of Deficiencies**

The regulations at 42 CFR § 488.26 states, “The decision as to whether there is compliance with a particular requirement, condition of participation, or condition for coverage, depends upon the manner and degree to which the provider or supplier satisfies the various standards within each condition.” When noncompliance with a condition of participation is noted, the determination of whether a lack of compliance is at the standard or condition level depends upon the nature (how severe, how dangerous, how critical, etc.) and extent (how prevalent, how many, how pervasive, how often, etc.) of the lack of compliance. The cited level of noncompliance is determined by the interrelationship between the nature and extent of the noncompliance.

A deficiency at the condition level may be due to noncompliance in a single standard or several standards, or parts of standards within the condition, or because of noncompliance with a single part (tag) representing a severe or critical health or safety breach. Even a seemingly small breach in critical actions or at critical times can kill or severely injure a patient, and represents a critical or severe health or safety threat.

A deficiency is at the standard level when there is noncompliance with any single requirement or several requirements within a particular standard that are not of such character as to substantially limit a facility’s capacity to furnish adequate care, or which would not jeopardize or adversely affect the health or safety of patients if the deficient practice recurred.

On a complaint investigation where the CAH states that it has corrected the deficient practice/issue (noncompliance) that is the basis of the complaint, issues for the survey team to consider would include:

- Is the corrective action superficial or inadequate, or is the corrective action adequate and systemic?
- Has the CAH implemented the corrective intervention(s) or action(s)?
- Has the CAH taken a QA approach to the corrective action to ensure monitoring, tracking and sustainability?

The survey team uses their judgment to determine if any action(s) taken by the CAH prior to the survey is sufficient to correct the noncompliance and to prevent the deficient practice from continuing or recurring. If the deficient practice is corrected prior to the survey, do not cite noncompliance. However, if the noncompliance with any requirements is noted during the survey, even when the CAH corrects the noncompliance during the survey, cite noncompliance.

All noted noncompliance must be cited even when corrected on site during the survey. Citing noncompliance at the appropriate level is important to the integrity of the survey process. Citing too high a level is unfair to the CAH. Citing noncompliance at a level

below the noted degree and manner of the noncompliance does not ensure that the CAH will develop acceptable plans of correction and implement corrective actions, does not depict whether the care provided adversely affects the health and safety of patients, and whether continued deficient practices may lead to adverse patient outcomes such as injury or death.

### **Gathering Additional Information**

If it is determined that the survey team needs additional information to determine facility compliance or noncompliance, the team coordinator should decide the best way to conduct the additional review.

## **Task 5 - Exit Conference**

### **General Objective**

The general objective of this task is to inform the facility staff of the team's preliminary findings.

### **Prior to the Exit Conference**

- The team coordinator is responsible for organization of the presentation of the exit.
- The team determines who will present the findings.
- If the team feels it may encounter a problem during the exit, they should contact their immediate supervisor.

### **Discontinuation of an Exit Conference**

It is CMS general policy to conduct an exit conference at the conclusion of each survey. However, there are some situations that justify refusal to continue or to conduct an exit conference. For example:

- If the provider is represented by counsel (all participants in the exit conference should identify themselves), surveyors may refuse to conduct the conference if the lawyer tries to turn it into an evidentiary hearing; or
- Any time the provider creates an environment that is hostile, intimidating, or inconsistent with the informal and preliminary nature of an exit conference, surveyors may refuse to conduct or continue the conference. Under such circumstances, it is suggested that the team coordinator stop the exit conference and call the State agency for further direction.

## **Recording the Exit Conference**

If the facility wishes to audio tape the conference, it must provide two tapes and tape recorders, recording the meeting simultaneously. The surveyors should take one of the tapes at the conclusion of the conference. Videotaping is also permitted if it is not disruptive to the conference, and a copy is provided at the conclusion of the conference. It is at the sole discretion of the surveyor(s) to determine if videotaping is permitted.

## **General Principles**

The following general principles apply when conducting an exit conference:

- The facility determines which CAH staff will attend the exit conference.
- The identity of an individual patient or staff member must not be revealed in discussing survey results. Identity includes not just the name of an individual patient or staff member, but also includes any references by which identity might be deduced.
- Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances in which the facility is unaware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.

## **Exit Conference Sequence**

The following discusses the sequence of events in conducting an exit conference.

### **A - Introductory Remarks:**

- Thank everyone for cooperation during the survey.
- Introduce all team members, mentioning any that have concluded their portion of the survey and have left the facility.
- Briefly mention the reason for the survey.
- Explain that the exit conference is an informal meeting to discuss preliminary findings.
- Indicate that official findings are presented in writing on the Form CMS-2567.

### **B - Ground Rules**

- Explain how the team will conduct the exit conference and any ground rules.

- Ground rules may include waiting until the surveyor finishes discussing each deficiency before accepting comments from facility staff.
- State that the provider will have an opportunity to present new information after the exit conference for consideration after the survey.

#### C - Presentation of Findings

- Avoid referring to data tag numbers.
- Present the findings of noncompliance, explaining why the findings are a violation. If the provider asks for the regulatory basis, provide it.
- Refrain from making any general comments (e.g., “Overall the facility is very good”). Stick to the facts. Do not rank findings. Treat requirements as equal as possible.
- Do not identify unmet requirements as condition or standard level. Avoid statements such as, “the condition was not met” or “the standard was not met.” It is better to state, “the requirement is not met.”
- If immediate jeopardy was identified, explain the significance and the need for immediate correction. Follow instructions in Appendix Q.
- Assure that all findings are discussed at the exit conference.

#### D - Closure

- Explain that a statement of deficiencies (Form CMS-2567) will be mailed within 10 working days to the CAH.
- Explain that the Form CMS-2567 is the document disclosed to the public about the facility’s deficiencies and what is being done to remedy them. The Form CMS-2567 is made public no later than 90 calendar days following completion of the survey. It documents specific deficiencies cited, the facility’s plans for correction and timeframes, and it provides an opportunity for the facility to refute survey findings and furnish documentation that requirements are met.
- Inform the facility that a written plan of correction must be submitted to the survey agency within 10 calendar days following receipt of the written statement of deficiencies.
- Explain the required characteristics of a plan of correction. The characteristics include:

- Corrective action to be taken for each individual affected by the deficient practice, including any system changes that must be made;
  - The position of the person who will monitor the corrective action and the frequency of monitoring;
  - Dates each corrective action will be completed;
  - The administrator or appropriate individual must sign and date the Form CMS-2567 before returning it to the survey agency;
  - The submitted plan of correction must meet the approval of the State agency, or in some cases the CMS Regional Office for it to be acceptable.
- If the exit conference was audio or video taped, obtain a copy of the tape in its entirety before leaving the facility.

All team members should leave the facility together immediately following the exit conference. If the facility staff provides further information for review, the team coordinator should decide the best way to conduct the further review. It is usually prudent for at least two individuals to remain.

## **Task 6 - Post-Survey Activities**

### **General Objective**

The general objective of this task is to complete the survey and certification requirements, in accordance with the regulations found at 42 CFR Part 488.

### **General Procedures**

Each State agency and CMS Regional Office should follow directives in the State Operations Manual. The procedures include:

- Timelines for completing each step of the process;
- Responsibilities of the team coordinator and other team members to complete the Form CMS-2567, Statement of Deficiencies, using the **Principles of Documentation** as reference;
- Notification to the facility staff regarding survey results;
- Additional survey activities based on the survey results (e.g., revisit, forwarding documents to the Regional Office for further action/direction);
- Compilation of documents for the provider file;

- Obtain signed Letter of Authorization to obtain facilities most recent accreditation survey and send to RO;
- Enter the information collected on the Hospital/CAH Medicare Database Worksheet into the Medicare database.

### **Plan of Correction**

Regulations at 42 CFR 488.28(a) allow certification of providers with deficiencies at the Standard or Condition level “only if the facility has submitted an acceptable Plan of Correction (POC) for achieving compliance within a reasonable period of time acceptable to the Secretary.” Failure to submit a POC may result in termination of the provider agreement as authorized by 42 CFR §§488.28(a) and 489.53(a)(1). After a POC is submitted, the surveying entity makes the determination of the appropriateness of the POC.

## CAH Swing-Bed Survey Module

When conducting a full survey of an accredited or unaccredited CAH that has swing bed approval, conduct a survey of the CAH swing-bed requirements found at 42 CFR Part 485.645. These requirements, as well as interpretive guidelines, are found in Appendix W of the State Operations Manual (SOM). The optional survey worksheet may be used.

### **Background**

Swing-bed patients are CAH patients who are situated in the CAH but for whom the CAH is receiving reimbursement for skilled nursing services, as opposed to acute-care reimbursement. The reference to swing-bed is a patient care and reimbursement status and has no relationship to geographic location in the facility. The patient may be in acute-care status one day and change to swing-bed status the next day. It is not necessary for the patient to change location in the hospital when the reimbursement status changes, but moving to a different location is allowed. A 3-day qualifying stay for the same spell of illness in any hospital or CAH is required prior to admission to swing-bed status. The 3-day qualifying stay does not need to be from the same facility as the swing-bed admission.

### **Regulatory Authority and Requirements for CAH Providers of Extended Care Services (“Swing Beds”)**

CAH swing-bed care is regulated by both the CAH requirements and the swing-bed requirements at 42 CFR Part 485. The actual swing-bed survey requirements are referenced in the Medicare Nursing Homes requirements at 42 CFR Part 483.

Section 18883 of the Act authorizes payment under Medicare for post-hospital SNF services provided by any CAH that meets certain requirements. By regulation, the Secretary has specified these requirements at 42 CFR § 485.645.

- The CAH has a Medicare provider agreement;
- The total number of beds that may be used at any time for furnishing swing-bed services or acute inpatient services does not exceed 25 beds.
- The CAH has not had a swing-bed approval terminated within two years previous to application; and
- The CAH meets the swing-bed CoP on Resident Rights; Admission, Transfer, and Discharge Rights; Resident Behavior and Facility Practices; Patients Activities; Social Services; Discharge Planning; Specialized Rehabilitative Services; and Dental Services.

## **Activities Conducted Prior to Swing-Bed Survey**

Prior to conducting the swing-bed survey, verify the following:

- The hospital's swing-bed approval is in effect and has not been terminated within the two previous years.

## **Survey Procedures**

In conducting the survey, verify that the CAH has fewer than 25 hospital-type beds. Count the hospital-type beds in each nursing unit. Count any hospital-type bed that is located in or adjoining any location where the bed could be used for inpatient care. Do not count beds in recovery rooms, labor and delivery rooms (do count birthing beds where patients remain after giving birth), operating rooms, newborn nurseries or stretchers in emergency departments. Do not count examination tables, procedure tables or stretchers. Do not count beds in Medicare certified rehabilitation or psychiatric distinct part units.

Swing bed certification is limited to the CAH itself and does not include any distinct part rehabilitation or psychiatric units. Swing bed services may not be provided in CAH distinct part units.

Assess the CAH's compliance with the swing-bed requirements at 42 CFR §485.645 found in appendix W of the SOM. Swing-bed requirements apply to any patient discharged from a hospital or CAH and admitted to a swing-bed for skilled nursing services. The requirements for acute-care CAHs also apply to swing-bed patients.

If swing bed patients are present during the on-site inspection, conduct an open record review and an environmental assessment. Include patient interviews and observations of care and services. However, if no swing-bed patients are present during the on-site inspection, review two closed records for compliance with swing-bed requirements. In all cases, review policies, procedures, and contracted services to assure that the CAH has the capability to provide the services needed.

It is important for surveyors to maintain on-going documentation of their findings during the course of the survey for later reference. Surveyors may use the optional swing-bed worksheet as note-taking tool to document and record their findings on the survey.

## **Exit Conference**

Any findings of noncompliance may be discussed during the time of the CAH exit conference.

### **Post-Survey Activities**

The findings for swing-bed deficiencies must be documented on a separate Form CMS-2567, even though the swing-bed survey is being conducted simultaneously with the CAH survey.

## **Regulations and Interpretive Guidelines for CAHs**

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### **C-0150**

#### **§485.608 Condition of Participation: Compliance With Federal, State, and Local Laws and Regulations**

**The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.**

#### **Interpretive Guidelines §485.608**

Failure of the CAH to meet a Federal, State or local law may only be cited when the Federal, State or local authority having jurisdiction has made both a determination of noncompliance and has taken a final adverse action as a result.

Refer or report suspected violations to the appropriate Federal, State, or local agency.

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### **C-0151**

#### **§485.608(a) Standard: Compliance With Federal Laws and Regulations**

**The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.**

#### **Survey Procedures §485.608(a)**

Interview the CEO, or appropriate individual, to determine whether the CAH is in compliance with Federal laws related to patient health and safety. For example, if the CAH has been convicted of violating a Federal law such as denying people with disabilities access to care, verify that satisfactory corrections have been made to bring the CAH into compliance with that law.

Refer noted noncompliance with Federal laws and regulations to the appropriate agency having jurisdiction (e.g., accessibility issues, blood borne pathogens, universal precautions, TB control to OSHA, hazardous chemical and waste issues to EPA, etc.)

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**C-0152****§485.608(b) Standard: Compliance With State and Local Laws and Regulations**

**All patient care services are furnished in accordance with applicable State and local laws and regulations.**

**Interpretive Guidelines §485.608(b)**

There are wide variations in the States' practice acts relative to the extent to which MD/DOs may delegate responsibilities to nurse practitioners, clinical nurse specialists, and physician assistants. Some states have updated their practice acts to include definitions and specific references to permitted/prohibited activities, supervision/guidance required by a MD/DO, and local situations in which nurse practitioners, clinical nurse specialists, and physician assistants may function.

**Survey Procedures §485.608(b)**

Prior to going on the survey, determine what professional specialists provide patient care services at the CAH and review State practice act requirements.

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**C-0153****§485.608(c) Standard: Licensure of CAH**

**The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.**

**Survey Procedures §485.608(c)**

Prior to the survey, determine whether the CAH is subject to licensure requirements and verify that the licensing agency has approved the CAH as meeting the standards for licensure as set forth by the agency of the State or locality responsible for licensing CAHs.

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**C-0154****§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.**

### **Interpretive Guidelines §485.608(d)**

All staff required by the State to be licensed must possess a current license. The CAH must ensure that these personnel are in compliance with the State's licensure laws. The laws requiring licensure vary from state to state. Examples of healthcare professionals that a state may require to be licensed could include: nurses, MD/DOs, physician assistants, dietitians, x-ray technologists, dentists, physical therapists, occupational therapists, respiratory technicians and facility administrators.

All CAH staff must meet all applicable standards required by State or local law for CAH personnel. This would include at a minimum:

- Certification requirements;
- Minimum qualifications; and
- Training/education requirements.

### **Survey Procedures §485.608(d)**

- Verify for those personnel required to be licensed by the State, that the CAH has established, and follows, procedures for determining that personnel providing patient care services are properly licensed.
- Check a sample of personnel files to verify that licensure information is up to date. Verify that appropriate categories of staff and personnel are licensed in accordance with State requirements. Verify state licensure compliance of the direct care personnel, as well as administrators and supervisory personnel, and any contracted personnel.
- Verify that there are procedures in place to guarantee licensure of employees working at the CAH under contract or agreement.
- Review CAH policies regarding certification, licensure, and registration of personnel. Are the CAH policies compliant with State and local laws? Are the personnel in compliance with CAH policy?

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## **C-0160**

### **§485.610 Condition of Participation: Status and Location**

#### **Interpretive Guidelines §485.610**

This COP only applies to initial surveys unless the facility relocates. If the CAH moves the location of the CAH to another location, the status and relocation must be reassessed.

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**C-0161****§485.610(a) Standard: Status**

The facility is--

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

**Interpretive Guidelines §485.610(a)**

Confirm that a CAH meets the basic status requirement prior to scheduling the survey. The appropriate RO will reverify the status requirement prior to approving a CAH for Medicare certification.

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**C-0162****§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.

- (1) The CAH meets the following requirements:**
  - (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 §412.62(f) of this chapter;**

**(ii) The CAH is not deemed to be located in an urban area under §412.63(b) of this chapter; and**

**(iii) The CAH has not been classified as an urban CAH 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 CAHs that have been redesignated to an adjacent urban area under §412.232 of this chapter.**

**(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with §412.103 of this chapter.**

#### **Interpretive Guidelines §485.610(b)**

“**Urban**” as defined at 42 CFR §412.62(f), means a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget, or the following New England Counties: Litchfield County, Connecticut; York County, Maine; Merrimack County, New Hampshire; Newport County, Rhode Island; and Fagadahoe County, Maine.

“**Urban area,**” as defined at 42 CFR §412.62 (f) and referenced in 42 CFR § 412.63(b), applies to CAHs located within an MSA or NECMA that crosses census division boundaries. In such cases, the MSA or NECMA in which the CAH is located is deemed to belong to the census divisions in which most of the CAHs within the MSA or NECMA are located.

A “**Metropolitan CAH**” is a CAH that is located within a MSA but is being treated as being located in a rural area. A CAH that wishes to convert to a CAH, and is located in an urban area, must be reclassified as a rural CAH by submitting an application, prior to conversion, to the regional office of CMS. Prior to conversion, the CAH must meet one of the following criteria and explain how they meet the criteria for reclassification as rural, including data and documentation necessary to support the request, in the application for reclassification. Reference 42 CFR §412.103.

- The CAH is located in a rural census tract of an MSA as determined under the most recent version of the Goldsmith Modification; or
- The CAH is located in an area designated as a rural area by any law or regulation of the State in which it is located; or
- The CAH is designated as a rural CAH by State law or regulation; or
- The CAH would qualify as a rural referral center or as a sole community hospital.

## **Survey Procedures §485.610(b)**

Determine that a CAH meets the basic location requirement prior to scheduling the survey. The appropriate RO will reverify the location requirement prior to approving a CAH for Medicare certification.

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## **C-0165**

**(Rev. 32, Issued: 01-18-08, Effective: 09-07-07, Implementation: 09-07-07)**

### **§485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification**

The CAH 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, 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.

#### **Interpretive Guidelines §485.610(c)**

A CAH that can document that it was designated by a State as a necessary provider CAH prior to January 1, 2006, does not have to meet the location relative to other facilities standard at §485.610(c). As of January 1, 2006, States do not have the authority to designate any new necessary provider CAHs. Necessary provider CAHs that were designated prior to that date are grandfathered by statute, subject to certain conditions if they relocate (see the discussion related to §485.610(d)). ROs and SAs should have the documentation related to a CAH's original designation as a necessary provider in the file on each CAH. If they do not, they should ask the CAH to supply copies of the original necessary provider designation documents.

For applicants seeking a new CAH provider agreement, or for CAHs that seek to relocate and do not have a grandfathered necessary provider designation, ROs will review the application and make the determination whether it satisfies the CAH location relative to other facilities standard at §485.610(c), using the guidance found in Chapter 2, §2256A of the State Operations Manual. At the conclusion of its review, the RO will notify the SA of its determination.

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## **C-0166**

**(Rev. 32, Issued: 01-18-08, Effective: 09-07-07, Implementation: 09-07-07)**

### **§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 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.

- (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--
  - (i) Serves at least 75 percent of the same service area that it served prior to its relocation;
  - (ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and
  - (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.
- (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, the action will be considered a cessation of business as described in §489.52(b)(3).

### **Interpretive Guidelines §485.610(d)**

Renovation or expansion of a CAH's existing building or addition of building(s) on the existing main campus of the CAH is not considered a relocation. However, as discussed in the adoption of this regulation (70 FR 47472), all newly-constructed, necessary provider CAH facilities, including entirely new replacement facilities constructed on the same site as the existing CAH main campus, are considered relocated facilities. The determination of whether or not CAHs with a necessary provider designation have met the requirements at §485.610(d) will be made by the RO, generally prior to an SA or accreditation survey. The RO will utilize the evaluation criteria set forth in the SOM, Chapter 2, §2256F to make this determination. At the conclusion of its review, the RO will notify the SA of its results.

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**C-0167**

*(Rev. 49, Issued: 06-12-09, Effective/Implementation: 06-12-09)*

**§485.610(e) Standard: Off-campus and Co-Location Requirements for CAHs**

**Standard: Off-campus and co-location requirements for CAHs. A CAH may continue to meet the location requirement of paragraph(c) of this section based only if the CAH meets the following:**

- (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.**
  
- (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 paragraph (e)(2) of this section,] the CAH's provider agreement will be subject to termination in accordance with the provisions of §489.53(a)(3) of this subchapter, unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.**

**Interpretive Guidelines §485.610(e)(1) & (3)**

*A CAH may not be co-located with another hospital or CAH, because this would violate the minimum distance requirement found at §485.610(c). However, some CAHs that were designated as necessary providers prior to January 1, 2006, and therefore exempted from this distance requirement, also chose to co-locate with another hospital. Co-location occurs when a necessary provider CAH shares the same campus and/or building in which the CAH is currently located with another hospital or necessary provider CAH. For example, a necessary provider CAH shares the same campus with an unrelated psychiatric or rehabilitation hospital.*

*Effective January 1, 2008, grandfathered necessary provider CAHs may no longer enter into co-location arrangements with another CAH or hospital (72 FR 66878). However,*

*necessary provider CAHs that had co-location arrangements in effect prior to January 1, 2008, are permitted to continue these arrangements as long as the type and scope of services offered by the facility co-located with the CAHs do not change. An example of a change in type of services would be when a hospital that provides only rehabilitation services chooses to provide general hospital acute care services. An example of a change in scope of services would be when a grandfathered necessary provider CAH is currently co-located with a 20 bed psychiatric hospital and the psychiatric hospital now decides to increase the number of beds to 30.*

*The determination of whether or not CAHs with a grandfathered necessary provider designation have met the requirements at §485.610(e)(1) is made by the RO. If the SA or accreditation organization (AO) becomes aware of a co-location arrangement, the SA or AO must notify the RO. The RO will utilize the co-location guidance in §2256G of the SOM to determine if such CAHs satisfy the co-location requirements at §485.610(e)(1). The RO will notify the CAH as well as the SA (and the AO, if applicable) of its determination.*

*A CAH found out of compliance with the requirements is subject to termination of its Medicare provider agreement under §489.53(a)(3). In such cases the CAH is placed on a 90-day termination track, as outlined in §3012 of the SOM. If the CAH corrects the situation, by terminating the co-location arrangement that led to the non-compliance during this 90 day period, then the provider agreement is not terminated.*

*A facility facing termination of its CAH designation as a result of non-compliance with §485.610(e)(1) could also continue to participate in Medicare by converting to a hospital, assuming that the facility satisfies all requirements for participation as a hospital in the Medicare program under the provisions at 42 CFR Part 482. Under this scenario, the CAH would apply to convert back to a hospital, with the effective date coinciding with the date of termination of CAH status. A new CMS Certification Number (CCN) would be assigned accordingly.*

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## **C-0168**

**(Rev. 49, Issued: 06-12-09, Effective/Implementation: 06-12-09)**

### **§485.610(e) Standard: Off-campus and Co-Location Requirements for CAHs (Con't.)**

**Standard: Off-campus and co-location requirements for CAHs. A CAH may continue to meet the location requirement of paragraph(c) of this section based only if the CAH meets the following:**

- (2) If a CAH or a necessary provider CAH operates an off-campus provider-based location, 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.*

*(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 paragraph (e)(2) of this section, the CAH's provider agreement will be subject to termination in accordance with the provisions of §489.53(a)(3) of this subchapter, unless the CAH terminates the off-campus arrangement or the co-location arrangement, or both.*

#### *Interpretive Guidelines §485.610(e)(2) & (3)*

*Section 42 CFR 485.610(e)(2) requires that if a CAH operates an off-campus provider-based facility as defined in §413.65(a)(2) (except for a rural health clinic (RHC)) or off-campus rehabilitation or psychiatric distinct part unit as defined at §485.647, that was created or acquired on or after January 1, 2008, then the off-campus facility must meet the requirement at 42 CFR 485.610(c) to be more than a 35 mile drive (or 15 miles in the case of mountainous terrain or an area with only secondary roads) from another hospital or CAH. Off-campus CAH facilities that were in existence prior to January 1, 2008, are not subject to this requirement.*

*The drive to another hospital or CAH is to be calculated from the provider-based facility's location to the main campus of the other hospital or CAH.*

*The distance to another hospital or CAH requirement does not apply to the following types of facilities/services, because such facilities or services are not eligible for provider-based status in accordance with §413.65(a)(1)(ii):*

- Ambulatory surgical centers (ASCs);*
- Comprehensive outpatient rehabilitation facilities (CORFs);*
- Home Health Agencies (HHAs);*
- Skilled nursing facilities (SNFs);*
- Hospices;*

- *Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services, facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services;*
- *ESRD facilities;*
- *Departments of providers that perform functions necessary for the successful operation of the CAH, but for which separate CAH payment may not be claimed under Medicare or Medicaid, e.g., laundry, or medical records department; and*
- *Ambulances.*

*In the case of Federally Qualified Health Centers (FQHCs), although CMS rules permit them to be provider-based, it is unlikely that there are new FQHCs that meet the provider-based criteria, since the Health Resources and Services Administration (HRSA) requirements for separate FQHC governance make it unlikely an FQHC could meet provider-based governance requirements. However, there are grandfathered FQHCs as well as facilities that participate as FQHCs by virtue of being tribally-owned or operated that are eligible for provider-based status.*

*Those CAHs seeking a provider-based determination for newly created or acquired provider-based departments, remote locations and/or psychiatric or rehabilitation units located off-campus must submit an attestation to the Regional Office (RO), as specified in §2254H of the SOM, who makes the determination of whether it satisfies the CAH provider-based criteria at §485.610(e)(2), and the provider-based rules at §413.65. At the conclusion of its review, the RO will notify the CAH and the SA (and accreditation organization (AO), if applicable) of its determination.*

*If the SA or AO becomes aware of a provider-based off-campus facility that appears not to comply with the provider-based location requirements, the SA or AO must notify the RO. The RO will utilize the guidance in §2254H of the SOM to determine if the CAH satisfies the provider-based location requirements at §485.610(e)(2). The RO will notify the CAH as well as the SA (and the AO, if applicable) of its determination.*

*A CAH found out of compliance with the off-campus location requirements at §485.610(e)(2) is subject to termination of its Medicare provider agreement. In such cases the CAH is placed on a 90-day termination track, as outlined in §3012 of the SOM. If the CAH corrects the situation, by terminating the off-campus provider-based arrangement that led to the non-compliance during this 90 day period, then the provider agreement is not terminated.*

*A facility facing termination of its CAH status as a result of non-compliance with §485.610(e)(2) could also continue to participate in Medicare by converting to a hospital, assuming that the facility satisfies all requirements for participation as a hospital in the Medicare program under the provisions at 42 CFR Part 482. Under this*

*scenario, the CAH would apply to convert back to a hospital, with the effective date coinciding with the date of termination of CAH status. A new CCN number would be assigned accordingly.*

## **C-0170**

### **§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.**

#### **Interpretive Guidelines §485.612**

This COP only applies to initial surveys. All facilities that apply to become a CAH are surveyed using the CAH CoP to determine compliance, whether they are:

- A currently operating CAH; or
- A re-opened CAH; or
- A CAH that down-sized to become a clinic.

If a facility has never been a Medicare participating hospital and wishes to be a CAH, the facility is a new provider to Medicare and must first meet the certification as a hospital and then put in a change of status request to be a CAH. In these cases, the facility must be surveyed twice. They must be initially surveyed using the hospital CoP and, when the change request is received, they must be surveyed again using the CAH CoP. In addition, these facilities are to be treated as new providers to Medicare necessitating completion of an application package as a new Medicare provider.

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## **C-0190**

### **§485.616 Condition of Participation: Agreements**

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## **C-0191**

### **§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:**

### **Interpretive Guidelines §485.616(a)**

Section 485.603 defines a rural health network as an organization that includes at least one hospital that the State has designated or plans to designate as a CAH, and at least one hospital that furnishes acute care (hospital) services.

### **Survey Procedures §485.616(a)**

- If the CAH is a member of a rural health network having a communications system, ask to see the agreement.
- How does the CAH participate with other hospitals and facilities in the network communications system?
  - Is a communications log kept at the facility?
  - Ask staff if there have been difficulties in contacting network members. If so, ask how the CAH deals with communication delays.
- How does the network's communications system compare with any available communications equipment in the CAH?
- When the network communications system is not in operation, how does the CAH communicate and share patient data with other network members?
- Review any policies and procedures related to the operation of any communications system.
- How is the CAH staff educated on the use of any communication system utilized in the facility?
- Review any written agreements with the local EMS service.

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### **C-0192**

**§485.616(a)(1) Patient referral and transfer;**

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### **C-0193**

**§485.616(a)(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**

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**C-0194**

**§485.616(a)(3) The provision of emergency and non-emergency transportation between the facility and the hospital.**

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**C-0195**

**§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--**

- (1) One hospital that is a member of the network;**
- (2) One QIO or equivalent entity; or**
- (3) One other appropriate and qualified entity identified in the State rural health care plan.**

**Interpretive Guidelines §485.616(b)**

Other qualified entities could include another CAH or any licensed firms, businesses, or agencies that provide credentialing and QA services. The location for these other qualified entities is not limited to local entities.

Agreements for QA need to include medical record review as part of the determination of the quality and medical necessity of medical care at the CAH.

**Survey Procedures §485.616(b)**

- Review any agreements related to credentialing or quality assurance to determine the level of assistance to be provided and the responsibilities of the CAH.
- Review policies and procedures to determine how information is to be obtained, utilized, and how confidentiality of information will be maintained.

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**C-0200**

**§485.618 Condition of Participation: Emergency Services**

**The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.**

## **Interpretive Guidelines §485.618**

All emergency services must be provided as a direct service in the CAH. The ED cannot be a provider-based off-site location. Emergency needs of patients must be met in accordance with acceptable standards of practice.

Acceptable standards of practice include maintaining compliance with applicable Federal and State laws, regulations, and guidelines governing all services provided in the CAH'S emergency department, as well as any standards and recommendations promoted by or established by nationally recognized professional organizations such as the American Medical Association, American Association for Respiratory Care, American Society of Emergency Medicine, American College of Surgeons, American Nursing Association, etc.

The CAH'S emergency services must be under the direction of a qualified member of the CAH'S medical staff. The CAH'S medical staff establishes criteria for the qualifications for the director of the CAH'S emergency services in accordance with State law and acceptable standards of practice.

The CAH'S medical staff must establish policies and procedures governing the medical care provided in the emergency services or emergency department. Emergency services or emergency department policies must be current and revised as necessary based on the ongoing monitoring conducted by the medical staff and the emergency service or department QA activities. The CAH'S emergency services must be integrated into the CAH-wide QA program.

The medical staff must establish criteria, in accordance with State law, regulations, and guidelines, delineating the qualifications a medical staff member must possess in order to be granted privileges for the provision of emergency care services. Qualifications include necessary education, experience and specialized training, consistent with State law and acceptable standards of practice.

The CAH must staff the emergency department with the appropriate numbers and types of professionals and other staff who possess the skills, education, certifications, specialized training and experience in emergency care to meet the written emergency procedures and needs anticipated by the facility. There must be sufficient medical and nursing personnel to respond to the emergency medical needs and care of the patient population being served.

The CAH must determine the categories and numbers of MD/DOs, specialists, RNs, EMTs, and emergency department support staff the CAH needed to meet its anticipated emergency needs. The medical staff must establish criteria, in accordance with State law and regulations and acceptable standards of practice delineating the qualifications required for each category of emergency services staff (e.g., emergency physicians, specialist MD/DO, RNs, EMTs, mid-level practitioners, etc.).

The CAH must conduct ongoing assessments of its emergency needs in order to anticipate the policies, procedures, staffing, training, and other resources that may be needed to address likely demands.

Emergency care necessary to meet the needs of its inpatients and outpatients would include the provision of respiratory services as needed by the CAH'S emergency patients. When respiratory services are provided those services must be provided in accordance with acceptable standards of practice. The scope of diagnostic and/or therapeutic respiratory services offered by the CAH should be defined in writing, and approved by the medical staff.

The CAH must provide the appropriate equipment and qualified personnel necessary to furnish all services offered in a safe manner in accordance with acceptable standards of practice.

There should be written policies for the delivery of any services provided. The policies and procedures must be developed and approved by the medical staff and include the participation of any mid-level practitioners working in the ED. The written policies should address the following services, as appropriate:

- Each type of service provided by the CAH;
- The qualifications, including job title, licensure requirements, education, training and experience of personnel authorized to perform each type of respiratory care service and whether they may perform it without supervision;
- Equipment assembly and operation;
- Safety practices, including infection control measures;
- Handling, storage, and dispensing of therapeutic gases;
- Cardiopulmonary resuscitation;
- Procedures to follow in the advent of adverse reactions to treatments or interventions;
- Pulmonary function testing;
- Therapeutic percussion and vibration;
- Bronchopulmonary drainage;
- Mechanical ventilatory and oxygenation support;
- Aerosol, humidification, and therapeutic gas administration;

- Administration of medications; and
- Procedures for obtaining and analyzing blood samples (arterial blood gases).

### **Survey Procedures §485.618**

- Verify that emergency services are organized under the direction of a qualified member of the medical staff.
- Verify that procedures and policies for emergency medical services (including triage of patients and any respiratory services provided) are established, evaluated, and updated on an ongoing basis.
- Verify that there are sufficient medical and nursing personnel qualified in the needs anticipated by the facility and that there are specific assigned duties for emergency care
- Review any policies and procedures for emergency services in the CAH. What evidence indicates that the CAH is capable of providing necessary emergency care for its inpatients and outpatients?
- Review a sample of patient records for patients treated in the emergency services department to see if the CAH followed its own policies and procedures.
- Verify that emergency services are provided in accordance with acceptable standards of practice.
- Interview staff to determine that they are knowledgeable, within their own level of participation in emergency care including:
  - Parenteral administration of electrolytes, fluids, blood and blood components;
  - Care and management of injuries to extremities and central nervous system;
  - Prevention of contamination and cross infection; and
  - Provision of emergency respiratory services.
- Determine if the CAH provides any degree of respiratory care services and that the type and amount of respiratory care provided meets the needs of the patients and is delivered in accordance with acceptable standards of practice.

- Review the CAH policies and procedures to verify that the scope of the diagnostic and/or therapeutic respiratory care services provided is defined in writing and approved by the medical staff.
- Review staffing schedules to determine that the number and type of staff available is appropriate to the volume and types of treatments furnished.
- If blood gases or other laboratory tests are performed as part of the delivery of respiratory services, verify that there is a current CLIA certificate.

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## **C-0201**

### **§485.618(a) Standard: Availability**

**Emergency services are available on a 24-hours a day basis.**

#### **Interpretive Guidelines §485.618(a)**

The CAH “makes available 24-hour emergency services.” This does not mean that the CAH must remain open 24 hours a day when it does not have inpatients (including swing-bed patients). A CAH that does not have inpatients may close with no staff present, provided that it has an effective system in place to meet the requirement. The system must ensure that a practitioner with training and experience in emergency care is on call and immediately available by telephone or radio, and available on site within 30 minutes, (or 1 hour in certain frontier areas), 24 hours a day.

In addition to these items, the CAH must maintain the types, quality and numbers of supplies, drugs and biologicals, blood and blood products, and equipment required by state and local law and in accordance with accepted standards of practice.

#### **Survey Procedures §485.618(a)**

Ascertain by record review of patients admitted through the emergency department, interviews with staff, patients, and families, and/or observations that ED services were made available to patients presenting on a 24-hour a day basis. How does the CAH ensure that emergency services are made available on a 24-hour a day basis?

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## **C-0202**

### **§485.618(b) Standard: Equipment, Supplies, and Medication**

**Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:**

### **Interpretive Guidance §485.618(b)**

In addition to these items, the CAH must maintain the types, quality and numbers of supplies, drugs and biologicals, blood and blood products, and equipment required by State and local law and in accordance with accepted standards of practice.

### **Survey Procedures §485.618(b)**

- How does the CAH ensure that the required equipment, supplies and medications are always readily available in the CAH?
- Interview staff and tour the ER to ascertain compliance and ability to provide emergency services.

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### **C-0203**

**§485.618(b)(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrhythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.**

### **Survey Procedures §485.618(b)(1)**

- How does the CAH ensure that staff knows where drugs and biologicals are kept?
- How is the inventory maintained?
- Who is responsible for monitoring drugs and biologicals?
- How are drugs and biologicals replaced?

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### **C-0204**

**§485.618(b)(2) Equipment and supplies commonly used in life-saving procedures, including 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.**

### **Survey Procedures §485.618(b)(2)**

- How does the CAH ensure that required equipment and supplies are readily available to staff?
- How does the CAH ensure that staff knows where emergency equipment and supplies are kept?

- How is the supply inventory maintained?
- Who is responsible for monitoring supplies?
- How are supplies replaced?
- When was the last time emergency supplies were used?
- Is there an equipment maintenance schedule (e.g., for the defibrillator)?
- Ask staff if equipment has ever failed to work when needed.
- Examine sterilized equipment (e.g., tracheostomy sets) for expiration dates when applicable.
- Examine the oxygen supply system to determine functional capabilities.
- Check the force of the vacuum (suction) equipment to see that it is in operating condition.

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## **C-0205**

### **§485.618(c) Standard: Blood and Blood Products**

**The facility provides, either directly or under arrangements, the following--**

**(1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis.**

#### **Interpretive Guidelines §485.618(c)(1)**

This requirement can be met at a CAH by providing blood or blood products on an emergency basis at the CAH, either directly or through arrangement, if that is what the patient's condition requires. There is no requirement in the regulation for a CAH to store blood on site, although it may choose to do so. In some cases, it may be more practical to transport a patient to the source of the blood supply than to bring blood to the patient at the CAH. A facility that has the capability of providing blood services on site would be in compliance even if, in virtually all cases, the patients were actually taken to the blood rather than vice versa.

A CAH that performs CLIA tests on blood on-site must have a CLIA certificate and is subject to survey under CLIA. A CAH that is only storing blood for transfusion and refers all related testing out to another laboratory, is not performing testing as defined by CLIA. However, under this regulation, the CAH must ensure that blood is appropriately stored to prevent deterioration, including documenting refrigerator temperatures. The

provision of blood services between the CAH and the testing laboratory should be reflected in the written agreement or arrangement between the two. Also, if the CAH is collecting blood, it must register with the Food and Drug Administration.

“**Availability**” in this context, means that the blood and blood products must be accessible to CAH staff in time to effectively treat emergency patients at the CAH. In order to comply with this requirement, a CAH must demonstrate that it has the capability (i.e., an effective system is in place regardless of whether, in actual practice, it has been utilized) of making blood products available to its emergency patients 24 hours a day.

If a CAH performs type and compatibility testing it must have the necessary equipment, (i.e., serofuge and heat block), as well as typing and cross matching reagents, some of which have a 30-day expiration date. Another way for a CAH to meet this requirement would be to properly store 4 units of O negative packed red blood cells (the universal donor type) for availability at all times for emergencies only. CAHs that choose to store O negative packed red blood cells for emergency release of uncross matched blood will require a release form to be signed by a doctor, prior to transfusion, acknowledging that the blood has not been cross matched for the patient. Facilities that elect to store units of O negative packed red blood cells should be able to demonstrate that they have an arrangement (e.g., with the Red Cross or other similar product provider) for the provision of fresh units of O negative packed red blood cells.

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## **C-0206**

**§485.618(c)(2) Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the persons directly responsible for the operation of the facility.**

### **Survey Procedures §485.618(c)(2)**

- If blood banking services are provided on site, what evidence shows that the blood facility is under the control and supervision of a pathologist or other qualified MD/DO?
- For blood banking services provided under arrangement, what evidence shows that the CAH medical staff and the person responsible for CAH operations have approved the arrangement?

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## **C-0207**

### **§485.618(d) Standard: Personnel**

**(1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner with training**

or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes:

(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or

(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:

(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.

(B) The State has determined under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the area served by the CAH.

(C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency.

(2) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if--

(i) The CAH has no greater than 10 beds;

(ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section;

(iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural health care plan with the State Boards of Medicine and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section;

(iv) Once a Governor submits a letter, as specified in paragraph (d)(2)(ii) of this

**section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage as specified in this paragraph (d).**

**(3) The request, as specified in paragraph (d)(2)(ii) of this section, and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.**

#### **Interpretive Guidance § 485.618(d)**

When State laws are more stringent and require more stringent staffing or expanded operational hours, the CAH must staff its emergency department in accordance with state laws. For example, if State law requires the CAH emergency department be open and be staffed with a MD/DO 24/7 then the CAH must comply.

#### **Survey Procedures §485.618(d)**

- Review on-call schedules to determine how the CAH ensures that a qualified staff member is on call 24 hours a day and available on site at the CAH within 30 minutes, or 60 minutes in certain frontier areas.
- Interview staff to determine how the CAH staff knows who is on call.
- What documentation demonstrates that a MD/DO, nurse practitioner, physician assistant, or registered nurse (as allowed under (d)(2)) with emergency training or experience has been on call and available on site at the CAH within 30 or 60 minutes, as appropriate?

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### **C-0209**

#### **§485.618(e) Standard: Coordination With Emergency Response Systems**

**The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.**

#### **Interpretive Guidelines §485.618(e)**

The CAH, not the local ambulance service, is responsible for ensuring that an effective procedure is in place to meet this requirement.

## **Survey Procedures §485.618(e)**

- Verify that the CAH has policies and procedures in place to ensure an MD/DO is available by telephone or radio, on a 24-hour a day basis to receive emergency calls and provide medical direction in emergency situations?
- What evidence demonstrates that the procedures are followed and evaluated for effectiveness?
- Interview staff to see how an MD/DO is contacted when emergency instructions are needed.

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## **C-0210**

### **§485.620 Condition of Participation: Number of Beds and Length of Stay**

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## **C-0211**

**(Rev. 34; Issued: 04-04-08; Effective/Implementation Dates: 04-04-08)**

### **§485.620(a) Standard: Number of Beds**

**Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.**

#### **Interpretive Guidelines §485.620(a)**

Section 1820(c)(2)(B)(iii) of the Social Security Act, codified at 42 USC 1395i-4(c)(2)(B)(iii) limits a CAH to a maximum of 25 inpatient beds that can be used for inpatient acute care or swing bed services. The statute also requires CAHs to provide inpatient acute care limited, on an annual average basis, to 96 hours per patient (see interpretive guidelines for §485.620(b)).

Section 1820(c)(2)(E) of the Act also permits a CAH to operate a 10-bed psychiatric distinct part unit (DPU) and a 10-bed rehabilitation DPU, without counting these beds toward the 25-bed inpatient limit.

The limit applies to the number of inpatient beds; not to the number of inpatients on any given day. CAHs that were larger hospitals prior to converting to CAH status may not maintain more than 25 inpatient beds, plus a maximum of 10 psychiatric DPU inpatient beds, and 10 rehabilitation DPU inpatient beds.

#### **Observation Services**

Observation beds are not included in the 25-bed maximum, nor in the calculation of the average annual acute care patient length of stay. This makes it essential for surveyors to determine that CAHs with observation beds are using them appropriately, and not as a means to circumvent the CAH size and length-of-stay limits.

Inappropriate use of observation services also subjects Medicare beneficiaries to an increased beneficiary coinsurance liability that could have been avoided, had the beneficiary been properly admitted as an inpatient. This is the case because, as CAHs are not paid under the hospital Outpatient Prospective Payment System (OPPS), the beneficiary in an observation status will be liable for a coinsurance charge equal to 20 percent of the CAH's customary charges for the services. Further, as CAHs are also not subject to the preadmission payment window, a Medicare beneficiary would be liable for the coinsurance charges for the observation status services even when subsequently admitted. Depending on the terms of their health insurance coverage, other CAH patients may also face similar increased and avoidable costs when inappropriately placed in an observation status.

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as an inpatient, or may be safely discharged. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after outpatient surgery, and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a clinical decision is made concerning their next placement. The CAH should ensure that once there is sufficient information to render this clinical decision, the patient should be expeditiously admitted, appropriately transferred, or discharged.

A patient may be in an observation status even though the CAH furnishes the patient overnight accommodation, food, and nursing care.

Observation services are **NOT** appropriate:

- As a substitute for an inpatient admission;
- For continuous monitoring;
- For medically stable patients who need diagnostic testing or outpatient procedures (e.g., blood transfusion, chemotherapy, dialysis) that are routinely provided in an outpatient setting;
- For patients awaiting nursing home placement;
- To be used as a convenience to the patient, his or her family, the CAH, or the CAH's staff;

- For routine prep or recovery prior to or following diagnostic or surgical services; or
- As a routine “stop” between the emergency department and an inpatient admission.

Observation services **BEGIN** and **END** with an order by a physician or other qualified licensed practitioner of the CAH.

- The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient’s medical record. The order may not be backdated. Orders should be clear for the level of care intended, such as “admit to inpatient” or “admit for observation.”
- Observation services end when the physician or other qualified licensed practitioner orders an inpatient admission, a transfer to another health care facility, or discharge. The inpatient stay begins on the date and time of the new order.
- Standing orders for observation services are not acceptable, since it is not necessary to employ observation services for every patient in a given category, e.g., every emergency department patient, in order to reach a clinical decision about the appropriate next step in the patient’s care.

Medicare generally will not pay for observation services lasting more than 48 hours. However, some States may have more stringent limits in their licensure or other regulatory requirements, e.g., 24 hours. In such cases the more stringent limit on the length of an observation stay applies to Medicare beneficiaries as well.

The CAHs must provide appropriate documentation upon surveyor request to show that an observation bed is not an inpatient bed. The CAH must be able to document that it has specific clinical criteria for admission to, and discharge from, the observation service, and that these criteria are clearly distinguishable from those used for inpatient admission and discharge. CMS expects a CAH to employ the same type of clinical criteria for observation versus inpatient status for all patients, regardless of their payer status. For example, if a CAH were routinely placing only Medicare beneficiaries in its dedicated observation unit, then this would suggest that non-clinical criteria were being used in the decision to admit versus place in observation status. This would not only call the observation bed status into question, but would violate the CAH’s provider agreement. (See 42 CFR 489.53(c)(2).)

CMS expects there to be a reasonable relationship between the size of the CAH’s inpatient and observation operations. For example, a 10-bed observation unit in a 25-bed CAH might be disproportionately large, and the surveyor must determine whether the observation unit is actually functioning as an inpatient overflow unit. A CAH

observation unit that routinely operates at a high occupancy rate could also be an indicator of the need to probe further.

### **Other Types of Beds**

Other bed types that do not count toward the 25 inpatient bed limit include:

- Examination or procedure tables;
- Stretchers;
- Operating room tables;
- Beds in a surgical recovery room used exclusively for surgical patients during recovery from anesthesia;
- Beds in an obstetric delivery room used exclusively for OB patients in active labor and delivery of newborn infants (do count beds in birthing rooms where the patient remains after giving birth);
- Newborn bassinets and isolettes used for well-baby boarders;
- Stretchers in emergency departments; and
- Inpatient beds in Medicare-certified distinct part rehabilitation or psychiatric units.

### **Hospice Services**

A CAH can dedicate beds to a hospice under arrangement, but the beds must count as part of the maximum bed count. The computation contributing to the 96 hour annual average length of stay does not apply to hospice patients. The hospice patient can be admitted to the CAH for any care involved in their hospice treatment plan or for respite care.

Medicare does not reimburse the CAH for the hospice CAH benefit. Medicare reimburses the hospice. The CAH must negotiate payment for services from the hospice through an agreement.

### **Survey Procedures §485.620(a)**

- Count the number of inpatient beds the CAH maintains, excluding any DPU beds.
- Ask the CAH how frequently it uses observation services, and for its policies and procedures governing use of observation services.

- Verify that patients are never pre-registered for observation services; there should be no scheduled observation stays.
- Check to see if the CAH has specific clinical criteria for admission to and discharge from the observation service, and that these clinical criteria are clearly distinguishable from those used for inpatient admission and discharge.
- If there is a separate unit of observation beds, ask the CAH for evidence of how its criteria for admission to the observation unit differ from admission criteria for an inpatient bed. Count the number of beds in the observation unit and compare them to the number of inpatient beds. The higher the proportion of observation beds, the greater is the CAH's burden to prove these are not being used as inpatient beds. Ask for the occupancy rates for the observation unit; the higher the occupancy rate, particularly if there are more than a couple of beds, the greater is the CAH's burden to prove these are not being used as inpatient beds.
- Review the medical records for patients who are in observation status at the time of survey. Verify that the medical record includes an order to place the patient in observation status, including the clinical reason for observation, as "Place patient in observation to rule out possible myocardial infarction (MI)."
- Select a sample of closed medical records for patients who were in an observation status. Verify that the medical record includes an order to place the patient in observation status, as well as a later order to admit, discharge, or transfer the patient.

Verify through medical record review that observation services are not ordered as a standing order following outpatient surgery or prior to admission from the emergency department.

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## C-0212

### **§485.620(b) Standard: Length of Stay**

**The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.**

#### **Interpretive Guidelines §485.620(b)**

The Fiscal Intermediary (FI) will determine compliance with this CoP. The FI will calculate the CAH'S length of stay based on patient census data. If a CAH exceeds the length of stay limit, the FI will send a report to the CMS-RO as well as a copy of the report to the SA. The CAH will be required to develop and implement a plan of correction (POC) acceptable to the CMS Regional Office or provide adequate information to demonstrate compliance.

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**C-0220****§485.623 Condition of Participation: Physical Plant and Environment****Interpretive Guidelines §485.623**

This CoP applies to all locations of the CAH, all campuses, all satellites, all provider-based activities, and all inpatient and outpatient locations.

The CAH'S departments or services responsible for the CAH'S building and equipment maintenance (both facility equipment and patient care equipment) must be incorporated into the CAH'S QA program and be in compliance with the QA requirements.

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**C-0221****§485.623(a) Standard: Construction**

**The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of direct services.**

**Interpretive Guidelines §485.623(a)**

Physical facilities must be large enough, numerous enough, appropriately designed and equipped, and of appropriate complexity to provide the services offered in accordance with Federal and State laws, regulations and guidelines and accepted standards of practice for that location or service.

**Survey Procedures §485.623(a)**

Verify through observation that the physical facilities are large enough and properly equipped for the scope of services provided and the number of patients served.

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**C-0222****§485.623(b) Standard: Maintenance**

**The CAH has housekeeping and preventive maintenance programs to ensure that--**

**(1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;**

### **Interpretive Guidelines §485.623(b)(1)**

The CAH must ensure that the condition of the physical plant and overall CAH environment is developed and maintained in a manner to ensure the safety and well being of patients. This includes ensuring that routine and preventive maintenance and testing activities are performed as necessary, in accordance with Federal and State laws, regulations, and guidelines and manufacturer's recommendations, by establishing maintenance schedules and conducting ongoing maintenance inspections to identify areas or equipment in need of repair. The routine and preventive maintenance and testing activities should be incorporated into the CAH'S QA plan.

**Facilities** must be maintained to ensure an acceptable level of safety and quality.

**Supplies** must be maintained to ensure an acceptable level of safety and quality.

**Equipment** must be maintained to ensure an acceptable level of safety and quality.

Equipment includes both facility equipment (e.g., elevators, generators, air handlers, medical gas systems, air compressors and vacuum systems, etc.) and medical equipment (e.g., biomedical equipment, radiological equipment, patient beds, stretchers, IV infusion equipment, ventilators, laboratory equipment, etc.).

There must be a regular periodical maintenance and testing program for medical devices and equipment. A qualified individual such as a clinical or biomedical engineer, or other qualified maintenance person, must monitor, test, calibrate and maintain the equipment periodically in accordance with the manufacturer's recommendations and Federal and State laws and regulations. Equipment maintenance may be conducted using CAH staff, contracts, or through a combination of CAH staff and contracted services.

### **Survey Procedures §485.623(b)(1)**

- Verify that the condition of the CAH is maintained in a manner to ensure the safety and well being of patients (e.g., condition of ceilings, walls, and floors, presence of patient hazards, etc.).
- Review the CAH'S routine and preventive maintenance schedules to determine that ongoing maintenance inspections are performed and that necessary repairs are completed.
- Interview the person in charge of medical equipment and determine if there is an adequate periodical maintenance and repair program.
- Verify that all medical devices and equipments are routinely checked by a clinical or biomedical engineer.

- Review maintenance logs for significant medical equipment (e.g., cardiac monitors, IV infusion pumps, ventilators, etc.).

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## **C-0223**

### **§485.623(b)(2) There is proper routine storage and prompt disposal of trash;**

#### **Interpretive Guidelines §485.623(b)(2)**

The term trash refers to common garbage as well as biohazardous waste. The storage and disposal of trash must be in accordance with Federal, State and local laws and regulations (i.e., EPA, OSHA, CDC, State environmental, health and safety regulations). The Radiology requirements address handling and storage of radioactive materials.

#### **Survey Procedures §485.623(b)(2)**

Verify that the CAH has developed and implemented policies for the proper storage and disposal of trash. Verify through observation that staff adhere to these policies and that the CAH has signage, as appropriate.

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## **C-0224**

### **§485.623(b)(3) Drugs and biologicals are appropriately stored;**

#### **Survey Procedures §485.623(b)(3)**

What standards, guidelines, State and Federal law is the CAH following to ensure that drugs and biologicals are appropriately stored (e.g., properly locked) in all storage areas?

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## **C-0225**

### **§485.623(b)(4) The premises are clean and orderly; and**

#### **Interpretive Guidelines §485.623(b)(4)**

“**Clean and orderly**” means an uncluttered physical environment where patients and staff can function safely. Equipment and supplies are stored in proper spaces, not in corridors. Spills are not left unattended. There are no floor obstructions. The area is neat and well kept. There is no evidence of peeling paint, visible water leaks, or plumbing problems.

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## C-0226

**§485.623(b)(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.**

### **Interpretive Guidelines §485.623(b)(5)**

There must be proper ventilation in at least the following areas:

- Areas using ethylene oxide, nitrous oxide, guteraldehydes, xylene, pentamidine, or other potentially hazardous substances;
- Locations where oxygen is transferred from one container to another;
- Isolation rooms and reverse isolation rooms (both must be in compliance with Federal and State laws, regulations, and guidelines such as OSHA, CDC, NIH, etc.);
- Pharmaceutical preparation areas (hoods, cabinets, etc.); and
- Laboratory locations.

There must be adequate lighting in all the patient care, food and medication preparation areas.

Temperature, humidity and airflow in the operating rooms must be maintained within acceptable standards to inhibit bacterial growth and prevent infection, and promote patient comfort. Excessive humidity in the operating room is conducive to bacterial growth and compromises the integrity of wrapped sterile instruments and supplies. Each operating room should have separate temperature control. Acceptable standards such as from the Association of Operating Room Nurses (AORN) or the American Institute of Architects (AIA) should be incorporated into CAH policy.

The CAH must ensure that an appropriate number of refrigerators and/or heating devices are provided and ensure that food and pharmaceuticals are stored properly and in accordance with nationally accepted guidelines (food) and manufacturer's recommendations (pharmaceuticals).

### **Survey Procedures §485.623(b)(5)**

- Verify that all food and medication preparation areas are well lit.
- Verify that the CAH is in compliance with ventilation requirements for patients with contagious airborne diseases, such as tuberculosis, patients receiving

treatments with hazardous chemical, surgical areas, and other areas where hazardous materials are stored.

- Verify that food products are stored under appropriate conditions (e.g., time, temperature, packaging, location) based on nationally-accepted sources such as the United States Department of Agriculture, the Food and Drug Administration, or other nationally-recognized standard.
- Verify that pharmaceuticals are stored at temperatures recommended by the product manufacturer.
- Verify that each operating room has temperature and humidity control mechanisms.
- Review temperature and humidity tracking logs to ensure that appropriate temperature and humidity levels are maintained.

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## **C-0227**

### **§485.623(c) Standard: Emergency Procedures**

**The CAH assures the safety of patients in non-medical emergencies by--**

**(1) Training staff in handling emergencies, including prompt reporting of fires, extinguishing of fires, protection and, where necessary, evacuation of patients, personnel, and guests, and cooperation with fire fighting and disaster authorities;**

#### **Survey Procedures §485.623(c)(1)**

- How does the CAH ensure that all personnel on its staff, including new additions to the staff, are trained to manage non-medical emergencies?
- Ask facility staff what they are supposed to do in case of an emergency such as a tornado or a blizzard.
- Review staff training documents and inservice records to validate training.
- Review the CAH'S written fire control plans to verify they contain the required provisions of the Life Safety Code or State law.
- Verify that CAH staff reported all fires as required to State officials.
- Interview staff throughout the facility to verify their knowledge of their responsibilities during a fire (this is usually done during the LSC survey, but health surveyors may also verify staff knowledge).

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## **C-0228**

### **§485.623(c)(2) Providing for emergency power and lighting in the emergency room and for battery lamps and flashlights in other areas;**

#### **Interpretive Guidelines §485.623(c)(2)**

The CAH must comply with the applicable provisions of the Life Safety Code, National Fire Protection Amendments (NFPA) 101, 2000 Edition and applicable references such as NFPA-99: Health Care Facilities, for emergency lighting and emergency power.

#### **Survey Procedures §485.623(c)(2)**

Use the Life Safety Code Survey Report Form (CMS-2786) to evaluate compliance with this item.

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## **C-0229**

### **§485.623(c)(3) Providing for an emergency fuel and water supply; and**

#### **Interpretive Guidelines §485.623(c)(3)**

The CAH must have a system to provide emergency gas and water as needed to provide care to inpatients and other persons who may come to the CAH in need of care. This includes making arrangements with local utility companies and others for the provision of emergency sources of water and gas. The CAH should consider nationally accepted references or calculations made by qualified staff when determining the need for at least water and gas. For example, one source for information on water is the Federal Emergency Management Agency (FEMA).

Emergency gases include fuels such as propane, natural gas, fuel oil, liquefied natural gas, as well as any gases the CAH uses in the care of patients such as oxygen, nitrogen, nitrous oxide, etc.

The CAH should have a plan to protect these limited emergency supplies, and have a plan for prioritizing their use until adequate supplies are available. The plan should also address the event of a disruption in supply (e.g., disruption to the entire surrounding community).

#### **Survey Procedures §485.623(c)(3)**

- Review the system used by CAH staff to determine the CAH'S emergency needs for gas and water. Verify that the system accounts for not only inpatients, but also staff and other persons who come to the CAH in need of care during emergencies.

- Determine the source of emergency gas and water, both the quantity of these supplies readily available at the CAH, and that are needed within a short time through additional deliveries.
- Verify that arrangements have been made with utility companies and others for the provision of emergency sources of critical utilities, such as water and gas.

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## **C-0230**

### **§485.623(c)(4) Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.**

#### **Interpretive Guidelines §485.623(c)(4)**

Assuring the safety and well being of patients would include developing and implementing appropriate **emergency preparedness** plans and capabilities. The CAH must develop and implement a comprehensive plan to ensure that the safety and well being of patients are assured during emergency situations. The CAH must coordinate with Federal, State, and local emergency preparedness and health authorities to identify likely risks for their area (e.g., natural disasters, bioterrorism threats, disruption of utilities such as water, sewer, electrical communications, fuel; nuclear accidents, industrial accidents, and other likely mass casualties, etc.) and to develop appropriate responses that will ensure the safety and well being of patients. The following issues should be considered when developing the comprehensive emergency plans(s):

- Differences needed for each location where the certified CAH operates;
- The special needs of patient populations treated at the CAH (e.g., patients with psychiatric diagnosis, patients on special diets, newborns, etc.);
- Security of patients and walk-in patients;
- Security of supplies from misappropriation;
- Pharmaceuticals, food, other supplies and equipment that may be needed during emergency/disaster situations;
- Communication to external entities if telephones and computers are not operating or become overloaded (e.g., ham radio operators, community officials, other healthcare facilities if transfer of patients is necessary, etc.);
- Communication among staff within the CAH itself;

- Qualifications and training needed by personnel, including healthcare staff, security staff, and maintenance staff, to implement and carry out emergency procedures;
- Identification, availability and notification of personnel that are needed to implement and carry out the CAH'S emergency plans;
- Identification of community resources, including lines of communication and names and contact information for community emergency preparedness coordinators and responders;
- Provisions for gas, water, electricity supply if access is shut off to the community;
- Transfer or discharge of patients to home or other healthcare settings
- Methods to evaluate repairs needed and to secure various likely materials and supplies to effectuate repairs.

#### **Survey Procedures §485.623(c)(4)**

Verify that the CAH has developed and implemented a comprehensive plan to ensure the safety and well being of patients during local emergency situations.

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#### **C-0231**

#### **§485.623(d) Standard: Life Safety From Fire**

**(1) Except as otherwise provided in this section, the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capital Street NW, Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.**

#### **Interpretive Guidelines §485.623(d)(1)**

Medicare-participating CAHs, regardless of size or number of beds, must comply with the Hospital/healthcare Life Safety Code requirements for all inpatient care locations. CAH departments and locations such as emergency departments, outpatient care

locations, etc. must comply with Hospital/healthcare Life Safety Code Requirements. Additionally, the CAH must be in compliance with all applicable codes referenced in the Life Safety Code, such as NFPA-99: Health Care Facilities.

This revision adopts the 2000 edition of the LSC and deletes provisions for the use of roller latches in the facility.

#### **Survey Procedures §482.41(b)(1)**

- There is a separate survey form, (CMS-2786) used by the Fire Authority surveyor to evaluate compliance with the Life Safety Code and a separate 1985 Life Safety Code Addendum to be used when surveying for compliance with the 1985 Life Safety Code. (Life Safety Code Guidelines and a copy of the 1985 Life Safety Code Addendum are contained in SOM Appendix I.)
- Survey the entire building occupied by the CAH unless there is a 2-hour firewall separating the space designated as the CAH from the remainder of the building. A 2-hour floor slab does not count; it must be a vertical firewall to constitute a separate building or part of a building.

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#### **C-0232**

**§485.623(d)(2) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects patients, CMS may allow the State survey agency to apply the State’s fire and safety code instead of the LSC.**

#### **Interpretive Guidelines §485.623(d)(2)**

This revision deletes “grandfathering” of older editions of the LSC and allows the use of a State code if approved by CMS.

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#### **C-0233**

**§485.623(d)(3) 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 CAH, but only if the waiver does not adversely affect the health and safety of patients.**

#### **Interpretive Guidelines §485.623(d)(3)**

Life Safety Code waivers may be recommended by the State survey agency but only CMS (at the regional office level) may grant those waivers for Medicare or Medicaid-participating CAHs.

### **Survey Procedures §485.623(d)(3)**

Consideration, assessment and recommendation for waivers of specific Life Safety Code provisions are handled by the Fire Authority surveyor as part of the Life Safety Code survey process.

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### **C-0234**

**§485.623(d)(4) The CAH maintains written evidence of regular inspection and approval by State or local fire control agencies.**

### **Survey Procedures §485.623(d)(4)**

Examine copies of inspection and approval reports from State and local fire control agencies.

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### **C-0235**

**§485.623(d)(5) A critical access CAH must be in compliance with the following provisions beginning on March 13, 2006:**

- (i) Chapter 19.3.6.3.2 exception number 2.**
- (ii) Chapter 19.2.9, Emergency Lighting.**

### **Interpretive Guidelines §485.623(d)(5)**

§ 485.623(d)(1) states, “Chapter 19.3.6.3.2 exception number 2 of the adopted edition of the Life Safety Code does not apply to CAH.” The wording in § 485.623(d)(5) and § 485.623(d)(5)(i) when used together means that after March 13, 2006 a CAH may no longer continue to keep in service existing roller latches even when these roller latches have been demonstrating the ability to keep the door closed against 5lbf.

Medicare-participating CAHs must be in compliance with chapter 19.3.6.3.2 of the 2000 Edition of NFPA 101 beginning March 13, 2006. Exception number 2 of chapter 19.3.6.3.2 will not be allowed in Medicare-participating CAHs.

CAHs should develop plans for compliance with this requirement so that in all applicable locations roller latches have been replaced by positive latches prior to March 13, 2006.

Beginning March 13, 2006, Medicare-participating CAHs must be in compliance with Chapter 19.2.9 of the 2000 Edition of NFPA 101.

This section gives facilities until March 13, 2006, to replace roller latches and to replace 1 hour batteries with 1-1/2 hour batteries in emergency lighting systems that use batteries as power sources.

After March 13, 2006 a CAH with doors in service with roller latches or with emergency lighting systems with less than 1-1/2 hour batteries will not be in compliance and will be cited at 485.623(d)(1).

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## **C-0240**

### **§485.627 Condition of Participation: Organizational Structure**

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## **C-0241**

### **§485.627(a) Standard: Governing Body or Responsible Individual**

**The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.**

#### **Interpretive Guidelines §485.627(a)**

The CAH must have only one governing body (or responsible individual) and this governing body (or responsible individual) is responsible for the conduct of the CAH as an institution. In the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are responsible for the conduct of the CAH operations.

The governing body (or responsible individual) must determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.

It is the responsibility of the governing body (or responsible individual) to appoint, with the advice of the medical staff, the individual practitioners to the medical staff. After considering medical staff recommendations, and in accordance with established CAH medical staff criteria and State and Federal laws and regulations, the governing body (or responsible individual) decides whether or not to appoint new medical staff members or to continue current members of the medical staff.

The governing body (or responsible individual) must ensure that the medical staff has bylaws that comply with State and Federal law and the requirements of the CAH CoP.

The governing body (or responsible individual) decides whether or not to approve medical staff bylaws submitted by the medical staff. The medical staff bylaws and any revisions must be approved by the governing body (or responsible individual) before they are considered effective.

The governing body (or responsible individual) must ensure that the medical staff is accountable to the governing body (or responsible individual) for the quality of care provided to patients. The governing body (or responsible individual) is responsible for the conduct of the CAH and this conduct would include the quality of care provided to patients.

All CAH patients must be under the care of a member of the medical staff or under the care of a practitioner who is under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner granted privileges to provide or order that care and is in accordance with State law.

Criteria for selection of both new medical staff members and selection of current medical staff members for continued membership must be based on:

- Individual character;
- Individual competence;
- Individual training;
- Individual experience; and
- Individual judgment

**Survey Procedures §485.627(a)**

- Verify that the CAH has an organized governing body or has written documentation that identifies the individual that is responsible for the conduct of the CAH operations.
- Review documentation and verify that the governing body (or responsible individual) has determined and stated the categories of practitioners that are eligible candidates for appointment to the medical staff.
- Have the facility's operating policies been updated to fully reflect its responsibilities as a CAH (e.g., PA responsibilities, provision of required CAH direct services)?
- What evidence (e.g., minutes of board meetings) demonstrates that the governing body or the individual who assumes responsibility for CAH operation is involved in the day-to-day operation of the CAH and is fully responsible for its operations?
- Evaluate records of medical staff appointments to substantiate the governing body's (or responsible individual's) involvement in appointments of medical staff members.

- Confirm that the governing body (or responsible individual) appoints all members to the medical staff in accordance with established policies based on the individual practitioner's scope of clinical expertise and in accordance with Federal and State law.
- Verify that the medical staff operates under current bylaws that are in accordance with Federal and State laws and regulations.
- Verify that the medical staff operates under current bylaws, rules and policies that have been approved by the governing body (or responsible individual).
- Verify that any revisions or modifications in the medical staff bylaws, rules, and policies, have been approved by the medical staff and the governing body (or responsible individual). For example, look at the bylaws and check for date of last review and initials by the person(s) responsible.
- Verify that the governing body (or responsible individual) is periodically apprised of the medical staff evaluation of patient care services provided in the CAH, at every patient care location of the CAH.
- Verify that any individual providing patient care services is a member of the medical staff or is accountable to a member of the medical staff qualified to evaluate the quality of services provided, and in turn, is responsible to the governing body (or responsible individual) for the quality of services provided.
- Verify that there are written criteria for staff appointments to the medical staff.
- Verify that selection of medical staff for membership, both new and renewal, is based upon an individual practitioner's compliance with the medical staff's membership criteria.
- Verify that at a minimum, criteria for selection to the medical staff are individual character, competence, training, experience, and judgment.

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## **C-0242**

### **§485.627(b) Standard: Disclosure**

**The CAH discloses the names and addresses of--**

**(1) Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with subpart C of part 420 of this chapter;**

**Survey Procedures §485.627(b)(1)**

- Review CAH policy for reporting changes of ownership.
  - How does the CAH implement its policy or procedure for reporting changes in ownership to the State agency?
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**C-0243**

**§485.627(b)(2) The person principally responsible for the operation of the CAH; and**

**Survey Procedures §485.627(b)(2)**

How does the CAH implement its policy or procedure for reporting changes in operating officials to the State agency?

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**C-0244**

**§485.627(b)(3) The person responsible for medical direction**

**Survey Procedures §485.627(b)(3)**

How does the CAH implement its policy or procedure for reporting changes in medical director to the State agency?

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**C-0250**

**§485.631 Condition of Participation: Staffing and Staff Responsibilities**

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**C-0251**

**§485.631(a) Standard: Staffing**

**(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.**

**Interpretive Guidelines §485.631(a)(1)**

A CAH may operate with a MD/DO on staff as well as with any combination of mid-level practitioners.

### **Survey Procedures §485.631(a)(1)**

- Review listings or organizational charts showing the names of all staff MD/DOs, nurse practitioners, clinical nurse specialists and physician assistants on the CAH staff.
- Review work schedules showing normal CAH hours of operation and coverage by members of the CAH staff.

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### **C-0252**

**§485.631(a)(2) Any ancillary personnel are supervised by the professional staff.**

### **Survey Procedures §485.631(a)(2)**

Use organizational charts and staff interviews to determine how the CAH ensures that the professional staff supervises all ancillary personnel.

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### **C-0253**

**§485.631(a)(3) The staff is sufficient to provide the services essential to the operation of the CAH.**

### **Survey Procedures §485.631(a)(3)**

- How does the CAH ensure that staff coverage is sufficient to provide essential services at the facility (e.g., emergency services, direct services, and nursing services)?
- Review staffing schedules and daily census records.

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### **C-0254**

**§485.631(a)(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.**

### **Interpretive Guidelines §485.631(a)(4)**

Section 485.635(b)(1) requires CAHs to provide “those diagnostic and therapeutic services and supplies that are commonly furnished in “a physicians office” such as low intensity outpatient services. In order to demonstrate compliance, a CAH must demonstrate that a practitioner is physically present and prepared to treat patients at the CAH when patients present at the CAH outpatient clinic during announced hours of outpatient clinic operation. This requirement does not mean the CAH must have a

practitioner physically present in the facility 24 hours per day, nor does it require their presence 24 hours per day when the CAH has inpatients, including swing-bed patients.

**Survey Procedures §485.631(a)(4)**

- If the CAH does not have regular announced hours of operation, ask the individual who is principally responsible for the operation of the CAH, when is the CAH is open to the public to provide outpatient services.
- What kinds of arrangements have been made by the CAH to ensure that a practitioner is available on site at all times the CAH operates to furnish patient care services?

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**C-0255**

**§485.631(a)(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.**

**Survey Procedures §485.631(a)(5)**

Review nursing staff schedules to ensure that a registered nurse, clinical nurse specialist or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

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**C-0256**

**§485.631(b) Standard: Responsibilities of the Doctor of Medicine or Osteopathy**

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**C-0257**

**485.631(b)(1) The doctor of medicine or osteopathy--**

- (i) Provides medical direction for the CAH'S health care activities and consultation for, and medical supervision of, the health care staff;**

**Interpretive Guidelines §485.631(b)(1)(i)**

A CAH must have a MD/DO on its staff. That individual must perform all of the medical oversight functions.

**Survey Procedures §485.631(b)(1)(i)**

What evidence demonstrates that an MD/DO provides medical direction for the CAH'S health care activities and is available for consultation and supervision of the CAH health care staff?

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**C-0258**

**§485.631(b)(1)(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH'S written policies governing the services it furnishes.**

**Survey Procedures §485.631(b)(1)(ii)**

- What evidence demonstrates that an MD/DO has participated in the development of policies governing CAH services?
- How does the CAH ensure that an MD/DO periodically reviews these policies?

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**C-0259**

**§485.631(b)(1)(iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH'S patient records, provides medical orders, and provides medical care services to the patients of the CAH; and**

**Survey Procedures §485.631(b)(1)(iii)**

- How does the CAH ensure that an MD/DO periodically reviews CAH patient records in conjunction with staff mid-level practitioners and provides medical care to CAH patients?
- What evidence demonstrates that there is a periodic review of patient records by the CAH MD/DO(s)?

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**C-0260**

**§485.631(b)(1)(iv) Periodically reviews and signs the records of patients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.**

**Interpretive Guidelines §485.631(b)(1)(iv)**

The CAH MD/DO(s) must review and sign all medical records for patients cared for by mid-level practitioners at the CAH.

**Survey Procedures §485.631(b)(1)(iv)**

Select a sample of inpatient and outpatient records, including both open and closed records, and verify that a **MD/DO has reviewed and signed all records for patients cared for by mid-level practitioners.**

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## **C-0261**

**§485.631(b)(2) A doctor of medicine or osteopathy is present for sufficient periods of time, at least once in every 2 week period (except in extraordinary circumstances) to provide the medical direction, medical care services, consultation, and supervision described in this paragraph, and is available through direct radio or telephone communication for consultation, assistance with medical emergencies, or patient referral. The extraordinary circumstances are documented in the records of the CAH. A site visit is not required if no patients have been treated since the latest site visit.**

### **Interpretive Guidelines §485.631(b)(2)**

An MD/DO must visit a CAH often enough to provide medical oversight for all patient services provided at the CAH in accordance with the scope of services provided.

### **Survey Procedures §485.631(b)(2)**

- What documentation shows that an MD/DO visits the facility at least once every two weeks?
- How does the CAH ensure that an MD/DO is available by telephone or radio contact for consultation, assistance and/or patient referral?

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## **C-0262**

### **§485.631(c) Standard: Physician Assistant, Nurse Practitioner, and Clinical Nurse Specialist Responsibilities**

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## **C-0263**

**485.631(c)(1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH'S staff--**

- (i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and**

### **Survey Procedures §485.631(c)(1)(i)**

- Interview any mid-level professional staff to ascertain their level of involvement in CAH policy development, execution, and periodic review.
- Does the CAH ensure that policies are updated to remain consistent with State standards of practice requirements for mid-level practitioners?

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**C-0264**

**485.631(c)(1)(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.**

**Survey Procedures §485.631(c)(1)(ii)**

How does the CAH ensure that mid-level practitioners at the CAH participate with an MD/DO in the review of their patients' health records?

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**C-0265**

**§485.631(c)(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:**

**(i) Provides services in accordance with the CAH'S policies.**

**Survey Procedures §485.631(c)(2)(i)**

- Review policies and procedures.
- Interview mid-level practitioners to gauge their knowledge and application of CAH policies.

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**C-0267**

**§485.631(c)(2)(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.**

**Survey Procedures §485.631(c)(2)(ii)**

Verify that there are policies and procedures for transferring patients to other facilities.

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**C-0268**

**§485.631(c)(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.**

### **Interpretive Guidelines §485.631(c)(3)**

The CAH regulations do permit licensed mid-level practitioners, as allowed by the State, to admit patients to a CAH. However, CMS regulations do require that Medicare and Medicaid patients be under the care of an MD/DO if admitted by a mid-level practitioner and the patient has any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner. Evidence of being under the care of an MD/DO must be in the patient's medical record. If a CAH allows a mid-level practitioner to admit and care for patients, as allowed by State law, the governing body (or responsible individual) and medical staff would have to establish policies and bylaws to ensure patient safety. As applicable, the patient's medical record must demonstrate MD/DO responsibility/care.

### **Survey Procedures §485.631(c)(3)**

- Verify that admitting privileges are limited to those categories of practitioners as allowed by State law.
- Verify that patients are admitted only by those practitioners who are currently licensed and have been granted admitting privileges by the governing body (or responsible individual) in accordance with State laws and medical staff bylaws.
- Verify that an MD/DO is responsible for and is monitoring the care of each Medicare or Medicaid patient for all medical problems during the hospitalization.
- If mid-level practitioners admit patients, verify that every Medicare/Medicaid patient is being monitored by an MD/DO who is responsible for any medical problem outside the scope of practice of the admitting practitioners.

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### **C-0270**

### **§485.635 Condition of Participation: Provision of Services**

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### **C-0271**

### **§485.635(a) Standard: Patient Care Policies**

**(1) The CAH'S health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.**

### **Survey Procedures §485.635(a)(1)**

- Review CAH health care services policies and sampled records.
- Observe staff delivering health care services to patients.

- What evidence indicates that patients are receiving care in accordance with written policies for health care services consistent with applicable State law?

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## **C-0272**

**§485.635(a)(2) The policies are developed with the advice of a group of professional personnel that includes 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 under the provisions of §485.631(a)(1); at least one member is not a member of the CAH staff.**

### **Interpretive Guidelines §485.635(a)(2)**

A CAH with a full time MD/DO is not required to have a mid-level practitioner on staff and would not have to obtain the services of a mid-level practitioner on a contractual or voluntary basis to participate in writing the facility's health care services policies.

### **Survey Procedures §485.635(a)(2)**

- Review any meeting minutes to determine group composition and to ascertain the extent of the group's interactions with the CAH.
- Interview the Director of Nursing to determine the extent of his/her interactions with this group concerning policy development.

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## **C-0273**

**§485.635(a)(3) The policies include the following:**

- (i) **A description of the services the CAH furnishes directly and those furnished through agreement or arrangement.**

### **Interpretive Guidelines §485.635(a)(3)(i)**

Policies should clearly explain what types of health care services are available at the CAH and which services are furnished through agreements or arrangements. For example, statements like “taking complete medical histories, providing complete physical examinations, laboratory tests including” (with a list of tests provided) would satisfy this requirement.

Arrangement and agreements include services provided through formal contracts, joint ventures, informal agreements, or lease arrangements.

Additional services furnished through referral should be clearly described in statements such as: “arrangements have been made with Hospital X for CAH patients to receive the

following services” (with a specific list of specialized diagnostic and laboratory testing, or specialized therapy).

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## **C-0274**

### **§485.635(a)(3)(ii) Policies and procedures for emergency medical services.**

#### **Interpretive Guidelines §485.635(a)(3)(ii)**

Policies should show how the CAH would meet all of its emergency services requirements.

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## **C-0275**

### **§485.635(a)(3)(iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.**

#### **Interpretive Guidelines §485.635(a)(3)(iii)**

Guidelines for the medical management of health problems should include a description of the scope of medical acts that may be performed by the mid-level practitioners. Guidelines represent an agreement between the MD/DO providing the CAH’S medical direction and the CAH’S mid-level practitioners relative to the privileges and limits of those acts of medical diagnosis and treatment that may be undertaken with direct MD/DO supervision.

Guidelines should describe the regimens to follow and also stipulate the condition in the illness or health care management when consultation or referral is required. Regardless of the format used by the CAH for its medical management guidelines, they should include the following essential elements:

- They should be comprehensive enough to cover most health problems that patients usually refer to a MD/DO;
- They should describe the medical procedures available to the PA, NP and/or CNS;
- They should describe the medical conditions, signs, or developments that require consultation or referral; and
- They should be compatible with State laws.

### Survey Procedures §485.635(a)(3)(iii)

- What evidence demonstrates that the CAH'S guidelines for medical management of health problems accurately reflect the actual clinical capabilities of the facility?
- What evidence demonstrates that the guidelines are followed?

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### C-0276

**§485.635(a)(3)(iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.**

### Interpretive Guidelines §485.635(a)(3)(iv)

Pharmaceutical services must be administered in accordance with accepted professional principles. Accepted professional principles include compliance with applicable Federal and State laws, regulations, and guidelines governing pharmaceutical services, as well as, standards or recommendations promoted by nationally recognized professional organizations such as the American Society of Health-System Pharmacists.

A fundamental purpose of pharmaceutical services is to ensure the safe and appropriate use of medications and medication-related devices. The pharmacy director, with input from appropriate CAH staff and committees, develops, implements and periodically reviews and revises policies and procedures governing provision of pharmaceutical services.

Methods a CAH uses to maintain professional principles include:

- Policies and procedures have been developed and are being followed;
- Drugs and biologicals are stored in accordance with manufacturer's directions and State and Federal requirements;
- Employees provide pharmaceutical services within their scope of license and education;
- Pharmacy records have sufficient detail to follow the flow of pharmaceuticals from their entry into the CAH through dispensation/administration;
- The pharmacy maintains controls over drugs and medications in all CAH locations, including floor stock;

- Maintaining pharmacy and accounting records pertaining to the requisitioning and dispensing of drugs and pharmaceutical supplies;
- Ensuring that drugs are being dispensed only by a licensed pharmacist; and
- Only pharmacists or pharmacy-supervised personnel compound, label and dispense drugs or biologicals.

Pharmaceutical services at a CAH can be provided either as direct services or through an agreement. The direction of pharmaceutical services may not require continuous on-premise supervision at the CAH'S pharmacy but may be accomplished through regularly scheduled visits, and/or telemedicine in accordance with Federal and State law and regulation and accepted professional principles.

A single pharmacist must be responsible for the overall administration of the pharmacy service whether employed by the CAH or obtained through agreement. The pharmacist must be responsible for developing, supervising, and coordinating all the activities of the CAH-wide pharmacy service and must be thoroughly knowledgeable about CAH pharmacy practice and management.

The job description or the written agreement for the responsibilities of the pharmacist should be clearly defined and include development, supervision and coordination of all the activities of pharmacy services.

Pharmacists and pharmacy technicians must perform their duties within the scope of their license and education. There must be sufficient personnel to respond to the pharmaceutical needs of the patient population being served. The pharmaceutical services staff must be sufficient in types, numbers, and training to provide quality services, including 24 hour, 7-day emergency coverage, or there may be an arrangement for emergency services, as determined by the needs of the patients and as specified by the medical staff.

There must be sufficient numbers and types of personnel to provide accurate and timely medication delivery, ensure accurate and safe medication administration and to provide appropriate clinical services as well as the participation in continuous quality improvement programs that meet the needs of the patient population being served.

The CAH must have a system that ensures that medication orders get to the pharmacy and drugs get back to patients promptly.

## **Record System**

Components of a record system to maintain current and accurate records of the receipt and disposition of scheduled drugs would include:

- Accountability procedures to ensure control of the distribution, use, and disposition of all scheduled drugs.
- Records of the receipt and disposition of all scheduled drugs must be current and must be accurate.
- Records trace the movement of scheduled drugs throughout the service.

The pharmacist is responsible for determining that all drug records are in order and that an account of all scheduled drugs is maintained and reconciled.

The record system, delineated in policies and procedures, tracks movement of all scheduled drugs from the point of entry into the CAH to the point of departure either through administration to the patient, destruction of the drug, or return to the manufacturer. This system provides documentation on scheduled drugs in a readily retrievable manner to facilitate reconciliation of the receipt and disposition of all scheduled drugs.

The CAH system should be capable of readily identifying loss or diversion of all controlled substances in such a manner as to minimize the time frame between the actual losses or diversion to the time of detection and determination of the extent of loss or diversion.

Facility policies and procedures should minimize scheduled drug diversion.

## **Receipt and Distribution of Drugs**

Drugs and biologicals must be controlled and distributed in accordance with applicable Federal and State laws and regulations, and in accordance with applicable standards of practice. Applicable standards of practice include compliance with all Federal and State laws, regulations, and guidelines, as well as, standards and recommendations promoted by nationally recognized professional organizations, that apply to pharmaceutical safety and the control and distribution of drugs and biologicals.

The procedures established to prevent unauthorized usage and distribution must provide for an accounting of the receipt and disposition of drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970.

The pharmacist, in consultation with appropriate CAH staff and committees, is to develop and implement guidelines, protocols, policies and procedures for the provision of

pharmaceutical services that ensure patient safety through the appropriate control and distribution of medications, medication-related devices, and biologicals.

All prescribers' medication orders (except in emergency situations) should be reviewed for appropriateness by a pharmacist before the first dose is dispensed.

Appropriate monitoring of medication therapy should be conducted. Medication-therapy monitoring includes an assessment of:

- Therapeutic appropriateness of a patient's medication regimen;
- Therapeutic duplication in the patient's medication regimen;
- Appropriateness of the route and method of administration;
- Medication-medication, medication-food, medication-laboratory test and medication-disease interactions;
- Clinical and laboratory data to evaluate the efficacy of medication therapy to anticipate or evaluate toxicity and adverse effects; and
- Physical signs and clinical symptoms relevant to the patient's medication therapy.

Sterile products should be prepared and labeled in a suitable environment by appropriately trained and qualified personnel.

The pharmacy should participate in CAH decisions about emergency medication kits. The supply and provision of emergency medications stored in the kits must be consistent with standards of practice and appropriate for a specified age group or disease treatment as well as consistent with applicable Federal and State laws.

The pharmacy should be involved in the evaluation, use and monitoring of drug delivery systems, administration devices and automated drug-dispensing machines. The evaluation and monitoring should include the potential for medication errors.

### **Dispensation of Drugs**

Medications must be prepared safely. Safe preparation procedures could include:

- Only the pharmacy compounds or admixes all sterile medications, intravenous admixtures, or other drugs except in emergencies or when not feasible (for example, when the product's stability is short).
- Whenever medications are prepared, staff uses safety materials and equipment while preparing hazardous medications.

- Wherever medications are prepared, staff uses techniques to ensure accuracy in medication preparation.
- Whenever medications are prepared, staff uses appropriate techniques to avoid contamination during medication preparation, which include, but are not limited, to the following:
  - Using clean or sterile technique as appropriate;
  - Maintaining clean, uncluttered, and functionally separate areas for product preparation to minimize the possibility of contamination;
  - Using a laminar airflow hood or other appropriate environment while preparing any intravenous (IV) admixture in the pharmacy, any sterile product made from non-sterile ingredients, or any sterile product that will not be used within 24 hours; and
  - Visually inspecting the integrity of the medications.

### **Drug Storage**

All drugs and biologicals must be kept in a locked room or container. If the container is mobile or readily portable, when not in use, it must be stored in a locked room, monitored location, or secured location that will ensure the security of the drugs or biologicals.

All drugs and biologicals must be stored in a manner to prevent access by unauthorized individuals. Persons without legal access to drugs and biologicals cannot have unmonitored access to drugs or biologicals.

Persons without legal access to drugs or biologicals cannot have keys to medication storage rooms, carts, cabinets, or containers. Whenever persons without legal access to the drugs or biologicals have unmonitored access to or could gain access to the drugs or biologicals stored in an area, the CAH would not be considered as in compliance with the requirement to store all drugs and biologicals in a locked storage area.

### **Nursing Medication Carts, Anesthesia Carts, and Other Medication Carts**

When not in use, nursing medication carts, anesthesia carts, and other medication carts (hereafter referred to as “carts”) containing drugs or biologicals must be locked or stored in a locked storage room. When carts are not in use, locked carts that contain drugs or biologicals must be stored in a locked room, monitored area, or secure location. If a cart containing drugs or biologicals is in use and unlocked, someone with legal access to the drugs and biologicals in the cart must be close by and directly monitoring the cart. That person could be a nurse, a physician, or other individual who in accordance with state and Federal law and CAH policy has legal access to the drugs and biologicals in the cart.

That person must monitor the cart and be aware of other people's activities near the cart. He/she is responsible for the security of the drugs and biologicals in the cart.

### **System for Labeling and Management of Outdated Drugs**

The CAH must have a pharmacy labeling, inspection, and inventory management system that ensures that outdated, mislabeled, or otherwise unusable drugs and biologicals are not available for patient use.

### **Survey Procedures §485.635(a)(3)(iv)**

- Interview the chief pharmacist or the individual delegated to fulfill the chief pharmacist's functions. Determine that either the medical staff has developed policies and procedures regarding the management of pharmaceuticals or that this function is fulfilled by the pharmacy service.
- Is the staff familiar with the medication-related policies and procedures?
- Is there a method to periodically review and evaluate the actual implementation of pharmaceutical policies and procedures by staff?
- Upon review of patient clinical record are issues with regard to provision of pharmaceutical services identified? Is the facility aware of the issues? Was there a failure to implement a policy and procedure?
- Determine whether the pharmacist is a full-time or part-time employee or employed on a consultative basis.
- Review the implementation of the chief pharmacist's responsibilities by:
  - Reviewing written status reports;
  - Reviewing minutes of meetings (if any) with facility staff regarding pharmaceutical services;
  - Reviewing schedules, time logs, etc.; and
  - Reviewing the job description or the written agreement to see that the responsibilities of the pharmacist are clearly defined and include development, supervision, and coordination of all the activities of pharmacy services.
- Determine whether the pharmacy director is actively involved in those committees responsible for establishing medication-related policies and procedures.

- Determine that the pharmaceutical services staff is sufficient in number and training to provide quality services, including 24 hour, 7-day emergency coverage, or there is an arrangement for emergency services, as determined by the needs of the patients and as specified by the medical staff. Review any agreements.
- Determine if there are sufficient personnel to provide accurate and timely medication delivery, ensure accurate and safe medication administration and to provide appropriate clinical services as well as the participation in continuous quality improvement programs that meet the needs of the patient population being served.
- Determine if there is a record system in place that provides information on controlled substances in a readily retrievable manner.
- Determine that the pharmacist is responsible for determining that all drug records are in order and that an account of all scheduled drugs is maintained and reconciled.
- Determine if there is a system, delineated in policies and procedures, that tracks movement of all scheduled drugs from the point of entry into the CAH to the point of departure either through administration to the patient, destruction of the drug, or return to the manufacture. Determine if this system provides documentation on scheduled drugs in a readily retrievable manner to facilitate reconciliation of the receipt and disposition of all scheduled drugs.
- Review the records to determine that they trace the movement of scheduled drugs throughout the service.
- Determine if the pharmacist is responsible for determining that all drug records are in order and that an account of all scheduled drugs is maintained and periodically reconciled.
- Is the CAH system capable of readily identifying loss or diversion of all controlled substances in such a manner as to minimize the time frame between the actual losses or diversion to the time of detection and determination of the extent of loss or diversion?
- Determine if facility policy and procedures minimize scheduled drug diversion.
- Is access to concentrated solutions (e.g. potassium chloride, sodium chloride Solutions greater than 0.9%) restricted?
- Identify and assess the quality assurance procedures for the preparation of sterile products.

- Is appropriate monitoring of medication therapy being conducted?
- Is the pharmacy involved in the evaluation, use and monitoring of drug delivery systems, administration devices and automated drug dispensing machines? The evaluation and monitoring should include the potential for medication errors.
- Review the procedures established to prevent unauthorized usage and distribution. These procedures must provide for an accounting of the receipt and disposition of drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970.
- Determine that only pharmacists or pharmacy supervised personnel compound, label and dispense drugs or biologicals in accordance with State and Federal laws and regulations and as accepted national principles by:
  - Reviewing policies and procedures;
  - Interviewing pharmacy and CAH staff to determine how drugs and biologicals are dispensed;
  - Observing on-site dispensing operations;
  - Reviewing records of drugs and biologicals removed from the pharmacy by non-pharmacy personnel; and
  - Inspecting drug storage areas.
- Verify through interviews of pharmacy and CAH staff, observation of on-site dispensing operations and review of pharmacy records that compounding, dispensing and packaging of drugs and biologicals are performed under the supervision of a pharmacist, in accordance with applicable laws.
- Determine that there is a policy for the safeguarding, transferring and availability of keys to the locked storage area.
- Determine by inspection whether all medications are stored in a manner that prevents unauthorized access.
- Determine if the facility identifies what personnel may have access to medications.
- Spot-check the labels of individual drug containers to verify that they conform to State laws, and/or contain the following minimal information:
  - Each patient's individual drug container bears his/her full name, the prescriber's name, and strength and quantity of the drug dispensed.

Appropriate accessory and cautionary statements are included as well as the expiration date.

- Each floor stock container bears the name and strength of the drug, lot and control number of equivalent, and expiration date.
- If the unit dose system is utilized, verify that each single unit dose package bears name and strength of the drug, lot and control number equivalent, and expiration date.
- Inspect patient-specific and floor stock medications to identify expired, mislabeled or unusable medications.
- Determine through pharmacy records that when the pharmacist is not available, drugs are removed from the pharmacy (drug storage area) only by a designated individual (in accordance with State law if applicable) and only in amounts sufficient for immediate therapeutic needs.
- Review policies and procedures to determine who is designated to remove drugs and biologicals from the pharmacy or storage area and the amount a non-pharmacist may remove in the absence of a pharmacist. The individual(s) designated should be identified by name and qualifications.
- Determine that a system is in place that accurately documents the removal of medications (type and quantity) from either the pharmacy or the after hours supply.
- Determine that the pharmacist reviews all medication removal activity and correlates the removal with current medication orders in the patient medication profile.
- Determine if the pharmacist routinely reviews the contents of the after-hours supply to determine if it is adequate to meet the after-hours needs of the CAH.
- Conduct a spot check of drug use and other inventory records to ensure that drugs are properly accounted for.
- Review reports of pharmaceutical services to determine if there are reported problems with controlled drugs and what actions have been taken to correct the situation.
- Interview the Pharmacy Director, pharmacist and pharmacy employees to determine their understanding of the controlled drug policies. Is there a policy and procedure for handling controlled drug discrepancies?

- Determine if controlled drug losses were reported to appropriate authorities in accordance with State and Federal laws.

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## **C-0277**

### **§485.635(a)(3)(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.**

#### **Interpretive Guidelines §485.635(a)(3)(v)**

Written procedures should require that medication errors and adverse drug reactions be reported immediately to the practitioner who ordered the drug. An entry, including the medication administered and the drug reaction, should be entered into the patient's medical record. Unexpected or significant adverse drug reactions should also be reported to the Food and Drug Administration in accordance with the MedWatch program. There must be a process to report serious adverse drug reactions to the FDA in accordance with the MedWatch program.

It is important to flag new types of mistakes as they occur and create systems to prevent their recurrences. The system should work through those mistakes and continually improve and refine things, based on what went wrong.

Reduction of medication errors and adverse reactions can be achieved by effective reporting systems that proactively identify causative factors and are used to implement corrective actions to reduce or prevent reoccurrences. To facilitate reporting, the facility should adopt a medication error and adverse drug reaction (ADR) definition that is broad enough in scope to capture “near misses” and suspected ADRs as well as actual medication errors and ADRs.

For high risk medications and high-risk patients (pediatric, geriatric or patients with renal or hepatic impairment) there should be systems in place to minimize adverse drug events. Such systems could include but not limited to: checklists, dose limits, pre-printed orders, special packaging, special labeling, double-checks and written guidelines.

One example of a definition is the National Coordinating Council Medication Error Reporting and Prevention definition of a medication error.

“Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.”

In addition to broad scope definitions, the facility must also proactively identify medication errors and adverse drug reactions. Reliance solely on incident reporting fails to identify the majority of adverse drug events. Proactive identification includes observation of medication passes, concurrent and retrospective review of patient's clinical records, ADR surveillance team, implementation of medication usage evaluations for high-alert drugs and identification of indicator drugs or "patient signals" that, when ordered, or noted automatically generate a drug regimen review for a potential adverse drug event.

The facility must have a method by which to measure the effectiveness of its reporting system so as to identify whether or not its system(s) is identifying as many medication errors and adverse drug reactions that would be expected for the size and scope of services provided by their CAH. Such methods could include use of established benchmarks or studies on reporting rates published in peer-reviewed journals.

To improve incident reporting the facility should adopt a non-punitive system with the focus on the system and not the involved health care professionals.

The facility should have immediately available sufficient texts and other resources on drug therapy. The pharmacist also should be readily available by telephone or other means to discuss drug therapy, interactions, side effects, dosage etc., with practitioners to assist in drug selection and with nursing personnel to assist in the identification of drug-induced problems.

The CAH should have policies and procedures to actively identify potential and actual adverse drug events. Proactive identification could include:

- Direct observation of medication administration;
- Review of patient's clinical records; and
- Identification of patient signals that would warrant immediate review of patient's medication therapy and implementation of medication use evaluation studies.

The CAH should have a means to incorporate external alerts and/or recommendations from national associations and governmental agencies for review and facility policy and procedure revision consideration. National associations could include Institute for Safe Medications Practice, National Coordination Council for Medication Error Reporting and Prevention and Joint Commission for Accreditation of Health Care Facilities, Sentinel Event Reports. Governmental agencies may include; Food and Drug Administration, Med Watch Program, and Agency for Health Care Research and Quality.

Provision of pharmaceutical services must meet the needs of the patients' therapeutic goal by promoting a safe medication use process that ensures optimal selection of medications, dose, dosage form, frequency, route, duration of therapy and that substantially reduces or eliminates adverse drug events and duplication of treatment.

The CAH pharmacy must ensure that drug orders are accurate and that medications are administered as ordered. When medications are returned unused, the pharmacy should determine the reason the medication was not used. For example, did the patient refuse the medication, was there a clinical reason the medication was not used, was the medication not used due to error?

Policies and procedures to minimize drug errors should include:

- High-alert medications with dosing limits, administration guidelines, packaging, labeling and storage;
- Limiting the variety of medication-related devices and equipment. For example, limit the types of general-purpose infusion pumps to one or two;
- Availability of up-to-date medication information;
- Availability of pharmacy expertise such as having a pharmacist available on-call when pharmacy does not operate 24 hours a day;
- Standardization of prescribing and communication practices;
- Avoidance of certain abbreviations;
- All elements of the order such as dose, strength, units (metric), route, frequency, and rate;
- Alert systems for look-alike and sound-alike drug names;
- Use of facility approved pre-printed order sheets whenever possible;
- A voluntary, non-punitive, reporting system to monitor and report adverse drug events (including medication errors and adverse drug reactions);
- The preparation, distribution, administration and proper disposal of hazardous medications;
- Medication recalls;
- Policies and procedures are reviewed and amended secondary to facility-generated reports of adverse drug events.

**Survey Procedures §485.635(a)(3)(v)**

- Examine the sources of drug information available at the nursing station and/or drug storage area and determine if they are current.

- Determine whether staff development programs on drug therapy are available to facility staff to cover such topics as new drugs added to the formulary, how to resolve drug therapy problems, and other general information as the need arises.
- Review the pharmaceutical policies and procedures, the CAH'S formulary and, if there is a pharmacy and therapeutic committee, the minutes of the committee meetings.
- Verify that the purpose of pharmaceutical policies and procedures is to minimize drug errors.
- Are there policies and procedures to minimize drug errors?
- Are policies and procedures reviewed and amended secondary to facility-generated reports of adverse drug events?
- Determine that the CAH has an effective procedure that ensures drug administration errors, adverse drug reactions, and drug incompatibilities are immediately reported to the attending physician.
- Review records of medication errors and adverse drug reactions to determine that they are reported immediately in accordance with written procedures, and that medications administered and/or drug reactions are promptly recorded in the patient's medical record.
- Determine if the facility's definition of an adverse drug reaction and medication error will generate sufficient number of reports.
- Review QA activities for medication errors and adverse reaction reports to determine if upon analyses of the reports that potential corrective actions are identified and implemented, if appropriate.
- Determine if the number of medication errors and adverse drug reactions reported is consistent with the size and scope of services provided by the CAH.
- Interview facility staff (nursing, pharmacy and medicine) to ascertain awareness of the facilities policy on reporting and documentation of medication errors and adverse drug reactions.
- Is there a process to report serious adverse drug reactions to the Federal MedWatch program?

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**C-0278****§485.635(a)(3)(vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.****Interpretive Guidelines §485.635(a)(3)(vi)**

The CAH must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the CAH. There must be a mechanism to evaluate the effectiveness of the program and to provide corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases as recommended by organizations such as the Centers for Disease Control and Prevention (CDC) Guidelines for Prevention and Control of Nosocomial Infections, the CDC Guidelines for Preventing the Transmission of Tuberculosis in Health Care Facilities, the Occupational Health and Safety Administration (OSHA) regulations, and the Association for Professionals in Infection Control and Epidemiology (APIC) infection control guidelines, etc.).

The active infection control program should have policies that address the following:

- Definition of nosocomial infections and communicable diseases;
- Measures for identifying, investigating, and reporting nosocomial infections and communicable diseases;
- Measures for assessing and identifying patients and health care workers, including CAH personnel, contract staff (e.g., agency nurses, housekeeping staff), and volunteers, at risk for infections and communicable diseases;
- Methods for obtaining reports of infections and communicable diseases on inpatients and health care workers, including all CAH personnel, contract such as agency nurses, housekeeping staff, and volunteers, in a timely manner;
- Measures for the prevention of infections, especially infections caused by organisms that are antibiotic resistant or in other ways epidemiologically important; device-related infections (e.g., those associated with intravascular devices, ventilators, tube feeding, indwelling urinary catheters, etc.); surgical site infections; and those infections associated with tracheostomy care, respiratory therapy, burns, immunosuppressed patients, and other factors which compromise a patient's resistance to infection;
- Measures for prevention of communicable disease outbreaks, especially tuberculosis;

- Provision of a safe environment consistent with nationally recognized infection control precautions, such as the current CDC recommendations for the identified infection and/or communicable disease;
- Isolation procedures and requirements for infected or immunosuppressed patients;
- Use and techniques for standard precautions;
- Education of patients, family members and caregivers about infections and communicable diseases;
- Methods for monitoring and evaluating practices of asepsis;
- Techniques for hand washing, respiratory protections, asepsis, sterilization, disinfection, food sanitation, housekeeping, fabric care, liquid and solid waste disposal, needle disposal, separation of clean from dirty, as well as other means for limiting the spread of contagion;
- Authority and indications for obtaining microbiological cultures from patients;
- A requirement that disinfectants, antiseptics, and germicides be used in accordance with the manufacturers' instructions to avoid harming patients, particularly central nervous system effects on children;
- Orientation of all new CAH personnel to infections, communicable diseases, and to the infection control program;
- Measures for the screening and evaluation of health care workers, including all CAH staff, contract workers such as agency nurses, housekeeping staff, and volunteers, for communicable diseases, and for the evaluation of staff and volunteers exposed to patients with non-treated communicable diseases;
- Employee health policies regarding infectious diseases and when infected or ill employees, including contract workers and volunteers, must not render patient care and/or must not report to work;
- A procedure for meeting the reporting requirements of the local health authority;
- Procedures for working with local, State, and Federal health authorities in emergency preparedness situations;
- Policies and procedures developed in coordination with Federal, State, and local emergency preparedness and health authorities to address communicable disease threats and outbreaks; and

- Provision for program evaluation and revision of the program, when indicated.

### **Designated Infection Control Officer**

The CAH must designate in writing an individual or group of individuals, qualified through education, training, experience, and certification or licensure, as an infection control officer or officers.

An infection control committee may delegate responsibility for infection functions, in accordance with CAH policy.

The infection control officer or officers must develop and implement policies governing the control of infections and communicable diseases.

The infection control officer(s) is responsible for:

- Implementing policies governing asepsis and infection control;
- Developing a system for identifying, investigating, reporting, and preventing the spread of infections and communicable diseases among patients and CAH personnel, including contract staff and volunteers;
- Identifying, investigating and reporting infections and outbreaks of communicable diseases among patients and CAH personnel, including contract staff and volunteers, especially those occurring in clusters;
- Preventing and controlling the spread of infections and communicable diseases among patients and staff;
- Cooperating with CAH-wide orientation and inservice education programs;
- Cooperating with other departments and services in the performance of quality assurance activities; and
- Cooperating with disease control activities of the local health authority.

It is recommended that the infection control officer or officers maintain a log of all incidents related to infections and communicable diseases, including those identified through employee health services. The log is not limited to nosocomial infections. All incidents of infection and communicable disease should be included in the log. The log documents infections and communicable diseases of patients and all staff (patient care, non patient care, employees, contract staff and volunteers).

The chief executive officer (CEO), the medical staff and the director of nursing (DON) must ensure that the CAH-wide Quality Assurance (QA) program and staff inservice training programs address problems identified through the infection control program.

The CEO, the medical staff, and the DON are responsible for implementing corrective action plans to address problems identified by the infection control officer(s). These plans should be evaluated for effectiveness and revised if needed, and documentation concerning corrective actions and outcomes should be maintained.

**Survey Procedures §485.635(a)(3)(vi)**

- Verify that there is a system (policies) for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and CAH personnel, including contract workers and volunteers.
- Determine that this system is an active program, that it is both CAH-wide and program-specific, and that it is implemented correctly.
- Throughout the CAH, observe the environment of care, noting the cleanliness of horizontal surfaces, bedside equipment, and air inlets, etc, because infectious organisms may spread from these places.
- Verify that an infection control officer (or officers) is designated and has the responsibility for the infection control program.
- Review the personnel file of the infection control officer(s) to verify that he/she is qualified through education, training, experience, and certification or licensure to oversee the infection control program.
- Verify that appropriate policies and procedures have been developed and implemented governing the control of infections and communicable diseases.
- Determine that the infection control officer(s) is responsible for the elements specified in the interpretive guidelines.
- Verify that the infection control officer(s) maintains a log of all incidents related to infections and communicable diseases, including those identified through employee health services.
- Determine that the CAH'S QA program and staff inservice training programs address problems identified by the infection control officer(s).
- Determine that problems identified are reported to the medical staff, nursing, and administration, and addressed in the CAH'S quality assurance and inservice training programs.

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## C-0279

**§485.635(a)(3)(vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) is met with respect to inpatients receiving post CAH SNF care.**

### **Interpretive Guidelines §485.635(a)(3)(vii)**

A CAH is not required to prepare meals itself and is free to obtain meals under contract with another supplier, but the CAH is responsible for the quality of arranged services on the same basis as if CAH employees had provided those services.

The food and dietetic services must be organized, directed and staffed in such a manner to ensure that the nutritional needs of the patients are met in accordance with practitioners' orders and recognized dietary practices.

### **Policies and Procedures for Dietary Services**

The CAH should have written policies and procedures that address at least the following:

- Availability of a diet manual and therapeutic diet menus to meet patients' nutritional needs;
- Frequency of meals served;
- System for diet ordering and patient tray delivery;
- Accommodation of non-routine occurrences such as enteral nutrition (tube feeding), total parenteral nutrition, peripheral parenteral nutrition, change in diet orders, early/late trays, nutritional supplements, etc.;
- Integration of the food and dietetic service into the CAH-wide QA and Infection Control programs;
- Guidelines for acceptable hygiene practices of food service personnel; and
- Guidelines for kitchen sanitation.

### **Compliance with Recognized Dietary Practices**

The CAH must be in compliance with Federal and State licensure requirements for food and dietary personnel as well as food service standards, laws and regulations.

## **Director of Food and Dietetic Services**

The CAH must have an employee (either on staff or contracted) who–

- Serves as director of the food and dietetic services;
- Is responsible for daily management of the dietary services; and
- Is qualified by experience or training.

The service director must be either an employee on staff or under contract, who has been granted the authority and delegated responsibility by the CAH'S governing body and medical staff for the operation of the dietary services. This authority and delegated responsibility includes the daily management of the service, implementing training programs for dietary staff, and assuring that established policies and procedures are maintained that address at least the following:

- Safety practices for food handling;
- Emergency food supplies;
- Orientation, work assignments, supervision of work and personnel performance;
- Menu planning, purchasing of foods and supplies, and retention of essential records such as cost, menus, personnel, training records, QA reports, etc.; and
- Dietary service QA program.

Additionally, the service director must demonstrate, through education, experience and/or specialized training, the qualifications necessary to manage the service, appropriate to the scope and complexity of the food service operation.

## **Qualified Dietitian**

A qualified dietitian must supervise the nutritional aspects of patient care. The dietitian can be part of the CAH staff or work under contract (may be full or part time) and is responsible for all inpatient nutrition including swing bed services. The dietitian must be licensed if required by State law. The dietitian's responsibilities include, but are not limited to:

- Approving patient menus and nutritional supplements;
- Patient, family, and caretaker dietary counseling;
- Performing and documenting nutritional assessments and evaluating patient tolerance to therapeutic diets when appropriate;

- Collaborating with other CAH services (e.g., medical staff, nursing services, pharmacy service, social work service, etc.) to plan and implement patient care as necessary in meeting the nutritional needs of the patients; and
- Maintaining pertinent patient data necessary to recommend, prescribe, or modify therapeutic diets as needed to meet the nutritional needs of the patients.

If the qualified dietitian does not work full-time, and when the dietitian is not available, the CAH must make adequate provisions for dietary consultation that meets the needs of the patients. The frequency of consultation depends on the total number of patients, their nutritional needs and the number of patients requiring therapeutic diets or other nutritional supplementation.

### **Dietary Support Staff**

There must be administrative and technical personnel competent in their respective duties.

This competency is demonstrated through education, experience and specialized training appropriate to the task(s) assigned. Personnel files should include documentation that each staff member is competent in their respective duties.

### **Recognized Dietary Practices**

Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner responsible for the care of the patients.

Recognized dietary practices include following current national standards for recommended dietary allowances such as the current Recommended Dietary Allowances (RDA) or the Dietary Reference Intake (DRI) of the Food and Nutrition Board of the National Research Council.

Menus provided by the CAH must be nutritionally balanced and meet the needs of the patients. In order to ensure that the CAH is meeting the nutritional needs of its patients, screening criteria should be developed to identify patients at nutritional risk. If a patient is identified as an altered nutritional status, a nutritional assessment should be performed on the patient. In addition to the initial nutritional assessment, the patient should be re-evaluated as necessary to ensure their ongoing nutritional needs are met. Examples of patients who may require a nutritional assessment include:

- All patients requiring artificial nutrition by any means (i.e., enteral nutrition (tube feeding), total parenteral nutrition, or peripheral parenteral nutrition);
- Patients whose medical condition, surgical intervention, or physical status interferes with their ability to ingest, digest or absorb nutrients;

- Patients whose diagnosis or presenting signs/symptoms indicates a compromised nutritional status (e.g., anorexia nervosa, bulimia, electrolyte imbalances, dysphagia, malabsorption, end stage organ diseases, etc.); and
- Patients whose medical condition can be adversely affected by their nutritional intake (e.g., diabetes, congestive heart failure, patients taking certain medications, renal diseases, etc.).

Therapeutic diets must be prescribed by the practitioner responsible for the care of the patient. Therapeutic diets should be:

- Prescribed in writing by a qualified practitioner or a qualified dietitian;
- Documented in the patient's medical record including information about the patient's tolerance to the therapeutic diet as ordered; and
- Evaluated for nutritional adequacy.

A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel.

**Survey Procedures §485.635(a)(3)(vii)**

- Review CAH personnel files to determine that staff is qualified based on education, experience, specialized training, and, if required by State law, is licensed, certified, or registered by the State.
- If the dietitian is part-time, determine that the number of hours spent working is appropriate to serve the nutritional needs of the patients, and that the CAH makes adequate provisions for qualified consultant coverage when the dietitian is not available.
- Review personnel files for administrative and technical staff to determine if they have appropriate credentials as required and have received adequate training and are competent in their respective duties.
- Ask the CAH to show you what national standard they are following in its menus to meet the nutritional needs of their patients.
- Review patient records to verify that diet orders are provided as prescribed by the practitioner responsible for the care of the patient.
- From the sample patient records, identify patients with special nutritional needs to determine:

- If their nutritional needs have been met;
  - If appropriate therapeutic diets have been ordered; and
  - If their dietary intake and nutritional status is being monitored, as appropriate.
  - Verify that therapeutic diet orders are prescribed and authenticated by the practitioner(s) responsible for the care of the patient.
  - Determine that the therapeutic diet manual is current and:
    - Has been approved by both the medical staff and a qualified dietitian;
    - Is readily available to MD/DOs, nursing and food service personnel;
    - Is in accordance with the current national standards, such as RDA or DRI;
    - Includes the different types of therapeutic diets routinely ordered at the CAH; and
    - Is consistently used as guidance for ordering and preparing patient diets.
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## **C-0280**

**§485.635(a)(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.**

### **Survey Procedures §485.635(a)(4)**

Review the meeting notes and policy and procedure books to verify that the patient care policies are reviewed on an annual basis by the professional group

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## **C-0281**

### **§485.635(b) Standard: Direct Services**

**(1) General. The CAH staff furnishes, as direct services, 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 CAH outpatient department or emergency department. These direct services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.**

## **Interpretive Guidelines §485.635(b)**

The CAH must provide outpatient and emergency room services as direct services at the CAH campus through the use of CAH personnel. The CAH can choose the level of services to be offered. They may offer only the basic services required by this CoP and State law or they may offer a more complex range of services. However, all the outpatient and emergency services offered must be provided at the CAH campus as direct services.

Outpatient Services are a required direct service of the CAH. All outpatient services that the CAH provides to its patients must meet the needs of the patients, in accordance with acceptable standards of practice. The CAH must provide adequate services, equipment, staff, and facilities adequate to provide the outpatient services for the scope of practices appropriate to the scope and complexity of services offered. The outpatient services may be offered at specific times. The CAH is not required to offer outpatient services 24/7 except for emergency room services.

Acceptable standards of practice include standards that are set forth in Federal or State laws, regulations or guidelines, as well as standards and recommendations promoted by nationally recognized professional organizations such as the American Medical Association, American College of Radiology, American College of Surgeons, etc.

The CAH'S outpatient services must be integrated with inpatient services (e.g., medical records, radiology, laboratory, surgical services, anesthesia services, other diagnostic services, etc), as appropriate to the outpatient services offered. The CAH must have written policies in place to ensure the integration of outpatient services, including an established method of communication between outpatient service departments to corresponding inpatient services.

The outpatient services department must be accountable to a single individual who directs the overall operation of the department. The CAH should define in writing the qualifications and competencies necessary to direct the outpatient services. Qualifications include, necessary education, experience and specialized training, consistent with State law, and acceptable standards of practice.

Adequate types and numbers of qualified professional and nonprofessional personnel must be available to provide patients with the appropriate level of care and services offered by the CAH'S outpatient department. The types and numbers of qualified personnel are based on the scope and complexity of outpatient services offered and the number and types of patients treated as outpatients.

## **Rehabilitation Services**

Rehabilitation services are optional CAH services and can include physical therapy, occupational therapy, audiology, and/or speech pathology services. If a CAH provides any degree of rehabilitative services to its patients, either directly or under arrangement,

either inpatient or outpatient, the services must be organized and staffed to ensure the health and safety of patients. This includes providing rehabilitative services in accordance with practitioner orders and acceptable standards of practice.

Acceptable standards of practice include any standards that are set forth in Federal or State laws, regulations or guidelines, as well as standards and recommendations promoted by nationally recognized professional organizations such as the American Physical Therapy Association, American Speech and Hearing Association, American Occupational Therapy Association, American College of Physicians, and the American Medical Association etc.

If rehabilitative services are provided, the CAH must provide, or ensure, the appropriate equipment and types and numbers of qualified personnel necessary to furnish the rehabilitation services offered by the CAH in accordance with acceptable standards of practice.

The scope of rehabilitation services offered by the CAH, both directly or under contract, should be defined in written policies and procedures and approved by the Medical staff. Each service, whether provided directly or through a contract, must function with established lines of authority and responsibility to ensure the health and safety of patients. There must be an adequate number of qualified staff available when needed to evaluate each patient, initiate the plan of treatment, and supervise supportive personnel when they furnish rehabilitation services. The number of qualified staff is based on the type of patients treated and the frequency, duration, and complexity of the treatment required.

The rehabilitation service must be accountable to an individual that directs the overall operation of the service. The director of the services must demonstrate through education, experience, and/or specialized training that he/she has the necessary knowledge, experience and capabilities to properly supervise and administer the service. The director may be part-time, full-time, and/or under contract. If part-time, the time spent directing the service should be appropriate with the scope of services provided.

The medical staff must define in writing the required qualifications and competencies for rehabilitation staff in each program or service offered. Qualifications should include the necessary education, experience, specialized training, and if applicable, licensure requirements appropriate for assigned responsibilities consistent with State law.

At least one qualified professional, of the applicable discipline, must be on site when needed to:

- Perform an initial evaluation of each patient for whom rehabilitative services were ordered;
- Initiate the plan of treatment based on the initial evaluation, input from family/caregivers and in accordance with the orders of the practitioner responsible for the care of the patient; and

- Supervise supportive personnel when they furnish services.

Each patient must have an individualized plan of treatment, based on the patient's specific rehabilitation needs, input from family/caregivers and therapeutic treatment goals, that are established in writing prior to the initiation of treatment. At a minimum, the treatment plan must:

- Be established by the practitioner ordering the service in collaboration with an individual qualified to provide the services;
- Be based on the patient's individualized assessment;
- Include the type, amount, frequency and duration of services;
- Include measurable short-term and long-term goals;
- Incorporate patient, family and caregiver goals; and
- Be reviewed and revised as necessary reflect changes in the patient's response to therapeutic intervention. Updated treatment goals should reflect the changes in the patient's status.

Changes to the treatment plan must be documented in writing and supported by clinical record information such as evaluation, test results, interdisciplinary staff conferences or MD/DO orders.

The activities described in the written plan of treatment must be within the scope of practice, State licensure, or certifications of the individual performing the activity.

#### **Survey Procedures §485.635(b)(1)**

- Determine the types of outpatient services provided.
- Verify that equipment, staff and facilities are adequate to provide the outpatient services and are in accordance with acceptable standards of practice.
- Verify that the outpatient services are organized in a manner appropriate to the scope and complexity of services offered.
- Verify that the CAH has an established method of communication and established procedures to assure integration with inpatient services to provide continuity of care.

- Review medical records of outpatients who were later admitted to the CAH in order to determine that pertinent information from the outpatient record has been included in the inpatient record.
- Determine that the outpatient services are integrated with the appropriate CAH inpatient services in accordance with the needs of the patient care provided.
- Verify that one person is assigned by the governing body (or responsible individual) to manage and be responsible for outpatient services.
- Review the position description and personnel file of the individual responsible for the outpatient services to ensure that he/she meets the qualifications, in accordance with State law, acceptable standards of practice and CAH policy.
- Review personnel files to verify that the staff qualifications, including education, experience, certifications, current licensure, where appropriate, and competencies are appropriate for assigned responsibilities.
- Verify that sufficient staff are available to provide care.
- Verify that the types and number of qualified personnel are appropriate for the types and numbers of patients receiving care and the complexity of services offered.
- Determine if the CAH provides any degree of rehabilitation services.
- Review the CAH'S policies and procedures to verify that the scope of rehabilitation services offered, either directly or under contract, is defined in writing.
- Review personnel files or contracts to verify current licensure, certifications and training of staff consistent with applicable State laws.
- Determine that adequate types and numbers of qualified staff are available to ensure safe and efficient provision of treatment.
- Review medical records to verify that a qualified professional evaluates the patient and initiates the treatment under medical orders and direction for each episode.
- Verify that each patient has a plan of treatment established in writing and that the plan is established by the practitioner ordering the service and is documented in the patient record along with treatment outcomes achieved.
- If the director of the service does not work full-time, determine that the number of hours spent working is appropriate to the scope of services provided.

- Interview the director to determine if he/she has the necessary knowledge, experience and capabilities to properly supervise and administer the service.

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## **C-0282**

### **§485.635(b)(2) Laboratory Services**

**The CAH provides, as direct services, 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. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include:**

- (i) Chemical examination of urine by stick or tablet method or both (including urine ketones);**
- (ii) Hemoglobin or hematocrit;**
- (iii) Blood glucose;**
- (iv) Examination of stool specimens for occult blood;**
- (v) Pregnancy tests; and**
- (vi) Primary culturing for transmittal to a certified laboratory.**

### **Interpretive Guidelines §485.635(b)(2)**

Basic laboratory services must be provided directly at the CAH campus by CAH staff in order to facilitate the immediate diagnosis and treatment of the patient. The CAH must have a current Clinical Laboratory Improvement Act (CLIA) certificate or waiver for all tests performed.

The provision of laboratory services that exceed the requirements for basic laboratory services is an optional requirement. The CAH must maintain or have available laboratory services, either directly or through arrangement, whenever its patients need those services. The CAH may maintain laboratory services at the CAH or may make laboratory services available through contractual agreements except for the required basic services. The scope and complexity of the CAH laboratory service must be adequate to meet the needs of its patients. All laboratory services, whether direct or contractual must be provided in accordance with CLIA requirements. Every CAH laboratory must be operating under a current CLIA certificate appropriate to the level of services performed.

The CAH must provide basic emergency laboratory services 24 hours a day, 7 days a week. The medical staff should determine which laboratory services are to be

immediately available to meet the emergency laboratory needs of patients who may be currently at the CAH or those patients who may arrive at the CAH in an emergency condition and how the services are to be provided. The emergency laboratory services available should reflect the scope and complexity of the CAH'S operation and be provided in accordance with Federal and State law, regulations and guidelines and acceptable standards of practice.

The laboratory must have written instructions for the collection, preservation, transportation, receipt, and reporting of tissue specimen results.

**Survey Procedures §485.635(b)(2)**

- Determine which services are provided directly by the facility and which are provided through contractual agreements.
- Determine if the referral laboratory is CLIA certified for the appropriate test specialty.
- Verify that all laboratory services are operating under a current CLIA certificate.
- Examine records and determine if the services, including emergency services, are provided in accordance with the CAH'S policies.
- Review the written description of the emergency laboratory services.
- Review records such as worksheets and test reports to verify the 24 hour availability of emergency services and that those services are provided when required.
- Verify the existence of a written description of the laboratory services provided, including those furnished on routine and stat basis (either directly or under an arrangement with an outside facility). Verify that the description of services is accurate and current.
- Verify that the laboratory has the appropriate CLIA certificate or waiver for the tests performed in the CAH laboratory.
- Verify that the CAH has a procedure in place for obtaining tests that are needed but unavailable at the CAH laboratory.
- Verify that the CAH has written policies and procedures to ensure that all laboratory results are recorded in the medical record.

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## C-0283

**§485.635(b)(3) Radiology services. Radiology services furnished at the CAH are provided as direct services by staff qualified under State law, and do not expose CAH patients or staff to radiation hazards.**

### **Interpretive Guidelines §485.635(b)(3)**

Radiological services must be provided by the CAH as direct services at the CAH campus by CAH staff. The CAH must maintain and have available diagnostic radiological services to meet the needs of their patients. These services must be available at all times. The CAH can choose the level of services offered. They may offer only a minimal set of services or a more complex range of services (including nuclear medicine) according to the needs of the patients of the CAH. While the CAH must directly provide all radiology services in the CAH, the interpretation of roentgenograms may be contracted out.

All radiological services provided by the CAH, including diagnostic, therapeutic, and nuclear medicine, must be provided in accordance with acceptable standards of practice and must meet professionally approved standards for safety. The scope and complexity of radiological services offered should be specified in writing and approved by the medical staff and governing body (or responsible individual).

Acceptable standards of practice include maintaining compliance with appropriate Federal and State laws, regulations and guidelines governing radiological services, including facility licensure and/or certification requirements, as well as any standards and recommendations promoted by nationally recognized professions such as the American Medical Association, American College of Radiology, etc.

The CAH must adopt policies and procedures that provide safety for patients and personnel. The CAH must implement and ensure compliance with its established safety standards. The policies should contain safety standards for at least:

- Adequate radiation shielding for patients, personnel and facilities;
- Labeling of radioactive materials, waste, and hazardous areas;
- Transportation of radioactive materials between locations within the CAH;
- Security of radioactive materials, including determining who may have access to radioactive materials and controlling access to radioactive materials;
- Testing of equipment for radiation hazards;
- Maintenance of personal radiation monitoring devices;

- Storage of radio nuclides and radio pharmaceuticals as well as radioactive waste; and
- Disposal of radio nuclides, unused radio pharmaceuticals, and radioactive waste.

The CAH must have policies and procedures in place to ensure that periodic inspections of radiology equipment are conducted, and that problems identified are corrected in a timely manner. The CAH must have a system in place and qualified employees to correct hazards. The CAH must be able to demonstrate current inspection and proper correction of all hazards.

There must be written policies developed and approved by the medical staff to designate which radiological tests must be interpreted by a radiologist.

Supervision of the radiology services includes, but is not limited, to the following:

- Enforcing safety standards;
- Ensuring that radiology reports are signed by the practitioner who interpreted them;
- Assigning duties to radiology personnel appropriate to their level of training, experience, and licensure if applicable;
- Enforcing infection control standards;
- Ensuring that emergency care is provided to patients who experience an adverse reaction to diagnostic agents in the radiology service;
- Ensuring that files, scans, and other image records are kept in a secure area and are readily retrievable; and
- Training radiology staff on how to operate the equipment safely, perform tests offered by the facility and on the management of emergency radiation hazards and accidents.

There should be written policies, developed and approved by the medical staff, consistent with State law, to designate which personnel are qualified to use the radiological equipment and administer procedures.

The CAH must maintain records for all radiology procedures performed. At a minimum, the records should include copies of reports and printouts, and any films, scans or other image records, as appropriate. The CAH should have written policies and procedures that ensure the integrity of authentication and protect the privacy of radiology records.

### **Survey Procedures §485.635(b)(3)**

- Verify that the CAH maintains, or has available, organized radiology services that meet the needs of the patients, are provided in accordance with accepted standards of practice, and are maintained or available at all times to meet the patient needs.
- Verify that patient shielding (aprons, etc) are properly maintained and routinely inspected.
- Verify that the CAH requires periodic tests of all radiology personnel and that the personnel are knowledgeable about radiation exposure.
- Review records to verify that periodic tests of radiology personnel by exposure meters or test badges are performed.
- Verify that hazardous materials are stored properly in a safe manner.
- Review the inspection records (logs) to verify that periodic inspections are conducted in accordance with manufacturer's instructions, Federal and State laws, regulations, and guidelines, and CAH policy.
- Determine that any problems identified are properly corrected in a timely manner.
- Review medical records to determine that radiological services are provided only on the orders of practitioners with clinical privileges authorized by the medical staff and the governing body (or responsible individual) to order radiological services, consistent with State law.
- Review records to determine that a radiologist interprets those tests that have been designated by the medical staff to require interpretation by a qualified radiologist.
- Verify that supervision of the radiology services is restricted to an individual who is credentialed by the medical staff.
- Review radiological records to determine that reports are signed by the practitioner who reads and evaluates the roentgenogram.
- Verify through observation and document review that radioactive materials, including radioactive waste, are properly stored and disposed of.
- Verify that the CAH maintains accurate records of the receipt and distribution of radio pharmaceuticals.

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**C-0284**

**§485.635(b)(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides as direct services medical emergency procedures as a first response to common life-threatening injuries and acute illness.**

**Survey Procedures §485.635(b)(4)**

Review policies and procedures for the provision of emergency services.

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**C-0285**

**§485.635(c) Standard: Services Provided Through Agreements or Arrangements**

**(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--**

**Interpretive Guidelines §485.635(c)(1)**

Individual agreements or arrangements should be well defined, but need not be contractual. They should describe routine procedures (e.g., for obtaining outside laboratory tests); and there should be evidence in the agreement or arrangement that the governing body (or responsible individual) is responsible for these services provided under agreement or arrangement. Individual agreements or arrangements should be revised when the nature and scope of services provided has changed.

The governing body (or responsible individual) has the responsibility for ensuring that CAH services are provided according to acceptable standards of practice, irrespective of whether the services are provided directly by CAH employees or indirectly by arrangement. The governing body must take actions through the CAH'S QA program to: assess the services furnished directly by CAH staff and those services provided under arrangement, identify quality and performance problems, implement appropriate corrective or improvement activities, and to ensure the monitoring and sustainability of those corrective or improvement activities.

**Survey Procedures §485.635(c)(1)**

Ascertain that all contractor services provided in the CAH are in compliance with the CoP for CAHs.

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**C-0286****§485.635(c)(1)(i) Inpatient CAH care;****Survey Procedures §485.635(c)(1)(i)**

How does the CAH ensure that it has arrangements or agreements with one or more facilities to provide inpatient care to its patients?

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**C-0287****§485.635(c)(1)(ii) Services of doctors of medicine or osteopathy;****Survey Procedures §485.635(c)(1)(ii)**

How does the CAH ensure that it has arrangements or agreements with one or more MD/DOs to meet its requirements at §485.631(b)?

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**C-0288****§485.635(c)(1)(iii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and****Interpretive Guidelines §485.635(c)(1)(iii)**

Laboratories that provide additional diagnostic and clinical laboratory services to a CAH by agreement or arrangement must be in compliance with CLIA requirements in 42 CFR Part 493 of this chapter. These laboratories will be surveyed separately for compliance with Part 493.

**Survey Procedures §485.635(c)(1)(iii)**

How does the CAH ensure through arrangements or agreements that it can obtain specialized diagnostic and clinical laboratory services?

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**C-0289****§485.635(c)(1)(iv) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.**

### **Survey Procedures §485.635(c)(1)(iv)**

If the CAH has an outside contract for nutritional services, how does the CAH ensure that it has arrangements or agreements for the provision of nutritional services that meet this requirement?

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### **C-0290**

**§485.635(c)(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.**

### **Survey Procedures §485.635(c)(2)**

- Review a sample of medical records of patients who were treated and transferred from the CAH. What documentation shows that:
  - Transferred patients were accepted and provided with inpatient care, as needed, at CAHs to which they were transferred?
  - Patients referred for diagnostic and/or laboratory tests had these tests performed as requested by the practitioner responsible for the patient?
  - MD/DOs and/or suppliers of services are providing services for the CAH in the manner described in the arrangement or agreement?

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### **C-0291**

**§485.635(c)(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.**

### **Survey Procedures §485.635(c)(3)**

- Review the list of contracted services and verify that there is a delineation of contractor responsibility.
- Review any arrangements or agreements to determine if the nature and scope of services defined is being provided to CAH patients and is in compliance with the CAH CoPs.

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### **C-0292**

**§485.635(c)(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:**

**(i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements.**

**Survey Procedures §485.635(c)(4)(i)**

How does the CAH ensure, (e.g., through operating policies and procedures, by-laws etc.) that the individual responsible for its operations is responsible for all services provided through arrangements or agreements?

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**C-0293**

**§485.635(c)(4)(ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.**

**Survey Procedures §485.635(c)(4)(ii)**

How does the CAH ensure that contracted services meet all of the CAH Conditions of Participation and standards for contracted services?

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**C-0294**

**§485.635(d) Standard: Nursing Services**

**Nursing services must meet the needs of patients.**

**Interpretive Guidelines §485.635(d)**

In order to meet the needs of patients, nursing services must be a well-organized service of the CAH and under the direction of a registered nurse.

The CAH and the director of the nursing service are responsible for the clinical activities of all nursing to include the clinical activities of all non-CAH nursing personnel (contract, agency, or volunteer). The CAH and the director of nursing service ensure that all CAH nursing staff and each non-CAH nursing staff person is adequately trained and oriented, is adequately supervised, that their clinical activities are evaluated, and that all nursing personnel know the CAH policies and procedures. An appropriately qualified CAH-employed RN should conduct the supervision and evaluation of the clinical activities of each non-CAH nursing staff.

## Survey Procedures §485.635(d)

- Observe the nursing care in progress to determine the adequacy of staffing and to assess the delivery of care. Other sources of information to use in the evaluation of the nursing services are: nursing care plans, medical records, accident and investigative reports, staffing schedules, nursing policies and procedures, credentialing and training files (including contracted staff), and QA activities and reports.
- Review the method for orienting non-CAH staff to CAH policies and procedures. The orientation should include at least the following:
  - The CAH and the unit;
  - Emergency procedures;
  - Nursing services policies and procedures; and
  - Safety policies and procedures.

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## C-0295

**485.635(d)(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.**

### Interpretive Guidelines §485.635(d)(1)

The nursing service ensures that patient needs are met by ongoing assessments of patients' needs and provides nursing staff to meet those needs. There must be sufficient personnel to respond to the appropriate medical needs and care of the patient population being serviced.

An RN must make all patient care assignments. The director of the nursing service and the CAH are to ensure that nursing personnel with the appropriate education, experience, licensure, competence and specialized qualifications are assigned to provide nursing care for each patient in accordance with the individual needs of each patient.

### Survey Procedures §485.635(d)(1)

- Review the nursing assignments. Did an RN make the assignments? Determine that the assignments take into consideration the complexity of patient care needs and the competence and specialized qualifications of the nursing staff.

- Determine that there are written staffing schedules that correlate to the number and acuity of patients.
- Verify that there is supervision of personnel performance and nursing care for each nursing unit.
- Interview the registered nurse responsible for supervising the nursing care of the patients and ask the following--
  - How are the specialized needs of patients determined? Who makes this determination?
  - How is staff assigned?
  - How is staff monitored to ensure that appropriately qualified staff provides the care needed?
  - How does the CAH ensure that care provided meets the needs of each patient?
  - If temporary nursing staff is utilized, how are these staff oriented and supervised relative to CAH nursing procedures?
- Interview one or more temporary staff, if available, to determine if they are adequately familiar with CAH nursing requirements.

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## **C-0296**

**485.635(d)(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.**

### **Interpretive Guidelines §485.635(d)(2)**

An RN (or PA where State law permits) must supervise and evaluate the nursing care for each patient. Evaluation would include assessing the patient's care needs as well as the patient's response to interventions.

### **Survey Procedures §485.635(d)(2)**

- Determine that a registered nurse (or PA where State law permits) supervises and evaluates the nursing care for each patient?
- Interview the RN (or PA where State law permits) who is responsible for supervising and evaluating the nursing care for CAH patients.

- Ask to see staffing schedules as needed to verify information
  - Observe the care provided by any non-CAH staff
    - Do they know and adhere to CAH policies?
    - Do they know appropriate emergency procedures?
    - Are they adequately supervised by an appropriately experienced CAH employed RN (or PA where State law permits)?
    - Are their clinical activities being evaluated adequately?
    - Are they licensed in accordance with State law?
  - Confirm with the director of nurses that a non-CAH nurse's performance is evaluated at least annually.
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## **C-0297**

**485.635(d)(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.**

### **Interpretive Guidelines §485.635(d)(3)**

All drugs and biologicals and intravenous medications must be administered by or under the supervision of a RN, MD, DO or where permitted by State law a PA, in accordance with written or signed orders, accepted standards of practice, and Federal and State laws. As permitted by State law and CAH policy, LPN's may administer medications if they are under the supervision of an RN, MD, DO or if permitted by State law a PA.

Drugs and biologicals must be prepared and administered in accordance with Federal and State laws.

Drugs and biologicals must be prepared and administered in accordance with the orders of the practitioner or practitioners responsible for the patient's care.

Drugs and biologicals must be prepared and administered in accordance with accepted standards of practice.

All orders for drugs and biologicals, including verbal orders, must be legible, timed, dated and authenticated with a signature by the practitioner or practitioners responsible

for the care of the patient. All entries in the medical record must be legible, timed, dated and authenticated.

A telephone or verbal order is written in the medical record by a nurse or other professional in accordance with State law and CAH policy as being able to accept verbal orders. The written verbal order must be legible and includes the date, time, the order, the name of the ordering practitioner and the signature of the accepting individual. The ordering practitioner must date and time the order at the time he or she signs the order and must sign a verbal order as soon as possible which would be the earlier of the following:

- The next time the prescribing practitioner provides care to the patient, assesses the patient, or documents information in the patient's medical record, or
- The prescribing practitioner signs or initials the verbal order within time frames consistent with Federal and State law or regulation and CAH policy.

The content of verbal orders should be clearly communicated. The entire verbal order should be repeated back to the prescriber. All verbal orders must be reduced immediately to writing and signed by the individual receiving the order. Verbal orders must be documented in the patient's medical record, and be reviewed and countersigned by the prescriber as soon as possible.

We recognize that in some instances, the ordering practitioner may not be able to authenticate his or her verbal order (e.g., the ordering practitioner gives a verbal order which is written and transcribed, and then is "off duty" for the weekend or an extended period of time). In such cases, it is acceptable for a covering practitioner to co-sign the verbal order of the ordering practitioner. The signature indicates that the covering practitioner assumes responsibility for his/her colleague's order as being complete, accurate and final. This practice must be addressed in the CAH'S policy. However, a qualified practitioner such as a physician assistant or nurse practitioner may not "co-sign" a MD/DO's verbal order or otherwise authenticate a medical record entry for the MD/DO who gave the verbal order.

When used, verbal orders must be used infrequently. Therefore, it is not acceptable to allow covering practitioners to authenticate verbal orders for convenience or to make this common practice. When assessing compliance with this requirement, surveyors review the frequency and practice of using verbal orders within the CAH.

Verbal orders are orders for medications, treatments, intervention or other patient care that are communicated as oral, spoken communications between senders and receivers face to face or by telephone.

Verbal communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible.

CAHs should establish policies and procedures that:

- Describe limitations or prohibitions on use of verbal orders;
- Provide a mechanism to ensure validity/authenticity of the prescriber;
- List the elements required for inclusion in a complete verbal order;
- Describe situations in which verbal orders may be used;
- List and define the individuals who may send and receive verbal orders; and
- Provide guidelines for clear and effective communication of verbal orders.

CAHs should promote a culture in which it is acceptable, and strongly encouraged, for staff to question prescribers when there are any questions or disagreements about verbal orders. Questions about verbal orders should be resolved prior to the preparation, or dispensing, or administration of the medication.

Elements that should be included in any verbal medication order include:

- Name of patient;
- Age and weight of patient, when appropriate;
- Date and time of the order;
- Drug name;
- Dosage form (e.g., tablets, capsules, inhalants)
- Exact strength or concentration;
- Dose, frequency, and route;
- Quantity and/or duration;
- Purpose or indication;
- Specific instructions for use; and
- Name of prescriber.

### Survey Procedures §485.635(d)(3)

- Select patients from the patient sample. Review their medication orders, medication administration records, and appropriate medication documentation in the medical record. Observe the preparation and administration of medications to those patients. Are medications prepared and administered in accordance with Federal and State laws, accepted national standards of practice, manufacturer's directions, and CAH policy?
- Ascertain that there is an effective method for the administration of drugs. Use the following indicators for assessing drug administration:
- Ascertain that there are policies and procedures approved by the medical staff covering who is authorized to administer medications, and that the policies are followed.
- Review a sample of medication administration records to see that they conform to the practitioner's order and that the order is current, and that drug and dosage are correct and administered as ordered.
- Observe the preparation of drugs and their administration to patients in order to verify that procedures are being followed. Are patients addressed by name and/or identifier checked? Does the nurse remain with the patient until medication is taken?
- Verify that nursing staff administering drugs have completed appropriate training courses.
- Check the QA activities to see if the administration of drugs is regularly monitored. The monitoring should include reports of medication irregularities or errors and corrective action taken.
- Determine that all drug orders, including verbal orders, are written in the patient charts and signed by the practitioner caring for the patient. Have verbal orders been signed or initialed by the prescribing practitioner as soon as possible?
- Request to see several patient charts with telephone orders. Check to determine if they are taken by authorized CAH personnel, and are correctly countersigned by the practitioner. Ask several nurses if they are permitted to take telephone and oral orders and how frequently they do so.
- Read the CAH'S policy for practitioner's orders. Does it require that orders must be in writing and signed by the attending practitioner?
- Verify that the prescriber has reviewed and authenticated the orders in accordance with medical staff policy and/or applicable State laws.

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**C-0298**

**485.635(d)(4) A nursing care plan must be developed and kept current for each inpatient.**

**Interpretive Guidelines §485.635(d)(4)**

Nursing care planning starts upon admission. It includes planning the patient's care while in the CAH as well as planning for discharge to meet post-CAH needs. A nursing care plan is based on assessing the patient's nursing care needs and developing appropriate nursing interventions in response to those needs. The nursing care plan is kept current by ongoing assessments of the patient's needs and the patient's response to interventions, and updating or revising the patient's nursing care plan in response to assessments. The nursing care plan is part of the patient's medical record and must comply with the requirements for patient records.

**Survey Procedures §485.635(d)(4)**

Select a sample of nursing care plans (6-12 as appropriate)

- Are the plans initiated as soon as possible after admission for each patient?
- Does the plan describe patient goals and appropriate physiological and psychosocial factors and patient discharge planning?
- Is the plan consistent with the attending practitioner's plan for medical care?
- Are the plans revised as the needs of the patient change?
- Are the plans implemented?

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**C-0300**

**§485.638 Condition of Participation: Clinical Records**

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**C-0301**

**§485.638(a) Standard: Records System**

**(1) The CAH maintains a clinical records system in accordance with written policies and procedures.**

## **Interpretive Guidelines §485.638(a)(1)**

The CAH must have a system of patient records, pertinent medical information, author identification, and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. The medical record system must correctly identify the author of every medical record entry. The medical record system must protect the security of all medical record entries. The medical record system must ensure that medical record entries are not lost, stolen, destroyed, altered, or reproduced in an unauthorized manner. All locations where medical records are stored or maintained must ensure the integrity, security and protection of the records.

The CAH must have a system in place that ensures that the identity of the author of each entry is correct. The author of every entry must take a specified action to identify himself/herself as the author (or responsible person) of the entry, the time and dating of the entry, that the entry is accurate, and that he/she takes responsibility for accuracy of the entry.

If the CAH uses computer entries there must be security system in place to ensure the integrity of the record system, to ensure that the author of each entry is correctly identified, to ensure that record entries are not altered or lost, that limits access to medical records to only authorized persons, and ensures that records are not released to unauthorized individuals. For the purposes of this regulation, electronic signatures comply with those medical record entries that include a requirements for a signature.

There should be a current list of authenticated signatures, as well as a list of computer codes and signature stamps (when used for authorship purposes) that have been authorized by the governing body and are protected by adequate safeguards. CAH policies and procedures should provide for appropriate sanctions for unauthorized or improper use of computer codes or signature stamps.

The CAH must maintain a medical record for each inpatient and outpatient evaluated or treated in any part or location of the CAH. A unit record for both inpatients and outpatients may be used; however, when two different systems are used they must be appropriately cross referenced. When a patient reimbursement status changes from acute care services to swing bed services, a single medical record may be used for both stays as long as the record is sectioned separately. Both sections must include admission and discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries.

The medical record must be properly filed and retained. The CAH must have a medical recording system that ensures the prompt retrieval of any medical record, of any patient evaluated or treated at any location of the CAH within the past 6 years.

The medical record must be accessible. The CAH must have a medical record system that allows the medical record of any patient, inpatient or outpatient, evaluated and/or

treated at any location of the CAH within the past 6 years to be accessible by appropriate staff, 24 hours a day, 7 days a week, whenever that medical record may be needed.

**Survey Procedures §485.638(a)(1)**

- Verify that a medical record is maintained for each person receiving care.
- Verify that written procedures ensure the integrity of authentication and protect the security of patient records.
- Verify that medical records are stored and maintained in locations where the records are secure, with protection from damage, flood, fire, theft, etc., and limits access to only authorized individuals.
- Verify that records are accurate, completed promptly, easily retrieved and readily accessible, as needed.
- Verify that there is an established system that addresses at least the following activities of the medical records services:
  - Timely processing and retrieval of records;
  - Protecting the confidentiality of medical information;
  - Compiling and retrieval of data of quality assurance activities.
- Verify that the system policies and procedures are reviewed and revised as needed.
- Verify that the CAH employs adequate medical record personnel who possess adequate education, skills, qualifications and experience to ensure the CAH complies with requirements of the medical records regulations and other appropriate Federal and State laws and regulations.
- Are medical records promptly completed in accordance with State law and CAH policy?
- Select a sample of past patients of the CAH (inpatient and/or outpatient). Request those patient's medical records. Can the CAH promptly retrieve those records?

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## **C-0302**

**§485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.**

### **Interpretive Guidelines §485.638(a)(2)**

All medical records must be accurately written. The CAH must ensure that all medical records accurately and completely document all orders, test results, evaluations, treatments, interventions, care provided and the patient's response to those treatments, interventions and care.

### **Survey Procedures §485.638(a)(2)**

For CAH surveys that are conducted after the initial certification survey, examine a sample of records using an adequate sample size to evaluate the scope of services provided. In a very small CAH, look at all inpatient and outpatients records, if appropriate.

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## **C-0303**

**§485.638(a)(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.**

### **Interpretive Guidelines §485.638(a)(3)**

The CAH must have one unified medical record service with a department head that has been appointed by the governing body (or responsible individual). The director of medical records must have responsibility for all medical records to include both inpatient and outpatient records.

### **Survey Procedures §485.638(a)(3)**

- Verify that the CAH employs adequate medical record personnel.
- Review the organizational structure and policy statements and interview the person responsible for the service to ascertain that the medical records service is structured appropriately to meet the needs of the CAH and the patients.

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## C-0304

**§485.638(a)(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable--**

**(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;**

### **Interpretive Guidelines §485.638(a)(4)(i)**

The medical record must include evidence of properly executed informed consent forms for any procedures or surgical procedures specified by the medical staff, or by Federal or State law, if applicable, that require written patient consent.

Informed consent means the patient or patient representative is given the information, explanations, consequences, and options needed in order to consent to a procedure or treatment.

A properly executed consent form contains at least the following:

- Name of patient, and when appropriate, patient's legal guardian;
- Name of CAH;
- Name of procedure(s);
- Name of practitioner(s) performing the procedures(s);
- Signature of patient or legal guardian;
- Date and time consent is obtained;
- Statement that procedure was explained to patient or guardian;
- Signature of professional person witnessing the consent;
- Name/signature of person who explained the procedure to the patient or guardian.

The medical record must contain information such as progress and nursing notes, documentation, records, reports, recordings, test results, assessments etc. to:

- Justify admission;

- Support the diagnosis;
- Describe the patient's progress;
- Describe the patient's response to medications; and
- Describe the patient's response to services such as interventions, care, treatments, etc.

The medical record must contain complete information/documentation regarding medical history, assessment of the health status and health care needs of the patient, and a summary of the episode, disposition, and instructions to the patient. This information and documentation is contained in a discharge summary.

A discharge summary discusses the outcome of the CAH stay, the disposition of the patient, and provisions for follow-up care. Follow-up care provisions include any post CAH appointment, how post CAH patient care needs are to be met, and any plans for post-CAH care by providers such as swing-bed services, home health, hospice, nursing homes, or assisted living. A discharge summary is required following any CAH acute care stay prior to and following a swing-bed admission and discharge.

The MD/DO or other qualified practitioner with admitting privileges in accordance with State law and CAH policy, who admitted the patient is responsible for the patient during the patient's stay in the CAH. This responsibility would include developing and entering the discharge summary.

The MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and physician assistants to the extent recognized under State law or a State's regulatory mechanism. The MD/DO may also delegate writing the discharge summary to another MD/DO who is familiar with the patient.

#### **Survey Procedures §485.638(a)(4)(i)**

- Verify that the medical staff have specified which procedures or treatments require a written informed consent.
- Verify that medical records contain consent forms for all procedures or treatment that are required by CAH policy.
- Verify that consent forms are properly executed.
- Examine a sample of patient records and/or facility records of requests for information contained in patient records to determine if there are signed and dated consent forms, when required, medical history, health status and care needs assessment, and discharge summary in each record, as needed.

- Review of sample of active and closed medical records for completeness and accuracy in accordance with Federal and State laws and regulations and CAH policy. The sample should be at least 10 percent of the average daily census, as appropriate.

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## **C-0305**

### **§485.638(a)(4)(ii) Reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings;**

#### **Interpretive Guidelines §485.638(a)(4)(ii)**

All or part of the history and physical exam (H & P) may be delegated to other practitioners in accordance with State law and CAH policy, but the MD/DO must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant meeting these criteria may perform the H & P.

#### **Survey Procedures §485.638(a)(4)(ii)**

- Determine that the bylaws require a physical examination and medical history be done for each patient.
- For sampled records, does the appropriate practitioner sign reports of physical examinations, diagnostic and laboratory test results, and consultative findings?

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## **C-0306**

### **§485.638(a)(4)(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment; and**

#### **Interpretive Guidelines §485.638(a)(4)(iii)**

The requirement means that the stated information is necessary to monitor the patient's condition and that this and other necessary information must be in the patient's medical record. In order for necessary information to be used it must be promptly filed in the medical record so that health care staff involved in the patient's care can access/retrieve this information in order to monitor the patient's condition and provide appropriate care.

The medical record must contain:

- All practitioner's orders (properly authenticated);
- All nursing notes;

- All reports of treatment (including complications and CAH-acquired infections);
- All medication records (including unfavorable reactions to drugs);
- All radiology reports;
- All laboratory reports;
- All vital signs; and
- All other information necessary to monitor the patient's condition.

All medical records must be promptly completed. Every medical record must be complete with all documentation of orders, diagnosis, evaluations, treatments, test results, consents, interventions, discharge summary, and care provided along with the patient's response to those treatments, interventions, and care.

**Survey Procedures §485.638(a)(4)(iii)**

- Verify that the patient records contain appropriate documentation of practitioners' orders, interventions, findings, assessments, records, notes, reports and other information necessary to monitor the patient's condition.
- Is necessary information included in patient records in a prompt manner so that health care staff involved in the care of the patient have access to the information necessary to monitor the patient's condition?

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**C-0307**

**§485.638(a)(4)(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.**

**Interpretive Guidelines §485.635(a)(4)(iv)**

Entries in the medical record may be made only by individuals as specified in CAH and medical staff policies. All entries in the medical record must be timed, dated, and authenticated, and a method established to identify the author. The identification may include written signatures, initials, computer key, or other code.

When rubber stamps are authorized, the individual whose signature the stamp represents shall place in the administrative offices of the CAH a signed statement to the effect that he/she is the only one who has the stamp and uses it. There shall be no delegation to another individual.

A list of computer or other codes and written signatures must be readily available and maintained under adequate safeguards. There shall be sanctions for improper or unauthorized use of stamp, computer key, or other code signatures. The CAH must have policies and procedures in place and operational before an electronic medical record system would be deemed acceptable.

The parts of the medical record that are the responsibility of the MD/DO must be authenticated by this individual. When non-MD/DOs have been approved for such duties as taking medical histories or documenting aspects of physical examination, such information shall be appropriately authenticated by the responsible MD/DO. Any entries in the medical record by house staff or non-MD/DOs that require counter signing by supervisory or attending medical staff members shall be defined in the medical staff rules and regulations.

All entries in the medical record must be authenticated.

Authentication would include at a minimum:

- The CAH has a method to establish the identify of the author of each entry. This would include verification of the author of faxed orders/entries or computer entries.
- The author takes a specific action to verify that the entry is his/her entry or that he/she is responsible for the entry, that the entry is accurate.
- The timing of the entry is noted and correct.

Timing documents the time and date of each entry (orders, reports, notes etc.). Timing establishes when an order was given, when an activity happened or when an activity is to take place. Timing and dating entries are necessary for patient safety and quality of care. Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or time lines of various signs, symptoms, or events. There must be a specific action by the author to indicate that the entry is, in fact, verified and accurate. Failure to disapprove an entry within a specific time period is not acceptable as authentication.

A system of auto-authentication in which a MD/DO or other practitioner authenticates a report before transcription is not consistent with these requirements. There must be a method of determining that the practitioner did, in fact, authenticate the document after it was transcribed.

#### **Survey Procedures §485.635(a)(4)(iv)**

- Verify that entries are authenticated.

- Verify that the department maintains a current list of authenticated signatures, written initials, codes, and stamps when such are used for authorship identification.
- Verify that computer or other code signatures are authorized by the CAH'S governing body and that a list of these codes is maintained under adequate safeguards by the CAH administration.
- Verify that the CAH'S policies and procedures provide for appropriate sanctions for unauthorized or improper use of the computer codes.
- Examine the CAH'S policies and procedures for using the system, and determine if documents are being authenticated after transcription.
- For sampled records, are there dated and authenticated signatures by appropriate MD/DOs and/or mid-level practitioners, as needed?

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## **C-0308**

### **§485.638(b) Standard: Protection of Record Information**

**(1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.**

#### **Interpretive Guidelines §485.638(b)(1)**

The CAH has sufficient safeguards to ensure that access to all information regarding patients is limited to those individuals designated by law, regulation, policy; or duly authorized as having a need to know. No unauthorized access or dissemination of clinical records is permitted. Clinical records are kept secure and are only viewed when necessary by those persons having a part in the patient's care.

The right to confidentiality means safeguarding the content of information, including patient paper records, video, audio, and/or computer stored information from unauthorized disclosure without the specific informed consent of the individual, parent of a minor child, or legal guardian. CAH staff and consultants, hired to provide services to the individual, should have access to only that portion of information that is necessary to provide effective responsive services to that individual.

Confidentiality applies to both central records and clinical record information that may be kept at dispersed locations.

#### **Survey Procedures §485.638(b)(1)**

- Verify that only authorized persons are permitted access to records maintained by the medical records department.

- Verify that the CAH has a policy to grant patients direct access to his/her medical record if the responsible official (e.g., practitioner responsible for patient's care) determines that direct access is not likely to have an adverse effect on the patient.
- Verify that medical records are released only for patient care evaluation, utilization review, treatment, quality assurance programs, in-house educational purposes, or in accordance with Federal or State law, court orders, or subpoenas.
- Verify that copies of medical records are released outside the CAH only upon written authorization of the patient, legal guardian, or person with an appropriate “power of attorney” to act on the patient's behalf, or only if there is a properly executed subpoena or court order, or as mandated by statutes.
- Verify that precautions are taken to prevent unauthorized persons from gaining access to or altering patient records.
- Verify that adequate precautions are taken to prevent physical or electronic altering, damaging or deletion/destruction of patient records or information in patient records.

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## **C-0309**

### **§485.638(b)(2) Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.**

#### **Interpretive Guidelines §485.638(b)(2)**

The CAH’S patient record system must ensure the security of patient records. The CAH must ensure that unauthorized individuals cannot gain access to patient records and that individuals cannot alter patient records. Patient records must be secure at all times and in all locations. This includes open patient records for patients who are currently inpatients in the CAH and outpatients in outpatient clinics.

#### **Survey Procedures §485.638(b)(2)**

- Observe the CAH’S security practices for patient records. Are patient records left unsecured or unattended? Are patient records unsecured or unattended in hallways, patient rooms, nurses stations, or on counters where an unauthorized person could gain access to patient records?
- If the CAH uses electronic patient records, are appropriate security safeguards in place? Is access to patient records controlled?
- Verify that the CAH has policies and procedures for the use and release of records and that these policies and procedures are enforced.

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**C-0310**

**§485.638(b)(3) The patient's written consent is required for release of information not required by law.**

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**C-0311****§485.638(c) Standard: Retention of Records**

**The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.**

**Interpretive Guidelines §485.638(c)**

Medical records are retained in their original form or legally reproduced form in hard copy, microfilm, or computer memory banks. The CAH must be able to promptly retrieve the complete medical record of every individual evaluated or treated in any part or location of the CAH within the last 6 years.

In accordance with Federal and State law and regulations, certain medical records may have retention requirements that exceed 6 years (for example: FDA, OSHA, EPA).

**Survey Procedures §485.638(c)**

Determine that records are retained for at least 6 years, or more if required by State or local laws.

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**C-0320****§485.639 Condition of Participation: Surgical Services.**

**Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH in accordance with the designation requirements under paragraph (a) of this section.**

**Interpretive Guidelines §485.639**

The provision of surgical services is an optional CAH service. However, if a CAH provides any degree of surgical services to its patients, the services must be organized and staffed in such a manner to ensure the health and safety of patients. Surgical services that are performed in a safe manner would be performed in accordance with acceptable standards of practice. In accordance with acceptable standards of practice includes maintaining compliance with applicable Federal and State laws, regulations and

guidelines governing surgical services or surgical service locations, as well as, any standards and recommendations promoted by or established by nationally recognized professional organizations (e.g., the American Medical Association, American College of Surgeons, Association of Operating Room Nurses, Association for Professionals in Infection Control and Epidemiology, etc.) Additionally, the quality of the CAH'S outpatient surgical services must be consistent with the CAH'S inpatient surgical services.

When the CAH offers surgical services, the CAH must provide the appropriate equipment and types and numbers of qualified personnel necessary to furnish the surgical services offered by the CAH in accordance with acceptable standards of practice.

The scope of surgical services provided by the CAH should be defined in writing and approved by the medical staff.

### **Supervision in the OR**

The operating room (inpatient and outpatient) must be supervised by an experienced staff member authorized by State law. The supervisor's experience could include education, background working in surgical services, and specialized training in the provision of surgical services/management of surgical service operations. The CAH should address its required qualifications for the supervisor of the CAH'S operating rooms in its policies.

If the CAH utilizes LPN or operating room technicians as "scrub nurses," those personnel must be under the supervision of an RN who is immediately available to physically intervene and provide care, as required in State law.

### **Policies and Procedures**

Policies governing surgical care should contain:

- Aseptic surveillance and practice, including scrub techniques
- Identification of infected and non-infected cases
- Housekeeping requirements/procedures
- Patient care requirements
  - Preoperative work-up
  - Patient consents and releases
  - Clinical procedures
  - Safety practices

- Patient identification procedures
- Duties of scrub and circulating nurse
- Safety practices
- The requirement to conduct surgical counts in accordance with accepted standards of practice
- Scheduling of patients for surgery
- Personnel policies unique to the OR
- Resuscitative techniques
- DNR status
- Care of surgical specimens
- Malignant hyperthermia
- Appropriate protocols for all surgical procedures performed. These may be procedure-specific or general in nature and will include a list of equipment, materials, and supplies necessary to properly carry out job assignments.
- Sterilization and disinfection procedures
- Acceptable operating room attire
- Handling infections and biomedical/medical waste

Policies and procedures must be written, implemented and enforced. Surgical services' policies must be in accordance with acceptable standards of medical practice and surgical patient care.

### **Pre-Operative History and Physical (H & P)**

A complete history and physical must be conducted in accordance with acceptable standards of practice, and the written document placed on the medical record, prior to surgery. All or part of the H & P may be delegated to other practitioners in accordance with State law and CAH policy, but the surgeon must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant, meeting these criteria, may perform the H & P.

In all circumstances, when an H & P has been conducted, but is not present on the chart prior to surgery, or in emergency situations where a complete H & P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include at a minimum critical information about the patient's condition including pulmonary status, cardiovascular status, BP, vital signs, etc.

### **Informed Consent**

A properly executed informed consent form contains at least the following:

- Name of patient, and when appropriate, patient's legal guardian;
- Name of CAH;
- Name of procedure(s);
- Name of practitioner(s) performing the procedure(s) or important aspects of the procedure(s), as well as the name(s) and specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon/practitioner. (Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues.);
- Signature of patient or legal guardian;
- Date and time consent is obtained;
- Statement that procedure was explained to patient or guardian;
- Signature of professional person witnessing the consent; and
- Name/signature of person who explained the procedure to the patient or guardian.

The responsible practitioner must disclose to the patient any information necessary to enable the patient to evaluate a proposed medical or surgical procedure before submitting to it. Informed consent requires that a patient have a full understanding of that to which he or she has consented. An authorization from a patient who does not understand what he/she is consenting to is not informed consent.

Patients must be given sufficient information to allow them to make intelligent choices from among the alternative courses of available treatment for their specific ailments. Informed consent must be given despite a patient's anxiety or indecisiveness.

The responsible practitioner must provide as much information about treatment options as is necessary based on a patient's personal understanding of the practitioner's explanation of the risks of treatment and the probable consequences of the treatment.

Informed consent means the patient or patient representative is given (in a language or means of communication he/she understands) the information needed in order to consent to a procedure or treatment.

An informed consent would include at least: an explanation of the nature and purpose of the proposed procedures, risks and consequences of the procedures, risks and prognosis if no treatment is rendered, the probability that the proposed procedure will be successful, and alternative methods of treatment (if any) and their associated risks and benefits. Furthermore, informed consent would include that the patient is informed as to who will actually perform surgical interventions that are planned. When practitioners other than the primary surgeon will perform important parts of the surgical procedures, even when under the primary surgeon's supervision, the patient must be informed of who these other practitioners are, as well as, what important tasks each will carry out.

### **Post-Operative Care/Recovery**

Adequate provisions for immediate post-operative care means:

- Post operative care must be in accordance with acceptable standards of practice.
- The post-operative care area or recovery room is a separate area of the CAH. Access is limited to authorized personnel.
- Policies and procedures specify transfer requirements to and from the recovery room. Depending on the type of anesthesia and length of surgery, the post-operative check before transferring the patient from the recovery room should include some of the following:
  - Level of activity
  - Respirations
  - Blood pressure
  - Level of consciousness
  - Patient color
- If the patients are not transferred to the recovery room, determine that provisions are made for close observation until they have regained consciousness, e.g., direct observation by an RN in the patient's room.

## **Operating Room Register**

The register should include at least the following information:

- Patient's name
- Patient's CAH identification number
- Date of the operation
- Inclusive or total time of the operation
- Name of the surgeon and any assistant(s)
- Name of nursing personnel (scrub and circulating)
- Type of anesthesia used and name of person administering it
- Operation performed
- Pre and post-op diagnosis
- Age of patient

## **Operative Report**

The operative report would include at least:

- Name and CAH identification number of the patient;
- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;

- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

### **Survey Procedures §485.639**

- Inspect all inpatient and outpatient operative rooms/suites. Request the use of proper attire for the inspection. Observe the practices to determine if the services are provided in accordance with acceptable standards of practice. Observe:
  - That access to the operative and recovery area is limited to authorized personnel and that the traffic flow pattern adheres to accepted standards of practice;
  - The conformance to aseptic and sterile technique by all individuals in the surgical area;
  - That there is appropriate cleaning between surgical cases and appropriate terminal cleaning applied;
  - That operating room attire is suitable for the kind of surgical case performed, that persons working in the operating suite must wear only clean surgical costumes, that surgical costumes are designed for maximum skin and hair coverage;
  - That equipment is available for rapid and routine sterilization of operating room materials and that equipment is monitored, inspected, tested, and maintained by the CAH'S biomedical equipment program; and
  - That sterilized materials are packaged, handled, labeled, and stored in a manner that ensures sterility e.g., in a moisture and dust controlled environment and policies and procedures for expiration dates have been developed and are followed in accordance with accepted standards of practice.
- Review the CAH'S organizational chart displaying the relationship of the operating room service to other services. Confirm that the operating room's organization chart indicates lines of authority and delegation of responsibility within the department or service.

- If LPNs and surgical technologists (STs) are performing circulating duties, verify that they do so in accordance with applicable State laws and approved medical staff policies and procedures.
- Verify in situations where LPNs and STs are permitted to circulate that a qualified RN supervisor is immediately available to respond to emergencies.
- Review policies and procedures, to ascertain whether they contain the minimum policies specified in the interpretive guidelines.
- Review a sample of medical records of surgical patients to determine if a complete history and physical examination by a surgeon is completed prior to surgery, except in an emergency, and in accordance with the methodology described above.
- Review a sample of medical records of surgical patients to verify that they contain consent forms. Ascertain that the completed forms contain at least the information specified in the interpretive guidelines.
- Check to determine that the operating room suite has available the items listed.
  - On-call system
  - Cardiac monitor
  - Resuscitator
  - Defibrillator
  - Aspirator (suction equipment)
  - Tracheotomy set (a cricothyroidotomy set is not a substitute)
- Verify that all equipment is working and, as applicable, in compliance with the CAH'S biomedical equipment inspection, testing, and maintenance program.
- Verify that the CAH has provisions for post-operative care.
- Determine that there are policies and procedures that govern the recovery room area.
- Examine the OR register or equivalent record which lists all surgery performed by the surgery service. Determine that the register includes items specified in the interpretive guidelines.

- Review a sample of medical records of patients who had a surgical encounter. Verify that they contain a surgical report that is dated and signed by the responsible surgeon and includes the information specified in the interpretive guidelines.

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## **C-0321**

### **§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--**

- (1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;**
- (2) A doctor of dental surgery or dental medicine; or**
- (3) A doctor of podiatric medicine.**

#### **Interpretive Guidelines §485.639(a)**

Surgical privileges should be reviewed and updated at least every 2 years. A current roster listing each practitioner's specific surgical privileges must be available in the surgical suite and area/location where the scheduling of surgical procedures is done. A current list of surgeons suspended from surgical privileges or whose surgical privileges have been restricted must be retained in these area/locations.

The CAH must delineate the surgical privileges of all practitioners performing surgery and surgical procedures. The medical staff is accountable to the governing body for the quality of care provided to patients. The medical staff bylaws must include criteria for determining the privileges to be granted to an individual practitioner and a procedure for applying the criteria to individuals requesting privileges. Surgical privileges are granted in accordance with the competencies of each practitioner. The medical staff appraisal procedures must evaluate each individual practitioner's training, education, experience, and demonstrated competence as established by the CAH'S QA program, credentialing process, the practitioner's adherence to CAH policies and procedures, and in accordance with scope of practice and other State laws and regulations.

The CAH must specify the surgical privileges for each practitioner that performs surgical tasks. This would include practitioners such as MD/DOs, dentists, oral surgeons, podiatrists, RN first assistants, nurse practitioners, surgical physician assistants, surgical technicians, etc. When a practitioner may perform certain surgical procedures under supervision, the specific tasks/procedures and the degree of supervision (to include whether or not the supervising practitioner is in the same OR in line of sight) be delineated in that practitioner's surgical privileges and included on the surgical roster.

When practitioners whose scope of practice for conducting surgical procedures requires the supervision of an MD/DO surgeon, the term “supervision” would mean the supervising MD/DO surgeon is present in the same room, working with the same patient.

Surgery and all surgical procedures must be conducted by a practitioner who meets the medical staff criteria and procedures for the privileges granted, who has been granted surgical privileges in accordance with those criteria established by the governing body (or responsible individual), and who is working within the scope of those granted and documented privileges.

#### **Survey Procedures §485.639(a)**

- Review the CAH’S method for reviewing the surgical privileges of practitioners. This method should require a written assessment of the practitioner's training, experience, health status, and performance.
- Determine that a current roster listing each practitioner's specific surgical privileges is available in the surgical suite and the area where the scheduling of surgical procedures is done.
- Determine that a current list of surgeons suspended from surgical privileges or who have restricted surgical privileges is retained in these areas/locations.

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#### **C-0322**

#### **§485.639(b) Standard: Anesthetic Risk and Evaluation**

**(1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.**

**(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.**

**(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.**

#### **Interpretive Guidelines §485.639(b)**

The pre-anesthesia evaluation must be performed prior to inpatient or outpatient surgery. The pre-anesthesia evaluation must be performed by an individual qualified to administer anesthesia. The pre-operative anesthetic evaluation should include:

- Notation of anesthesia risk

- Anesthesia, drug and allergy history
- Any potential anesthesia problems identified
- Patient's condition prior to induction of anesthesia

The post-anesthesia follow-up report must be written on all inpatients and outpatients prior to discharge from surgery and anesthesia services. The post-anesthesia evaluation must be written by the individual who is qualified to administer the anesthesia. An MD/DO may delegate the post-anesthesia assessment and the writing of the post-anesthesia follow-up report to practitioners qualified to administer anesthesia in accordance with State law and CAH policy. When delegation of the post-anesthesia follow-up report is permitted, the medical staff must address its delegation requirements and methods in its bylaws. The post-anesthesia follow-up report must be documented in the patient's medical record, whether the patient is an inpatient or outpatient of the CAH, and must include at a minimum:

- Cardiopulmonary status;
- Level of consciousness;
- Any follow-up care and/or observations; and
- Any complications occurring during post-anesthesia recovery.

#### **Survey Procedures §485.639(b)**

- Review records to determine that each patient has a pre-anesthesia evaluation by an individual qualified to administer anesthesia. The evaluation must be performed prior to surgery.
- Review medical records to determine that a post-anesthesia follow-up report is written for each patient receiving anesthesia services, by the individual who administered the anesthesia prior to discharge from anesthesia services. Documentation should include those items specified in interpretive guidelines.

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### **C-0323**

#### **§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.**

**(1) Anesthesia must be administered by only--**

- (i) A qualified anesthesiologist;**
- (ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;**
- (iii) A doctor of dental surgery or dental medicine;**
- (iv) A doctor of podiatric medicine;**
- (v) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter;**
- (vi) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or**
- (vii) A supervised trainee in an approved educational program, as described in §§ 413.85 or 413.86 of this chapter.**

**Interpretive Guidelines §485.639(c)(1)**

The medical staff bylaws must include criteria for determining the privileges to be granted to an individual practitioner and a procedure for applying the criteria to individuals requesting privileges. The CAH must specify the anesthesia privileges for each practitioner that administers anesthesia, or who supervises the administration of anesthesia by another practitioner. The privileges granted must be in accordance with State law and CAH policy. The type and complexity of procedures for which the practitioner may administer anesthesia, or supervise another practitioner supervising anesthesia, must be specified in the privileges granted to the individual practitioner.

A dentist, oral surgeon, or podiatrist may administer anesthesia in accordance with State law, their scope of practice and CAH policy. The anesthesia privileges of each practitioner must be specified. Anesthesia privileges are granted in accordance with the practitioner's scope of practice, State law, the individual competencies of the practitioner and the practitioner's compliance with the CAH'S credentialing criteria.

When a CAH permits operating practitioners to supervise CRNA administering anesthesia, the medical staff must specify in the statement of privileges for each category of operating practitioner, the type and complexity of procedures they may supervise. A CRNA may administer anesthesia when under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed (unless supervision is exempted in accordance with §485.639(e)). An anesthesiologist's assistant may administer anesthesia when under the supervision of an anesthesiologist who is immediately available if needed. Available to immediately intervene includes at a minimum, that the supervising anesthesiologist or operating practitioner, as applicable, is:

- Physically located within the operative suite or in the labor and delivery unit; and
- Is prepared to immediately conduct hands-on intervention if needed; and
- Is not engaged in activities that could prevent the supervising practitioner from being able to immediately intervene and conduct hands-on interventions if needed

#### **Survey Procedures §485.639(c)(1)**

- Review the qualifications of individuals authorized to deliver anesthesia.
- Determine that there is documentation of current licensure or current certification status for all persons administering anesthesia.

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#### **C-0324**

**§485.639(c)(2) In those cases in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.**

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#### **C-0325**

#### **§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.**

#### **Interpretive Guidelines §485.639(d)**

Any exceptions to this requirement must be made by the attending practitioner and annotated on the clinical record.

#### **Survey Procedures §485.639(d)**

Verify that the CAH has policies and procedures in place to govern discharge procedures and instructions.

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#### **C-0326**

#### **§485.639(e) Standard: State Exemption**

**(1) A CAH may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the**

**CAH is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from MD/DO supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current MD/DO supervision requirement, and that the opt-out is consistent with State law.**

**(2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.**

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## **C-0330**

### **§485.641 Condition of Participation: Periodic Evaluation and Quality Assurance Review**

#### **Interpretive Guidelines §485.641**

While conducting the survey, a surveyor may identify a patient care practice or other CAH practice with which the surveyor is unfamiliar. Health care and CAH practice are continually changing due to new laws, regulations and standards of practice. In order for the surveyor to determine compliance with the CAH CoP, the surveyor should interview appropriate CAH staff to gather additional information, such as:

- Tell me about this practice.
- Is the practice a requirement or standard of practice?
- What is your source for this requirement, activity or standard of practice?
- Show me your source material for this practice.

If the CAH produces a law, regulation, or standard of practice from a nationally recognized organization, evaluate whether the CAH'S policies and procedures reflect the law, regulation, or standard of practice. Then, evaluate whether the CAH'S actual practice reflects their policies and procedures, as well as the law, regulation or standard of practice.

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## **C-0331**

### **§485.641(a) Standard: Periodic Evaluation**

**(1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of--**

### **Survey Procedures §485.641(a)(1)**

- How is information obtained to be included in the periodic evaluation?
  - How does the CAH conduct the periodic evaluation?
  - Who is responsible for conducting the periodic evaluation?
- 

### **C-0332**

**§485.641(a)(1)(i) The utilization of CAH services, including at least the number of patients served and the volume of services;**

### **Survey Procedures §485.641(a)(1)(i)**

How does the CAH ensure that the yearly program evaluation includes a review of all CAH services, the number of patients served and the volume of services provided?

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### **C-0333**

**§485.641(a)(1)(ii) A representative sample of both active and closed clinical records; and**

### **Interpretive Guidelines §485.641(a)(1)(ii)**

“A representative sample of both active and closed clinical records” means not less than 10 percent of both active and closed patient records.

### **Survey Procedures §485.641(a)(1)(ii)**

- Who is responsible for the review of both active and closed clinical records?
- How are records selected and reviewed in the periodic evaluation?
- How does the evaluation process ensure that the sample of records is representative of services furnished?
- What criteria are utilized in the review of both active and closed records?

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**C-0334**

**§485.641(a)(1)(iii) The CAH'S health care policies.**

**Survey Procedures §485.641(a)(1)(iii)**

What evidence demonstrates that the health care policies of the CAH are evaluated, reviewed and/or revised as part of the annual program evaluation?

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**C-0335**

**§485.641(a)(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.**

**Survey Procedures §485.641(a)(2)**

- How does the CAH use the results of the yearly program evaluation?
- Were policies, procedures and /or facility practices added, deleted or revised as a result of the yearly program evaluation if needed?

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**C-0336**

**§485.641(b) Standard: Quality Assurance**

**The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--**

**Interpretive Guidelines §485.641(b)**

There is nothing in this requirement to preclude a CAH from obtaining QA through arrangement. Whether the CAH has a freestanding QA program or QA by arrangement, all of the requirements for QA must be met. If a CAH chooses to have a freestanding QA program, the QA program should be facility wide, including all departments and all services provided under contract. For services provided to the CAH under contract, there should be established channels of communication between the contractor and CAH staff.

“An effective quality assurance program” means a QA program that includes:

- Ongoing monitoring and data collection;
- Problem prevention, identification and data analysis;

- Identification of corrective actions;
- Implementation of corrective actions;
- Evaluation of corrective actions; and
- Measures to improve quality on a continuous basis.

### **Survey Procedures §485.641(b)**

Review a copy of the CAH QA plan and other documentation regarding QA activities, (e.g., meeting notes from QA committees, reports produced by the QA director and/or QA committees, if designated, and follow-up communication relative to corrective actions) to become familiar with the scope, methodology and organization of the CAH QA program.

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### **C-0337**

**§485.641(b)(1) All patient care services and other services affecting patient health and safety, are evaluated;**

### **Survey Procedures §485.641(b)(1)**

- Who is responsible to evaluate CAH patient care services?
  - How are patient care services evaluated?
  - What other services are evaluated?
  - How does the CAH ensure quality assurance data is provided to the medical staff and governing body?
- 

### **C-0338**

**§485.641(b)(2) Nosocomial infections and medication therapy are evaluated;**

### **Survey Procedures §485.641(b)(2)**

- What methodology does the CAH use to evaluate nosocomial infections and medications therapy?
- Review committee meeting minutes for current issues or projects, etc.

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**C-0339**

**§485.641(b)(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;**

**Survey Procedures §485.641(b)(3)**

- How does the CAH ensure that a doctor of medicine or osteopathy evaluates the quality of care provided by mid-level practitioners in the CAH?
- How is clinical performance of mid-level practitioners evaluated?
- What evidence demonstrates that there is an ongoing evaluation of care provided by mid-level practitioners (e.g., reports, periodic written evaluation, QA meeting notes)?
- How does the reviewing MD/DO inform the CAH if he/she determines that there are problems relative to the diagnosis and treatment provided by mid-level practitioners?
- What follow-up actions are called for in the QA plan?

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**C-0340**

**§485.641(b)(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by--**

- (i) One hospital that is a member of the network, when applicable;**
- (ii) One QIO or equivalent entity; or**
- (iii) One other appropriate and qualified entity identified in the State rural health care plan; and**

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**C-0341**

**§485.641(b)(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.**

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**C-0342**

**§485.641(b)(5)(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.**

**Survey Procedures §485.641(b)(5)(ii)**

- How does the CAH ensure that proper remedial actions are taken to correct deficiencies identified in the quality assurance program?
- Who is responsible for implementing remedial actions to correct deficiencies identified by the quality assurance program?

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**C-0343**

**§485.641(b)(5)(iii) The CAH documents the outcome of all remedial action.**

**Survey Procedures §485.641(b)(5)(iii)**

How does the CAH document the outcome of any remedial action?

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**C-0344**

**§485.643 Condition of Participation: Organ, Tissue, and Eye Procurement**

**The CAH must have and implement written protocols that:**

**Interpretive Guidelines §485.643**

The CAH must have written policies and procedures to address its organ procurement responsibilities.

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**C-0345**

**§485.643(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;**

## **Interpretive Guidelines §485.643(a)**

The CAH must have a written agreement with an Organ Procurement Organization (OPO), designated under 42 CFR Part 486. At a minimum, the written agreement must address the following:

- The criteria for referral, including the referral of all individuals whose death is imminent or who have died in the CAH;
- Includes a definition of “imminent death”;
- Includes a definition of “timely notification”;
- Addresses the OPO’s responsibility to determine medical suitability for organ donation;
- Specifies how the tissue and/or eye bank will be notified about potential donors using S notification protocols developed by the OPO in consultation with the CAH-designated tissue and eye bank(s);
- Provides for notification of each individual death in a timely manner to the OPO (or designated third party) in accordance with the terms of the agreement;
- Ensures that the designated requestor training program offered by the OPO has been developed in cooperation with the tissue bank and eye bank designated by the CAH;
- Permits the OPO, tissue bank, and eye bank access to the CAH’S death record information according to a designated schedule, e.g., monthly or quarterly;
- Includes that the CAH is not required to perform credentialing reviews for, or grant privileges to, members of organ recovery teams as long as the OPO sends only “qualified, trained individuals” to perform organ recovery; and
- The interventions the CAH will utilize to maintain potential organ donor patients so that the patient organs remain viable.

CAHs must notify the OPO of every death or imminent death in the CAH. When death is imminent, the CAH must notify the OPO both before a potential donor is removed from a ventilator and while the potential donor’s organs are still viable. The CAH should have a written policy, developed in coordination with the OPO and approved by the CAH’S medical staff and governing body, to define “imminent death.” The definition for “imminent death” should strike a balance between the needs of the OPO and the needs of the CAH’S care givers to continue treatment of a patient until brain death is declared or the patient’s family has made the decision to withdraw supportive measures.

Collaboration between OPOs and CAHs will create a partnership that furthers donation, while respecting the perspective of CAH staff.

The definition for “imminent death” might include a patient with severe, acute brain injury who:

- Requires mechanical ventilation;
- Is in an intensive care unit (ICU) or emergency department; **AND**
- Has clinical findings consistent with a Glasgow Coma Score that is less than or equal to a mutually-agreed-upon threshold; **or**
- MD/DOs are evaluating a diagnosis of brain death; **or**
- An MD/DO has ordered that life sustaining therapies be withdrawn, pursuant to the family’s decision.

CAHs and their OPO should develop a definition of “imminent death” that includes specific triggers for notifying the OPO about an imminent death.

In determining the appropriate threshold for the Glasgow Coma Score (GCS), it is important to remember that if the threshold is too low, there may be too many “premature” deaths or situations where there is a loss of organ viability. Standards for appropriate GCS thresholds may be obtained from the CAH’S OPO or organizations such as the Association of Organ Procurement Organizations.

Note that a patient with “severe, acute brain injury” is not always a trauma patient. For example, post myocardial infarction resuscitation may result in a patient with a beating heart and no brain activity.

The definition agreed to by the CAH and the OPO may include all of the elements listed above or just some of the elements. The definition should be tailored to fit the particular circumstances in each CAH.

CAHs may not use “batch reporting” for deaths by providing the OPO with periodic lists of patient deaths, even if instructed to do so by the OPO. If the patient dies during a transfer from one CAH to another, it is the receiving CAH’S responsibility to notify the OPO.

“**Timely notification**” means a CAH must contact the OPO by telephone as soon as possible after an individual has died, has been placed on a ventilator due to a severe brain injury, or who has been declared brain dead (ideally within 1 hour). That is, a CAH must notify the OPO while a brain dead or severely brain-injured, ventilator-dependent individual is still attached to the ventilator and as soon as possible after the death of any

other individual, including a potential non-heart-beating donor. Even if the CAH does not consider an individual who is not on a ventilator to be a potential donor, the CAH must call the OPO as soon as possible after the death of that individual has occurred.

Referral by a CAH to an OPO is timely if it is made:

- As soon as it is anticipated a patient will meet the criteria for imminent death agreed to by the OPO and CAH or as soon as possible after a patient meets the criteria for imminent death agreed to by the OPO and the CAH (ideally, within one hour); **AND**
- Prior to the withdrawal of any life sustaining therapies (i.e., medical **or** pharmacological support).

Whenever possible, referral should be made early enough to allow the OPO to assess the patient's suitability for organ donation before brain death is declared and before the option of organ donation is presented to the family of the potential donor. Timely assessment of the patient's suitability for organ donation increases the likelihood that the patient's organs will be viable for transplantation (assuming there is no disease process identified by the OPO that would cause the organs to be unsuitable), ensures that the family is approached only if the patient is medically suitable for organ donation, and ensures that an OPO representative is available to collaborate with the CAH staff in discussing donation with the family.

It is the OPO's responsibility to determine medical suitability for organ donation, and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose.

#### **Survey Procedures §485.643(a)**

- Review the CAH'S written agreement with the OPO to verify that it addresses all required information.
- Verify that the CAH'S governing body has approved the CAH'S organ procurement policies.
- Review a sample of death records to verify that the CAH has implemented its organ procurement policies.
- Interview the staff to verify that they are aware of the CAH'S policies and procedures for organ, tissue and eye procurement.
- Verify that the organ, tissue and eye donation program is integrated into the CAH'S QA program.

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**C-0346**

**§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;**

**Interpretive Guidelines §485.643(b)**

The CAH must have an agreement with at least one tissue bank and at least one eye bank. The OPO may serve as a “gatekeeper” receiving notification about every CAH death and should notify the tissue bank chosen by the CAH about potential tissue and eye donors.

It is not necessary for a CAH to have a separate agreement with a tissue bank if it has an agreement with its OPO to provide tissue procurement services; not is it necessary for a CAH to have a separate agreement with an eye bank if its OPO provides eye procurement services. The CAH is not required to use the OPO for tissue or eye procurement but is free to have an agreement with the tissue bank or eye bank of its choice. The tissue banks and eye banks define “usable tissues” and “usable eyes.”

The requirements of this regulation 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 CAH. The CAH may continue current successful direct arrangements with tissue and eye banks as long as the direct arrangement does not interfere with organ procurement.

**Survey Procedures §485.643(b)**

Verify that the CAH has an agreement with at least one tissue bank and one eye bank that specifies criteria for referral of all individuals who have died in the CAH. The agreement must also acknowledge that it is the OPO’s responsibility to determine medical suitability for tissue and eye donation, unless the CAH has an alternative agreement with a different tissue and/or eye bank.

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**C-0347**

**§485.643(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;**

### **Interpretive Guidelines §485.643(c)**

It is the responsibility of the OPO to screen for medical suitability in order to select potential donors. Once the OPO has selected a potential donor, that person's family must be informed of the family's donation options.

Ideally, the OPO and the CAH will decide together how and by whom the family will be approached.

The individual designated by the CAH to initiate the request to the family must be a designated requestor.

A “**designated requestor**” is defined as a CAH-designated individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community. If possible, the OPO representative and a designated requestor should approach the family together.

The CAH must ensure that any “designated requestor” for organs, tissues or eyes has completed a training course either offered or approved by the OPO, which addresses methodology for approaching potential donor families.

### **Survey Procedures §485.643(c)**

- Verify that the CAH ensures that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, including the option to decline to donate.
- Review training schedules and personnel files to verify that all designated requestors have completed the required training.
- How does the CAH ensure that only designated requestors are approaching families to ask them to donate?

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## **C-0348**

**§485.643(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the family of potential donors;**

### **Interpretive Guidelines §485.643(d)**

Using discretion does not mean a judgment can be made by the CAH that certain families should not be approached about donation. CAHs should approach the family with the belief that a donation is possible and should take steps to ensure the family is treated with respect and care. The staff's perception that a family's grief, race, ethnicity, religion or

socioeconomic background would prevent donation should never be used as a reason not to approach a family.

All potential donor families must be approached and informed of their donation rights.

#### **Survey Procedures §485.643(d)**

- Interview a CAH-designated requestor regarding approaches to donation requests.
- Review the designated requestor training program to verify that it addresses the use of discretion.
- Review the facility complaint file for any relevant complaints.

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#### **C-0349**

**§485.643(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place.**

**§485.643(f) For purpose of these standards, the term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).**

#### **Interpretive Guidelines §485.643(e)**

Appropriate staff, including all patient care staff, must be trained regarding donation issues and how to work with the OPO, tissue bank and eye bank. Those CAH staff who may have to contact or work with the OPO, tissue bank and eye bank staff, must have appropriate training on donation issues including their duties and roles.

The training program must be developed in cooperation with the OPO, tissue bank and eye bank, and should include, at a minimum:

- Consent process;
- Importance of using discretion and sensitivity when approaching families;
- Role of the designated requestor;
- Transplantation and donation, including pediatrics, if appropriate;
- Quality improvement activities; and
- Role of the organ procurement organization.

Training should be conducted with new employees annually, whenever there are policy/procedure changes, or when problems are determined through the CAH'S QA program.

CAHs must cooperate with OPOs, tissue banks and eye banks in regularly/periodically reviewing death records. This means that a CAH must develop policies and procedures which permit the OPO, tissue bank and eye bank access to death record information that will allow the OPO, tissue bank and eye bank to assess the CAH'S donor potential, ensure that all deaths or imminent deaths are being referred to the OPO in a timely manner, and identify areas where the CAH, OPO, tissue bank and eye bank staff performance might be improved. The policies must address how patient confidentiality will be maintained during the review process.

The CAH must have policies and procedures, developed in cooperation with the OPO, that ensure that potential donors are maintained in a manner that maintain the viability of their organs. The CAH must have policies in place to ensure that potential donors are identified and declared dead within an acceptable time frame by an appropriate practitioner.

#### **Survey Procedures §485.643(e)**

- Review inservice training schedules and attendance sheets.
- How does the CAH ensure that all appropriate staff have attended an educational program regarding donation issues and how to work with the OPO, tissue bank, and eye bank?
- Verify by review of policies and records that the CAH works with the OPO, tissue bank, and eye bank in reviewing death records.
- Verify that the effectiveness of any protocols and policies is monitored as part of the CAH'S quality improvement program.
- Validate how often the reviews are to occur. Review the protocols that are in place to guide record reviews and analysis.
- Determine how confidentiality is ensured.
- Verify that there are policies and procedures in place to ensure coordination between the facility staff and the OPO staff in maintaining the potential donor.
- Determine by review, what policies and procedures are in place to ensure that potential donors are identified and declared dead by an appropriate practitioner within an acceptable timeframe.

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## C-0350

### **§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.**

#### **Interpretive Guidelines §485.645**

The swing-bed concept allows a CAH to use their beds interchangeably for either acute-care or post-acute care. A “swing-bed” is a change in reimbursement status. The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.

Medicare allows a CAH to operate swing-beds through the issuance of a “swing-bed approval.” If the facility fails to meet the swing-bed requirements, and the facility does not develop and implement an accepted plan of correction, the facility loses the approval to operate swing-beds and receive swing-bed reimbursement. The facility does not go on a termination track. If the CAH continues to meet the CoP for the provider type, it continues to operate but loses swing-bed approval.

Swing-beds need not be located in a special section of the CAH. The patient need not change locations in the facility merely because his/her status changes unless the facility requires it.

The change in status from acute care to swing-bed status can occur within one facility or the patient can be transferred from another facility for swing-bed admission.

There must be discharge orders from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to swing-bed status regardless of whether the patient stays in the same facility or transfers to another facility. If the patient does not change facilities, the same chart can be utilized but the swing-bed section of the chart must be separate with appropriate admission orders, progress notes, and supporting documents.

There is no length of stay restriction for any CAH swing-bed patient. There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes.

Medicare reimbursement requires a 3-day qualifying stay in any CAH or CAH prior to admission to a swing-bed. The swing-bed stay must fall within the same spell of illness as

the qualifying stay. This requirement does not apply to patients who are not receiving Medicare reimbursement.

There is no requirement for a CAH to use the MDS form for recording the patient assessment or for nursing care planning.

Swing-bed patients receive a SNF level of care, and the CAH is reimbursed for providing a SNF level of care, however swing-bed patients are not SNF patients. Swing-bed patients in CAHs are considered to be patients of the CAH.

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## **C-0351**

### **§485.645(a) Eligibility**

**A CAH must meet the following eligibility requirements:**

- (1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and**
- (2) The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.**

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## **C-0352**

### **§485.645(b) Facilities Participating as Rural Primary Care Hospitals (RPHs) on September 30, 1997**

**These facilities must meet the following requirements:**

- (1) Notwithstanding paragraph (a) of this section, a hospital that participated in Medicare as a RPH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and limitations that were applicable at the time these approvals were granted..**
- (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 under paragraph (b)(1) of this section.**

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**C-0355****§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.

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**C-0360****§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:

- (1) Resident rights (§483.10(b)(3) through (b)(6), (d), (e), (h), (i), (j)(1)(vii) and (viii), (1), and (m) of this chapter).
- (2) Admission, transfer, and discharge rights (§483.12(a) of this chapter).
- (3) Resident behavior and facility practices (§483.13 of this chapter).
- (4) Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.
- (5) Social services (§483.15(g) of this chapter).
- (6) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).
- (7) Specialized rehabilitative services (§483.45 of this chapter).
- (8) Dental services (§483.55 of this chapter).
- (9) Nutrition (§483.25(i) of this chapter).

### **§483.10 Resident Rights**

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the following rights:

#### **§483.10(a) Exercise of Rights**

- (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.**
- (2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.**
- (3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.**
- (4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.**

#### **§483.10(b) Notice of Rights and Services**

- (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;**
- (2) The resident or his or her legal representative has the right--**
  - (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and**
  - (ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.**

**(3) The resident has 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;**

#### **Interpretive Guidelines §483.10(b)**

The intent of this requirement is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, during the resident's stay, and when the facility's rules changes. A facility must promote the exercise of rights for all residents, including those who face barriers such as communication problems, hearing problems and cognition limits. These rights include the resident's right to:

- Be informed about what rights and responsibilities the resident has (§483.10(b)(3 through 6));
- Choose a MD/DO (§483.10(d));
- Participate in decisions about treatment and care planning (§483.10(d));
- Have privacy and confidentiality (§483.10(e));
- Work or not work (§483.10(h));
- Have privacy in sending and receiving mail (§483.10(i));
- Visit and be visited by others from outside the facility (§483.10(j)(1)(vii and viii));
- Retain and use personal possessions (§483.10(l));
- Share a room with a spouse (§483.10(m)).

**“Total health status”** includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments. Information on health status must be presented in language that the resident can understand.

Communicating with the resident in language that the resident can understand includes minimizing the use of technical words, providing interpreters for non-English speaking residents, using sign language when needed, or other interventions, as appropriate.

#### **Survey Procedures §483.10(b)**

- Look for on-going efforts on the part of facility staff to keep residents informed.

- Look for evidence that information is communicated in a manner that is understandable to residents.
- Is information available when it is most useful to the residents such as when they are expressing concerns, raising questions, and on an on-going basis?
- Is there evidence in the medical record that the patient was informed of his rights, including the right to accept or refuse medical or surgical treatment?

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## **C-0362**

**§483.10(b)(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph 8 of this section; and**

### **Interpretive Guidelines §483.10(b)(4)**

“**Treatment**” is defined as care provided for purposes of maintaining/restoring health, improving functional level, or relieving symptoms.

“**Experimental research**” is defined as development and testing of clinical treatments, such as an investigational drug or therapy that involve treatment and/or control groups. For example, a clinical trial of an investigational drug would be experimental research.

“**Advance directive**” means a written instruction, such as living will or durable power of attorney for health care, recognized under state law, relating to the provisions of health care when the individual is incapacitated.

A resident who has the capacity to make a health care decision and who withholds consent to treatment or makes an explicit refusal of treatment either directly or through an advance directive, may not be treated against his/her wishes.

The resident has the right to refuse to participate in experimental research. A resident being considered for participation in experimental research must be fully informed of the nature of the experiment and understand the possible consequences of participating. The opportunity to refuse to participate in experimental research must occur prior to the start of the research. Aggregated resident statistics that do not identify individual residents may be used for studies without obtaining resident permission.

### **Survey Procedures §483.10(b)(4)**

If the facility participates in any experimental research involving residents, does it have an Institutional Review Board or other committee that reviews and approves research protocols? The requirement at §483.75(c) Relationship to Other HHC Regulations may apply, see 45 CFR Part 46, Protection of Human Subjects of Research). “Although these regulations at §483.75(c) are not in themselves considered requirements under this part,

their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.”

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## **C-0363**

### **§483.10(b)(5) The facility must--**

**(i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of--**

**(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;**

**(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and**

**(ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.**

**(6) The facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility’s per diem rate.**

### **Interpretive Guidelines: §483.10(b)(5-6)**

If Medicare or Medicaid does not make payment for services, the provider must fully inform the resident of any related charges both at the time of admission and prior to the time that changes will occur in their bills.

Listed below are general categories and examples of items and services that the facility may charge to resident funds, if they are requested and agreed to by a resident.

- Telephone;
- Television/radio for personal use;
- Personal comfort items including smoking materials, notions, novelties, and confection;
- Cosmetic and grooming items and services in excess of those for which payment is made;
- Personal clothing;

- Personal reading matter;
- Gifts purchased on behalf of a resident;
- Flowers and plants;
- Social events and entertainment offered outside the scope of the activities program;
- Non-covered special care services such as privately hired nurses or aides;
- Private room, except when therapeutically required, for example, isolation for infection control;
- Specially prepared or alternative food requested;

**NOTE:** 42 CFR §483.10(b)(8), containing advance directive requirements, guidelines, procedures and probes, is contained below.

**§483.10(b)(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, facility may give advance directive information to the individual’s family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.**

**“Advance directive” means a written instruction, such as a living will or durable power of attorney for health care recognized under State law, relating to the provision of health care when the individual is incapacitated.**

### **Interpretive Guidelines §483.10(b)(8)**

This provision applies to residents admitted on or after December 1, 1991. The regulation at 42 CFR §489.102 specifies that at the time of admission of an adult resident, the facility must:

- Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care;
- Provide written information concerning his or her rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives;
- Document in the resident's medical record whether or not the individual has executed an advance directive;
- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- Ensure compliance with requirements of State law regarding advance directives;
- Provide for educating staff regarding the facility's policies and procedures on advance directives; and
- Provide for community education regarding issues concerning advance directives.

The facility is not required to provide care that conflicts with an advance directive. In addition, the facility is also not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive, and state law allows the provider to conscientiously object.

The sum total of the community education efforts must include a summary of the state law, the rights of residents to formulate advance directives, and the facility's implementation policies regarding advance directives. Video and audiotapes may be used in conducting the community education effort. Individual education programs do not have to address all the requirements if it would be inappropriate for a particular audience.

### **Survey Procedures §483.10(b)(8)**

Review the records of sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements.

- Determine to what extent the facility educates its staff regarding advance directives.
- Determine to what extent the facility provides education for the community regarding individual rights under State law to formulate advance directives.

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## **C-0364**

### **§483.10(d) Free Choice**

**The resident has the right to--**

**(1) Choose a personal attending MD/DO;**

#### **Interpretive Guidelines §483.10(d)(1)**

The right to choose a personal MD/DO does not mean that the MD/DO must serve the resident. If the MD/DO of the resident's choosing fails to fulfill a given requirement, such as frequency of MD/DO visits, the facility will have the right, after informing the resident, to seek alternate MD/DO participation to assure provision of appropriate and adequate care and treatment. A facility may not place barriers in the way of residents choosing their own MD/DO. If a resident does not have a MD/DO, or if the resident's MD/DO becomes unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his/her choice in finding another MD/DO. A resident can choose his/her own MD/DO, but cannot have a MD/DO who does not have swing-bed admitting privileges.

The requirement for free choice is met if a resident is allowed to choose a personal MD/DO from among those who have practice privileges.

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## **C-0365**

**§483.10(d)(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and**

#### **Interpretive Guidelines §483.10(d)(2)**

"Informed in advance" means that the resident receives information necessary to make a health care decision. The information should include his/her medical condition, changes in his/her medical condition, the benefits and reasonable risks of the recommended treatment, and reasonable alternatives. If there are any financial costs to the resident in the treatment options, they should be disclosed in advance and in writing to the resident prior to his/her decision.

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**C-0366**

**§483.10(d)(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.**

**Interpretive Guidelines §483.10(d)(3)**

“Participates in planning care and treatment” means that the resident is afforded the opportunity to select from alternative treatments, to the level of his ability to understand. This applies both to initial decisions about care and treatment and to decisions about changes in care and treatment. The resident has the right to participate in care planning and to refuse treatment.

**Survey Procedures §483.10(d)(3)**

- Look for evidence that the resident was afforded the right to participate in care planning or was consulted about care and treatment changes.
- If there appears to be a conflict between a resident’s right and the resident’s health or safety, determine if the facility attempted to accommodate both the exercise of the resident’s rights and the resident’s health, including exploration of care alternatives through a thorough care planning process in which the resident may participate.
- If a resident whose ability to make decisions about care and treatment is impaired, was he kept informed and consulted on personal preferences to the level of his ability to understand?

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**C-0367**

**§483.10(e) Privacy and Confidentiality**

**The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.**

**(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;**

**(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;**

**(3) The resident's right to refuse release of personal and clinical records does not apply when--**

**(i) The resident is transferred to another health care institution; or**

**(ii) Record release is required by law.**

**Interpretive Guidelines §483.10(e)**

**“Right to personal privacy”** means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include both visual and auditory privacy. Private space may be created flexibly and need not be dedicated solely for visitation purposes.

For example, privacy for visitation or meetings might be arranged by using a dining area between meals, a vacant chapel, office or room; or an activities area when activities are not in progress. Arrangements for private space could be accomplished through cooperation between the facility's administration and resident or family groups so that private space is provided for those requesting it without infringement on the rights of other residents.

Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual's need for privacy. Only authorized staff directly involved in treatment should be present when treatments are given. People not involved in the care of the individual should not be present without the individual's consent while he/she is being examined or treated. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services.

**Survey Procedures §483.10(e)**

Document any instances where you observe a resident's privacy being violated. Completely document how the resident's privacy was violated.

**Documentation Example:** Resident #12 left without gown or bed covers and unattended on 2B Corridor at 3:30 p.m. February 25, 2001. Identify the responsible party, if possible.

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## C-0368

### §483.10(h) Work

The resident has the right to--

- (1) Refuse to perform services for the facility;
- (2) Perform services for the facility, if he or she chooses, when--
  - (i) The facility has documented the need or desire for work in the plan of care;
  - (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid;
  - (iii) Compensation for paid services is at or above prevailing rates; and
  - (iv) The resident agrees to the work arrangement described in the plan of care.

#### Interpretive Guidelines §483.10(h)

All resident work, whether of a voluntary or paid nature, must be part of the plan of care. A resident's desire for work is subject to medical appropriateness. As part of the plan of care, the resident must agree to a therapeutic work assignment. The resident also has the right to refuse such treatment at any time that he or she wishes. At the time of development or review of the plan, voluntary or paid work can be negotiated.

The “**prevailing rate**” is the wage paid to workers in the community surrounding the facility for the same type, quality, and quantity of work requiring comparable skills.

#### Survey Procedures §483.10(h)

- Are residents engaged in work (e.g., doing housekeeping, doing laundry, preparing meals)?
- Pay special attention to the possible work activities of residents with mental retardation or mental illness.
- If a resident is performing work, determine whether it is voluntary, and whether it is described in the plan of care. Is the work mutually agreed upon between the resident and the treatment team?

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**C-0369****§483.10(i) Mail**

**The resident has the right to privacy in written communications, including the right to--**

- (1) Send and promptly receive mail that is unopened; and**
- (2) Have access to stationery, postage, and writing implements at the resident's own expense.**

**Interpretive Guidelines §483.10(i)**

**“Promptly”** means delivery of mail or other materials to the resident within 24 hours of delivery by the postal service (including a post office box) and delivery of outgoing mail to the postal service within 24 hours of regularly scheduled postal delivery and pickup service.

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**C-0370****§483.10(j) Access and Visitation Rights**

**(1) The resident has the right and the facility must provide immediate access to any resident by the following:**

- (vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and**
- (viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.**

**Interpretive Guidelines §483.10(j)(1)(vii)-(viii)**

The facility may set reasonable hours for visitation.

If it would violate the rights of a roommate to have visitors in the resident's room, the facility must establish alternate areas in the facility for visiting. These areas could include the chapel, a suitable office area, a dining room, or a porch or patio area.

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**C-0371****§483.10(l) Personal Property**

**The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.**

**Interpretive Guidelines §483.10(l)**

The intent of this regulation is to encourage residents to bring personal possessions into the facility, as space, safety considerations and fire code permits. All residents' possessions must be treated with respect and safeguarded.

The facility has the right to limit personal property due to space limitations in the facility or for safety considerations.

**Survey Procedures §483.10(l)**

If residents' rooms have few personal possessions, ask residents and families if--

- They are encouraged to have and to use personal items;
- Their personal property is safe in the facility.

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**C-0372****§483.10(m) Married Couples**

**The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.**

**Interpretive Guidelines §483.10(m)**

The requirement means that when a room is available for a married couple to share, the facility must permit them to share it if they choose.

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**C-0373****§483.12 Admission, Transfer and Discharge Rights****§483.12(a) Transfer and Discharge**

**(1) Definition: 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.**

**Interpretive Guidelines §483.12(a)(1)**

The intent of the regulation on transfer and discharge provisions is to significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility to prevent dumping of high care or difficult residents. This requirement applies to transfer or discharges that are initiated by the facility, not by the resident.

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**C-0374**

**§483.12(a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless--**

- (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;**
- (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;**
- (iii) The safety of individuals in the facility is endangered;**
- (iv) The health of individuals in the facility would otherwise be endangered;**
- (v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or**
- (vi) The facility ceases to operate.**

### **Interpretive Guidelines §483.12(a)(2)**

If transfer is due to a significant change in the resident's condition, the facility must conduct the appropriate assessment, prior to any transfer or discharge to determine if a new care plan would allow the facility to meet the resident's needs.

If the significant change in the resident's condition is an emergency, immediate transfer should be arranged.

### **Survey Procedures §483.12(a)(2)**

During closed record review, determine the reasons for transfer/discharge.

- Do records document accurate assessments and attempts through care planning to address the resident's needs through multidisciplinary interventions, accommodation of individual needs, and attention to the resident's customary routine?
- Did the resident's MD/DO document the record if the resident was transferred/discharged for the sake of the resident's welfare and the resident's needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization) or the resident's health improved to the extent that the transferred/discharged resident no longer needed the services of the facility?
- Did a MD/DO document the record if residents were transferred because the health of individuals in the facility is endangered?
- Do the records of residents who are transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary?
- If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident's MD/DO justify why the facility could not meet the needs of this resident.

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### **C-0376**

**§483.12(a)(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by--**

- (i) The resident's MD/DO when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and**

**(ii) A MD/DO when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.**

**Interpretive Guidelines §483.12(a)(3)**

A physician extender may complete documentation of the transfer/discharge unless prohibited by State law or facility policy.

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**C-0377**

**§483.12(a)(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--**

- (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.**
- (ii) Record the reasons in the resident's clinical record; and**
- (iii) Include in the notice the items described in paragraph (a)(6) of this section.**

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**C-0378**

**§483.12(a)(5) Timing of the notice.**

- (i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.**
- (ii) Notice may be made as soon as practicable before transfer or discharge when--**
  - (A) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section;**
  - (B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section;**
  - (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section;**
  - (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or**
  - (E) A resident has not resided in the facility for 30 days.**

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**C-0379**

**§483.12(a)(6) Contents of the notice. The written notice specified in paragraph (a)(4) of this section must include the following:**

- (i) The reason for transfer or discharge;**
- (ii) The effective date of transfer or discharge;**
- (iii) The location to which the resident is transferred or discharged;**
- (iv) A statement that the resident has the right to appeal the action to the State;**
- (v) The name, address and telephone number of the State long term care ombudsman;**
- (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and**
- (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.**

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**C-0380**

**§483.12(a)(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.**

**Interpretive Guidelines §483.12(a)(7)**

“**Sufficient preparation**” means the facility informs the resident where he or she is going and assures safe transportation. The facility should actively involve the resident and the resident’s family in selecting the new residence. Some examples of orientation may include trial visits by the resident to a new location; working with family; and orienting staff in the receiving facility to the resident’s daily patterns.

**Survey Procedures §483.12(a)(7)**

During resident reviews, check social service notes to see if appropriate referrals have been made and, if necessary, if resident counseling has occurred.

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## C-0381

### §483.13 Resident Behavior and Facility Practices

#### §483.13(a) Restraints

**The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.**

#### Interpretive Guidelines §483.13(a)

The intent of this requirement is for each person to reach his/her highest practicable well being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

**“Physical restraints”** are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body.

**“Chemical Restraint”** is defined as a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.

**“Discipline”** is defined as any action taken by the facility for the purpose of punishing or penalizing residents.

**“Convenience”** is defined as any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interest.

Medical symptoms that would warrant the use of restraints should be reflected in the comprehensive assessment and care planning. The facility must engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities).

#### Survey Procedures §483.13(a)

- Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints.
- Determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated.

- Did the team institute measures in the care plan to address reversal of any decline in health status?
- Determine the intended use of any restraints. Was the use for convenience or discipline?

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## **C-0382**

### **§483.13(b) Abuse**

**The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.**

#### **Interpretive Guidelines §483.13(b)**

The intent of this regulation is to assure that each resident is free from abuse, corporal punishment, and involuntary seclusion. The facility is responsible for preventing abuse, but also for those practices and omissions, neglect and misappropriation of property, which if left unchecked, lead to abuse.

Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals.

“**Abuse**” is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish.

“**Verbal abuse**” is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; and saying things to frighten a resident, such as telling a resident that she will never be able to see her family again.

“**Sexual abuse**” includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

“**Physical abuse**” includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment and restraints.

“**Mental abuse**” includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

“**Involuntary seclusion**” is defined as separation of a resident from other residents or from his or her room or confinement to his or her room (with or without roommates) against the resident’s will, or the will of the resident’s legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident’s needs.

### **Survey Procedures §483.13(b)**

- Offsite, pre-survey review of complaints can focus the survey team’s on-site review of actual incidents and predisposing factors to abuse or neglect and misappropriation of property.
- Report and record **any** instances where the survey team **observes** an abusive incident. Completely document who committed the abusive act, the nature of the abuse, and where and when it occurred. Ensure that the facility addresses that incident immediately.
- If the survey team’s observations and resident’s responses signal the presence of abuse, determine how the facility prevents and reports abusive behavior.
- If a resident is being temporarily separated from other residents, for less than 24 hours, as an emergency short-term intervention, answer these questions:
  - o What are the symptoms that led to the consideration of the separation?
  - o Are these symptoms caused by failure to:
    - Meet individual needs;
    - Provide meaningful activities;
    - Manipulate the resident’s environment?
  - o Can the cause(s) be removed?
  - o If the cause(s) cannot be removed, has the facility attempted to use alternatives short of separation?
  - o Does the facility use the separation for the least amount of time?

- o To what extent has the resident, surrogate or representative participated in care planning and made an informed choice about separation?
- o Does the facility monitor and adjust care to reduce negative outcomes, while continually trying to find and use less restrictive alternatives?
- o If residents are temporarily separated in secured units, staff should carry keys to these units at all times.
- o If the purpose of the unit is to provide specialized care for residents who are cognitively impaired (through a program of therapeutic activities designed to enable residents to attain and maintain the highest practicable physical, mental or psychosocial well-being) then placement in the unit is not in violation of resident rights, as long as the resident's individual care plan indicates the need for the stated purpose and services provided in the unit and the resident, surrogate, or representative has participated in the placement decision.

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## **C-0383**

### **§483.13(c) Staff Treatment of Residents**

**The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.**

**(1) The facility must--**

- (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;**

#### **Interpretive Guidelines §483.13(c)**

The intent of this regulation is to assure that the facility has in place an effective system that prevents mistreatment, neglect and abuse of residents, and misappropriation of resident's property.

**“Misappropriation of resident's property”** is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

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**C-0384****§483.13(c)(1)(ii) Not employ individuals who have been--**

- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or**
  - (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and**
- (iii) Report 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 to the State nurse aide registry or licensing authorities.**
- (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).**
- (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.**
- (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.**

**Interpretive Guidelines §483.13(c)(1-4)**

The intent of this regulation is to prevent employment of individuals who have been convicted of abusing, neglecting, or mistreating individuals in a health care related setting.

In addition to inquiry of the State nurse aide registry or other licensing authorities, the facility should check all staff references and make reasonable efforts to uncover information about any past criminal prosecutions.

“Found guilty...by a court of law” applies to situations where the defendant pleads guilty, is found guilty, or pleads nolo contendere.

“**Finding**” is defined as a determination made by the State that validates allegations of abuse, neglect, mistreatment of residents or misappropriation of their property.

Any facility staff found guilty of neglect, abuse, or mistreating residents or misappropriation of property by a court of law must have his or her name entered into the nurse aide registry, or reported to the licensing authority, as appropriate.

### **Survey Procedures §483.13(c)(1-4)**

During Sample Selection--

- If the team has identified a problem in mistreatment, neglect or abuse of residents or misappropriation of their property, then request--
  - A copy of the facility's policies and procedures regarding abuse prevention: Note particularly the extent to which those policies concern the areas uncovered through complaints and/or previous survey;
  - Reports of action(s) by a court of law against employees;
  - Reports of alleged violations involving mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident's property;
  - Reports of the results of these investigations; and
  - Records of corrective actions taken.
- Spot check employment applications for questions about convictions or mistreatment, neglect or abuse of residents, or misappropriation of their property. Determine if applicants have answered these questions and if affirmative answers had resulted in rejections of employment candidates.
- Contact the State Nurse Aide Registry or Board of Nursing, as appropriate. Determine if applicants with a finding concerning mistreatment, neglect, and abuse of residents or misappropriation of their property have been rejected.
- Ask for the results of any in-house investigations of mistreatment, neglect, or abuse of residents, misappropriation of their property, or injuries of unknown sources.
  - Was the administrator notified of the incident and when?
  - Did investigations begin promptly after the report of the problem?
  - Is there a record of statements or interviews of the resident, suspect (if one is identified), any eyewitnesses and any circumstantial witnesses?

- o Was relevant documentation reviewed and preserved (e.g., dated dressing which was not changed when treatment recorded change)?
- o Was the alleged victim examined promptly (if injury was suspected) and the finding documented in the report?
- o What steps were taken to protect the alleged victim from further abuse (particularly where no suspect has been identified)?
- o What actions were taken as a result of the investigation?
- o What corrective action was taken, including informing the nurse aide registry, State licensure authorities, and other agencies (e.g., long-term care ombudsman; adult protective services; Medicaid fraud and abuse unit)?

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**C-0385**

**§483.15(f) Activities**

**(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.**

**(2) The activities program must be directed by a qualified professional who--**

**(i) Is a qualified therapeutic recreation specialist or an activities professional who--**

**(A) Is licensed or registered, if applicable, by the State in which practicing; and**

**(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or**

**(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or**

**(iii) Is a qualified occupational therapist or occupational therapy assistant; or**

**(iv) Has completed a training course approved by the State.**

### **Interpretive Guidelines §483.15(f)**

A “**recognized accrediting body**” refers to those organizations or associations recognized as such by certified therapeutic recreation specialists or certified activity professionals or registered occupational therapists.

The activities program should be multi-faceted and reflect individual resident’s needs on their care plan. Activities can occur at anytime and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers, and visitors.

**In a Critical Access Hospital**, the services at §483.15(f) may be directed either by a qualified professional meeting the requirements of §483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.

### **Survey Procedures §483.15(f)**

- Observe individual, group and bedside activities.
  - o Are residents who are confined or choose to remain in their rooms provided with suitable in-room activities (e.g., music, reading, visits with individuals who share their interests)? Do any facility staff members assist the resident with activities?
  - o If residents sit for long periods of time with no apparently meaningful activities, is the cause:
    - The resident’s choice;
    - Failure of any staff or volunteers either to inform residents when activities are occurring or to encourage resident involvement in activities;
    - Lack of assistance with ambulation;
  - o Lack of sufficient supplies and/or staff to facilitate attendance and participation in the activity programs; or
  - o Program design that fails to reflect the interests or ability levels of residents, such as activities that are too complex?
  - o For residents selected for review, determine to what extent the activities resident’s assessment.

- o Review the activity calendar for the month prior to the survey to determine if the formal activity program:
  - Reflects the schedules, choices and rights of the residents;
  - Offers activities at hours convenient to the residents (e.g., morning, afternoon, some evenings and weekends);
  - Reflects the cultural and religious interests of the resident population; and
  - Would appeal to both men and women and all age groups living in the facility.
- o Review clinical records and activity attendance records of residents to determine if:
  - Activities reflect individual resident history indicated by the comprehensive assessment;
  - Care plans address activities that are appropriate for each resident based on the comprehensive assessment;
  - Activities occur as planned; and
  - Outcomes/responses to activities interventions are identified in the progress notes of each resident.
- o If there are problems with provision of activities, determine if qualified staff provide these service.

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## **C-0386**

### **§483.15(g) Social Services**

**(1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.**

**(2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis.**

**(3) Qualifications of social worker. A qualified social worker is an individual with--**

**(i) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and**

**(ii) One year of supervised social work experience in a health care setting working directly with individuals.**

**Interpretive Guidelines §483.15(g)**

The intent of this regulation is to assure that all facilities provide for the medically-related social services needs of each resident. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. A qualified social worker need not personally provide all of these services. It is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate discipline.

**“Medically-related social services”** means services provided by the facility’s staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs. These services could include:

- Making arrangements for obtaining needed adaptive equipment, clothing, and personal items;
- Maintaining contact with family (with resident’s permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;
- Assisting staff to inform residents and those they designate about the resident’s health status and health care choices;
- Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);
- Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);
- Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);
- Providing or arranging provision of needed counseling services;

- Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions;
- Finding options that meet the physical and emotional needs of each resident;
- Meeting the needs of residents who are grieving; and
- Assisting residents with dental/denture care, podiatric care; eye care; hearing services, and obtaining equipment for mobility or assistive eating devices.

Where the Medicaid State Plan does not cover needed services, facilities are still required to attempt to obtain these services.

### **Survey Procedures §483.15(g)**

For residents selected for review:

- How do facility staff implement social services interventions to assist the resident in meeting treatment goals?
- How do staff that are responsible for social work monitor the resident's progress in improving physical, mental and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly?
- How does the care plan link goals to psychosocial functioning/well being?
- Has the staff responsible for social work established and maintained relationships with the resident's family or legal representative?
- What attempts does the facility make to access services for Medicaid recipients when a Medicaid State Plan does not cover those services?
- Look for evidence that social services interventions successfully address residents' needs and link social supports, physical care, and physical environment with residents' needs and individuality.

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## **C-0388**

### **§483.20 Resident Assessment**

**The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.**

**(b) Comprehensive assessment.**

**(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs. The assessment must include at least the following:**

- (i) Identification and demographic information.**
- (ii) Customary routine.**
- (iii) Cognitive patterns.**
- (iv) Communication.**
- (v) Vision.**
- (vi) Mood and behavior patterns.**
- (vii) Psychosocial well-being.**
- (viii) Physical functioning and structural problems.**
- (ix) Continence.**
- (x) Disease diagnoses and health conditions.**
- (xi) Dental and nutritional status.**
- (xii) Skin condition.**
- (xiii) Activity pursuit.**
- (xiv) Medications.**
- (xv) Special treatments and procedures.**
- (xvi) Discharge potential.**
- (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.**
- (xviii) Documentation of participation in assessment.**

**The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.**

### **Interpretive Guidelines §483.20(b)(1)**

The intent of this regulation is to provide the facility with ongoing assessment information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status. The facility is expected to use resident observation and communication as the primary source of information when completing the assessment. In addition to direct observation and communication with the resident, the facility should use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's MD/DO, family members, or outside consultants and review of the resident's record.

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### **C-0389**

**§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.**

**(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)**

### **Interpretive Guidelines §483.20(b)(2)**

The intent of this regulation is to assess residents in a timely manner.

**"Admission"** to the facility is defined as an initial stay or a return stay (not a readmission) in the facility. A "return stay" applies to those residents who are discharged without expectation that they will return to the facility, but who do return to the facility.

A **"readmission"** is an expected return to the facility following a temporary absence for hospitalization, off-site visit or therapeutic leave.

Items in (b)(2) of this section would include comprehensive assessments of a resident which were done within 14 days of admission; within 14 days of a significant change in the resident's physical or mental condition; or done on an annual review. These assessments need to be in the final discharge summary.

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### **C-0390**

**§483.20(b)(2)(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's**

**physical or mental condition. (For purposes of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both.)**

**(iii) Not less often than once every 12 months.**

#### **Interpretive Guidelines §483.20(b)(2)(ii)-(iii)**

A “**significant change**” may include, but is not limited to, any of the following, or may be determined by a MD/DO’s decision if uncertainty exists.

- Deterioration in two or more activities of daily living (ADLs), or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appear permanent. For example, pronounced deterioration in function and communication following a stroke.
- Loss of ability to ambulate freely or to use hands to grasp small objects to feed or groom oneself, such as spoon, toothbrush, or comb. Temporary loss of ability, such as during an acute illness, is not included.
- Deterioration in behavior or mood, to the point where daily problems arise or relationships have become problematic and staff conclude that these changes in the resident’s psychosocial status are not likely to improve without staff intervention.
- Deterioration in a resident’s health status, where this change places the resident’s life in danger (e.g., stroke, heart disease, metastatic cancer); where the change is associated with a serious clinical complication (e.g., initial development of a stage III pressure sore, prolonged delirious state, or recurrent decline in level of consciousness); or change that is associated with an initial diagnosis of a condition that is likely to affect the resident’s physical, mental, or psychosocial well-being over a prolonged period of time (e.g., Alzheimer’s disease or diabetes); or the onset of significant, unplanned weight loss (5% in the last 30 days, 10% in the last 180 days).

### **§483.20(k) Comprehensive Care Plans**

**(1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following--**

**(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and**

**(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).**

#### **Interpretive Guidelines §483.20(k)(1)**

An interdisciplinary team, in conjunction with the resident, resident's family, surrogate, or representative, as appropriate, should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain, based on the comprehensive assessment. The care plan must reflect intermediate steps for each outcome objective if identification of those steps will enhance the resident's ability to meet his/her objectives. Facility staff will use these objectives to follow resident progress. Facilities may, for some residents, need to prioritize needed care. This should be noted in the clinical record or on the plan of care.

The requirements reflect the facility's responsibility to provide necessary 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.

However, in some cases, a resident may wish to refuse certain services or treatments that professional staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being. Desires of the resident should be documented in the clinical record.

#### **Survey Procedures §483.20(k)(1)**

- Does the care plan address the needs, strengths and preferences identified in the comprehensive assessment?
- Is the care plan oriented toward preventing avoidable declines in functioning or functional levels?

- How does the care plan attempt to manage risk factors?
- Does the care plan build on resident strengths?
- Do treatment objectives have measurable outcomes?
- Does the care plan reflect standards of current professional practice?
- Corroborate information regarding the resident's goals and wishes for treatment in the plan of care by interviewing residents; especially those identified as refusing treatment.
- Determine whether the facility has provided adequate information to the resident so that the resident was able to make an informed choice regarding treatment.
- If the resident has refused treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem?

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## **C-0396**

### **§483.20(k)(2) A comprehensive care plan must be--**

- (i) Developed within 7 days after the completion of the comprehensive assessment;**
- (ii) Prepared by an interdisciplinary team, that includes the attending MD/DO, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and**
- (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.**

### **Interpretive Guidelines §483.20(k)(2)**

“**Interdisciplinary**” means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. It does not mean that every goal must have an interdisciplinary approach. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) are at the discretion of the facility.

The MD/DO must participate as part of the interdisciplinary team, and may arrange with the facility for alternative methods, other than attendance at care planning conferences, of providing his/her input, such as one-to-one discussions and conference calls.

The resident has the right to refuse specific treatments and to select among treatment options before the care plan is instituted. The facility should encourage residents, surrogates, and representatives to participate in care planning, including encouraging attendance at care planning conferences if they so desire.

**Survey Procedures §483.20(k)(2)**

- Was interdisciplinary expertise utilized to develop a plan to improve the resident's functional abilities?
  - o For example, did an occupational therapist design needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?
  - o Do the dietitian and the speech therapist determine, for example, the optimum textures and consistency for the resident's food that provide both a nutritionally adequate diet and effectively use oropharyngeal capabilities of the resident?
  - o Is there evidence of MD/DO involvement in development of the care plan (e.g., presence at care planning meetings, conversations with team members concerning the care plan, conference calls)?
- In what ways does staff involve residents and families, surrogate, and/or representatives in care planning?
- Does staff make an effort to schedule care plan meetings at the best time of the day for residents and their families?
- Do facility staff attempt to make the process understandable to the resident/family?
- Is the care plan evaluated and revised as the resident's status changes?
- Ask in your resident interviews, "Have you had concerns or questions about your care and brought them to the attention of facility staff?" If yes, "What happened as a result?"

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**C-0397****§483.20(k)(3) The services provided or arranged by the facility must--**

- (i) Meet professional standards of quality; and**

**Interpretive Guidelines §483.20(k)(3)(i)**

The intent of this regulation is to assure that persons providing services are qualified to do so, that the resident's plan of care is implemented, and that those services provided meet professional standards of quality and are provided by appropriate qualified persons (e.g., licensed, certified).

**“Professional standards of quality”** means services that are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting. Standards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency. Recommended practices to achieve desired resident outcomes might also be found in clinical literature.

**Survey Procedures §483.20(k)(3)(i)**

Question those practices that have a negative outcome or have a potential negative outcome.

- Do nurses notify MD/DOs, as appropriate, and show evidence of discussions of acute medical problems?
- Are residents with acute conditions promptly hospitalized, as appropriate?
- Are there errors in medication administration?
- Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and care plan?
- Are MD/DOs' orders carried out, unless otherwise indicated by an advanced directive?
- Can staff describe the care, services and expected outcomes of the care they provide?

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## C-0398

**§483.20(k)(3)(ii) Be provided by qualified persons in accordance with each resident's written plan of care.**

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## C-0399

### **§483.20(l) Discharge Summary**

**When the facility anticipates discharge a resident must have a discharge summary that includes--**

- (1) A recapitulation of the resident's stay;**
- (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and**
- (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.**

#### **Interpretive Guidelines §483.20(l)**

The intent of this regulation is to ensure appropriate discharge planning and communication of necessary information to the continuing care provider.

**“Post discharge plan of care”** means the discharge planning process that includes assessing continuing care needs and developing a plan designed to ensure that the individual's needs will be met after discharge from the facility into the community.

When the facility **“anticipates discharge”** the discharge is not an emergency discharge (e.g., hospitalization for an acute condition) and is not due to the resident's death.

**“Adjust to his or her living environment”** means that the post discharge plan should describe the resident's and family's preferences for care, how the resident and family will access these services, and how care should be coordinated if continuing treatment involves multiple care givers. It should identify specific resident needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe resident/care giver education needs to ensure the resident/care giver is able to meet care needs after discharge.

## Survey Procedures §483.20(1)

- Does the discharge summary have information pertinent to continuing care for the resident?
- Is there evidence of discharge planning in the records of discharged residents who had an anticipated discharge or those residents to be discharged shortly (e.g., in the next 7-14 days)?
- Do discharge plans address necessary post discharge care?
- Has the facility aided the resident and his/her family in locating and coordinating post discharge services?
- What types of pre-discharge preparation and education has the facility provided the resident and his/her family?

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## C-0400

### §483.25(i) Nutrition

**Based on a resident's comprehensive assessment, the facility must ensure that a resident:**

**(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and**

#### **Interpretive Guidelines §483.25(i)(1)**

Parameters of nutritional status that are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels).

Weight: Since ideal body weight charts have not yet been validated for the institutionalized elderly, weight loss (or gain) is a guide in determining nutritional status. An analysis of weight loss or gain should consider the loss or gain in light of the individual's former life style as well as the current diagnosis.

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**C-0401****§483.25(i)(2) Receives a therapeutic diet when there is a nutritional problem.****Interpretive Guidelines §483.25(i)(2)**

Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

<b>Interval</b>	<b>Significant Loss</b>	<b>Severe Loss</b>
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

The following formula determines percentage of loss:

$$\% \text{ of body weight loss} = (\text{usual weight} - \text{actual weight} \times 100) \text{ divided by usual weight}$$

In evaluating weight loss, consider the resident's usual weight through adult life; the assessment of potential for weight loss; and care plan for weight management. Also, was the resident on a calorie restricted diet, or if newly admitted and obese, and on a normal diet, are fewer calories provided than prior to admission? Was the resident edematous when initially weighed, and with treatment, no longer has edema? Has the resident refused food?

Suggested laboratory values are:

Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion) Plasma Transferrin >60 yr.: 180 - 380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.)

Hemoglobin	Males	14-17 g/dl
	Females:	12-15 g/dl
Hematocrit	Males:	41 - 53
	Females	36 - 46
Potassium	3.5 - 5.0 mEq/L	
Magnesium	1.3 - 2.0 mEq/L	

Some laboratories may have different "normals." Determine range for the specific laboratory. Because some healthy elderly people have abnormal laboratory values, and because abnormal values can be expected in some disease processes, do not expect

laboratory values to be within normal ranges for all residents. Consider abnormal values in conjunction with the resident's clinical condition and baseline normal values.

**NOTE:** There is no requirement that facilities order the tests referenced above.

**Clinical Observations:** Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, and swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting.

Risk factors for malnutrition are--

- Drug therapy that may contribute to nutritional deficiencies such as--
  - o Cardiac glycosides;
  - o Diuretics;
  - o Anti-inflammatory drugs;
  - o Antacids (antacid overuse);
  - o Laxatives (laxative overuse);
  - o Psychotropic drug overuse;
  - o Anticonvulsants;
  - o Antineoplastic drugs;
  - o Phenothiazines;
  - o Oral hypoglycemics;
- Poor oral health status or hygiene, eyesight, motor coordination, or taste alterations;
- Depression or dementia;
- Therapeutic or mechanically altered diet;
- Lack of access to culturally acceptable foods;
- Slow eating pace resulting in food becoming unpalatable, or in staff removing the tray before resident has finished eating; and
- Cancer.

Clinical conditions demonstrating that the maintenance of acceptable nutritional status may not be possible include, but are not limited to--

- Refusal to eat and refusal of other methods of nourishment;
- Advanced disease (i.e., cancer, malabsorption syndrome);
- Increased nutritional/caloric needs associated with pressure sores and wound healing (e.g., fractures, burns);
- Radiation or chemotherapy;
- Kidney disease, alcohol/drug abuse, chronic blood loss, hyperthyroidism;
- Gastrointestinal surgery; and
- Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice.

“Therapeutic diet” means a diet ordered by a MD/DO as part of treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet, (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food the resident is able to eat (e.g., a mechanically altered diet).

#### **Survey Procedures §483.25(i)(2)**

Determine if residents selected for a comprehensive review, or focused review as appropriate, have maintained acceptable parameters of nutritional status. Where indicated by the resident’s medical status, have clinically appropriate therapeutic diets been prescribed?

For sampled residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable--

- Did the facility identify factors that put the resident at risk for malnutrition?
- What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition (e.g., provision of an adequate diet with supplements or modifications as indicated by nutrient needs)?
- Were staff responsibilities for maintaining nutritional status clear, including monitoring the amount of food the resident is eating at each meal and offering substitutes?
- Was this care provided consistently?

- Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?

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## C-0402

### §483.45 Specialized Rehabilitative Services

#### §483.45(a) Provision of Services

If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must--

(1) Provide the required services; or

(2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

#### Interpretive Guidelines §483.45(a)

The intent of this regulation is to assure that residents receive necessary specialized rehabilitative services as determined by the comprehensive assessment and care plan, to prevent avoidable physical and mental deterioration and to assist them in obtaining or maintaining their highest practicable level of functional and psychosocial well being.

Specialized rehabilitative services are considered a facility service and are included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services.

A facility is not obligated to provide **specialized rehabilitative services** if it does not have residents who require these services. If a resident develops a need for these services after admission, the facility must either provide the services, or, where appropriate, obtain the service from an outside resource.

For a resident with mental illness (MI) or mental retardation (MR) to have his or her specialized needs met, the individual must receive all services necessary to assist the individual in maintaining or achieving as much independence and self determination as possible. Specialized services for mental illness or mental retardation refers to those services to be provided by the State which can only be delivered by personnel or programs other than those of the nursing facility (NF) because the overall level of NF services is not as intense as necessary to meet the individuals needs.

“Mental health **rehabilitative services** for MI and MR” refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff who come into contact with the resident who is mentally ill or who has mental retardation. These services are necessary regardless of whether or not they require additional services to be provided for or arranged by the State as specialized services.

Mental health rehabilitative services for MI and MR may include, but are not limited to—

- Consistent implementation during the resident’s daily routine and across settings, of systematic plans that are designed to change inappropriate behaviors;
- Drug therapy and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness;
- Provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal);
- Development, maintenance and consistent implementation across settings of those programs designed to teach individuals the daily living skills they need to be more independent and self determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skills, health, drug therapy, mental health education, money management, and maintenance of the living environment;
- Crisis intervention services;
- Individual, group, and family psychotherapy;
- Development of appropriate personal support networks; and
- Formal behavior modification progress.

### **Survey Procedures §483.45(a)**

Determine the extent of follow through with the comprehensive care plan. Verify from the chart that the resident is receiving frequency and type of therapy as outlined in the care plan.

#### **1. Physical Therapy**

- What did the facility do to improve the resident’s muscle strength? The resident’s balance?

- What did the facility do to determine if an assistive device would enable the resident to reach or maintain his/her highest practicable level of physical function?
- If the resident has an assistive device, is he/she encouraged to use it on a regular basis?
- What did the facility do to increase the amount of physical activity the resident could do (for example, the number of repetitions of an exercise, the distance walked)?
- What did the facility do to prevent or minimize contractures, which could lead to decreased mobility and increased risk of pressure ulcer occurrence?

## **2. Occupational Therapy**

- What did the facility do to decrease the amount of assistance needed to perform a task?
- What did the facility do to decrease behavioral symptoms?
- What did the facility do to improve gross and fine motor coordination?
- What did the facility do to improve sensory awareness, visual-spatial awareness, and body integration?
- What did the facility do to improve memory, problem solving, attention span, and the ability to recognize safety hazards?

## **3. Speech, Language Pathology**

- What did the facility do to improve auditory comprehension?
- What did the facility do to improve speech production?
- What did the facility do to improve expressive behavior?
- What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received an audiology evaluation?
- For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication?

#### **4. Rehabilitative Services For MI And MR**

- What did the facility do to decrease incidents of inappropriate behaviors, for individuals with MR, or behavioral symptoms for persons with MI? To increase appropriate behavior?
- What did the facility do to identify and treat the underlying factors behind tendencies toward isolation and withdrawal?
- What did the facility do to develop and maintain necessary daily living skills?
- How has the facility modified the training strategies it uses with its residents to account for the special learning needs of its residents with MI or MR?
- Questions to ask individuals with MI or MR--
  - o Who do you talk to when you have a problem or need something?
  - o What do you do when you feel happy? Sad? Can't sleep at night?
  - o In what activities are you involved, and how often?

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### **C-0403**

#### **§483.45(b) Qualifications**

**Specialized rehabilitative services must be provided under the written order of a MD/DO by qualified personnel.**

#### **Interpretive Guidelines §483.45(b)**

A qualified professional provides specialized rehabilitative services for individuals under a MD/DO's order. Once the assessment for specialized rehabilitative services is completed, a care plan must be developed, followed, and monitored by a licensed professional. Once a resident has met his or her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative aides will follow to maintain functional and physical status.

**“Qualified personnel”** means that professional staff are licensed, certified or registered to provide specialized therapy/rehabilitative services in accordance with applicable State laws. Health rehabilitative services for MI and MR must be implemented consistently by all staff unless the nature of the services is such that they are designated or required to be implemented only by licensed or credentialed personnel.

## **Survey Procedures §483.45(b)**

- Determine if there are any problems in quality of care related to maintaining or improving functional abilities. Determine if these problems are attributable in part to the qualifications of specialized rehabilitative services staff.
- Determine from the care plan and record that qualified personnel provide rehabilitative services under the written order of a MD/DO. If a problem in a resident's rehabilitative care is identified that is related to the qualifications of the care providers, it might be necessary to validate the care provider's qualifications.
- If the facility does not employ professional staff who have experience working directly with or designing training or treatment programs to meet the needs of individuals with MI or MR, how has the facility arranged for the necessary direct or staff training services to be provided?

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## **C-0404**

### **§483.55 Dental Services**

**The facility must assist residents in obtaining routine and 24-hour emergency dental care.**

#### **Interpretive Guidelines §483.55**

This requirement makes the facility directly responsible for the dental care needs of its residents. The facility must ensure that a dentist is available for residents. It can satisfy this requirement by employing a staff dentist or having a contract/arrangement with a dentist to provide services.

For Medicare and private pay residents, facilities are responsible for having the services available, but they may impose an additional charge for the services. Medicaid residents may not be charged.

For all residents of the facility, if they are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems so that the resident is able to maintain his/her highest practicable level of well being.

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## **C-0405**

### **§483.55(a) Skilled Nursing Facilities**

**A facility--**

**(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident;**

**(2) May charge a Medicare resident an additional amount for routine and emergency dental services;**

#### **Interpretive Guidelines §483.55(a)(1-2)**

**“Routine dental services”** means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures (e.g., taking impressions for dentures and fitting dentures).

**“Emergency dental services”** includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that requires immediate attention.

**“Prompt referral”** means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.

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## **C-0406**

**§483.55(a)(3) Must if necessary, assist the resident--**

**(i) In making appointments; and**

**(ii) By arranging for transportation to and from the dentist’s office; and**

**(4) Promptly refer residents with lost or damaged dentures to a dentist.**

#### **Survey Procedures §483.55(a)(3-4)**

- Do residents selected for comprehensive or focused reviews, as appropriate, with dentures, use them?

- Are residents missing teeth and may be in need of dentures?
- Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene?
- Are resident's dentures intact? Properly fitted?

**NOTE:** §483.55(b) Nursing Facilities does not usually apply to Medicare reimbursed swing-bed residents because Medicare swing-bed residents receive skilled nursing care comparable to services provided in a SNF not a NF. If a swing-bed resident is a NF level patient, apply standard §483.55(b) as appropriate.

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## **C-0407**

### **§483.55(b) Nursing Facilities**

#### **The facility**

**(1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident:**

- (i) Routine dental service (to the extent covered under the State plan); and**
- (ii) Emergency dental services;**

#### **Interpretive Guidelines §483.55(b)(1)**

**“Routine dental services”** means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor dental plate adjustments, smoothing of broken teeth, and limited prosthodontic procedures (e.g., taking impressions for dentures and fitting dentures).

**“Emergency dental services”** includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that requires immediate attention.

**“Prompt referral”** means, within reason, as soon as the dentures are lost or damaged. Referral does not mean that the resident must see the dentist at that time, but does mean that an appointment (referral) is made, or that the facility is aggressively working at replacing the dentures.

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**C-0408**

**§483.55(b)(2) Must, if necessary, assist the resident--**

**(i) In making appointments; and**

**(ii) By arranging for transportation to and from the dentist's office; and**

**(3) Must promptly refer residents with lost or damaged dentures to a dentist.**

**Survey Procedures §483.55(b)(2-3)**

- Do residents selected for comprehensive or focused reviews, as appropriate, with dentures, use them?
- Are residents missing teeth and may be in need of dentures?
- Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene?
- Are resident's dentures intact? Properly fitted?

## Transmittals Issued for this Appendix

<b>Rev #</b>	<b>Issue Date</b>	<b>Subject</b>	<b>Impl Date</b>	<b>CR#</b>
<a href="#">R49SOM</a>	06/12/2009	New Critical Access Hospital (CAH) Requirements Under 42 CFR 485.610(e) Related to CAH Co-location and CAH Provider-based Locations	06/12/2009	N/A
<a href="#">R34SOM</a>	04/04/2008	Revision to Appendix W, "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs)"	04/04/2008	N/A
<a href="#">R32SOM</a>	01/18/2008	Revisions to Chapter 2, "Critical Access Hospitals (CAHs) and Appendix W, "Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs"	09/2007	N/A
<a href="#">R01SOM</a>	05/21/2004	Initial Release of Pub 100-07	N/A	N/A