Emergency Management (EM) Chapter

EM.01.01.01

The critical access hospital engages in planning activities prior to developing its written Emergency Operations Plan.

Note: An emergency is an unexpected or sudden event that significantly disrupts the organization’s ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization’s services. Emergencies can be either human-made (for example, an electrical system failure or cyberattack) or natural (for example, a tornado or an infectious disease outbreak such as Ebola, Zika, influenza), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety, or security functions.

Element(s) of Performance for EM.01.01.01

4. The critical access hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community’s capability to meet its needs. This communication and identification occur at the time of the critical access hospital’s annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1)

4. The critical access hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community’s capability to meet its needs. This communication and identification occur at the time of the critical access hospital’s review of its Emergency Operations Plan, which occurs at least every two years and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1)

EM.02.01.01

Key: ☐ indicates that documentation is required; ☐ indicates an identified risk area;
The critical access hospital has an Emergency Operations Plan. Note: The critical access hospital's Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This all-hazards approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan’s response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

**Element(s) of Performance for EM.02.01.01**

16. The critical access hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated on an annual basis; the format of these documents is at the discretion of the critical access hospital.

16. The critical access hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated at least every two years; the format of these documents is at the discretion of the critical access hospital.

**EM.02.02.01**

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will communicate during emergencies.

**Element(s) of Performance for EM.02.02.01**

22. The critical access hospital maintains documentation of completed and attempted contact with the local, state, tribal, regional, and federal emergency preparedness officials in its service area. This contact is made for the purpose of communication and, where possible, collaboration on coordinated response planning for a disaster or emergency situation. Note: Examples of these contacts may be written or e-mail correspondence; in-person meetings or conference calls; regular participation in health care coalitions, working groups, boards, and committees; or educational events sponsored by a third party (such as a local or state health department).

22. The critical access hospital has a process for cooperation and collaboration with the local, state, tribal, regional, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

**EM.02.02.07**

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage staff during an emergency.

**Element(s) of Performance for EM.02.02.07**

Key: D indicates that documentation is required; R indicates an identified risk area;
13. Initial and ongoing training relevant to their emergency response roles is provided to staff, volunteers, and individuals providing on-site services under arrangement. This training is documented and then reviewed and updated annually and when these roles change. Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

13. The critical access hospital provides emergency preparedness training to staff, volunteers, and individuals providing on-site services under arrangement at the following intervals:
- Initial training
- At least every two years
- When roles or responsibilities change
- When policies and procedures are significantly updated
This training is documented.
Note: Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

21. The critical access hospital has an emergency preparedness training program based on its Emergency Operations Plan. This training program is reviewed and updated at least every two years.

EM.03.01.01

The critical access hospital evaluates the effectiveness of its emergency management planning activities.

Element(s) of Performance for EM.03.01.01

1. The critical access hospital conducts an annual review of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (See also EM.01.01.01, EPs 2 and 4)

1. The critical access hospital conducts a review at least every two years of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (See also EM.01.01.01, EPs 2 and 4)

2. The critical access hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.

2. The critical access hospital conducts a review at least every two years of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.

Key: D indicates that documentation is required; R indicates an identified risk area;
4. The annual emergency management planning reviews are forwarded to senior critical access hospital leadership for review. (See also LD.04.01.10, EP 2)
   Note: Senior critical access hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The critical access hospital may determine that all senior critical access hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior critical access hospital leaders to review this information.

4. At least every two years, the emergency management planning reviews are forwarded to senior critical access hospital leadership for review. (See also LD.04.01.10, EP 2)
   Note: Senior critical access hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The critical access hospital may determine that all senior critical access hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior critical access hospital leaders to review this information.

EM.03.01.03
The critical access hospital evaluates the effectiveness of its Emergency Operations Plan.

Element(s) of Performance for EM.03.01.03

1. As an emergency response exercise, the critical access hospital activates its Emergency Operations Plan twice a year at each site included in the Plan.
   Note 1: If the critical access hospital activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.
   Note 2: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code*) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.
   Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.
   Note 4: In order to satisfy the twice-a-year requirement, the critical access hospital must first evaluate the performance of the previous exercise and make any needed modifications to its Emergency Operations Plan before conducting the subsequent exercise in accordance with EPs 13–17.
   Footnote*: The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2012 for occupancy classifications.

2. For each site of the critical access hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the critical access hospital’s two emergency response exercises includes an influx of simulated patients.
   Note 1: Tabletop sessions, though useful, cannot serve for this portion of the exercise.
   Note 2: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.

3. For each site of the critical access hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the critical access hospital’s two emergency response exercises includes an escalating event in which the local community is unable to support the critical access hospital.
   Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 4.
   Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.
3. The critical access hospital conducts exercises to test the emergency plan at least twice per year.

   The first annual exercise is selected from one of the following:
   - A full-scale, community-based exercise
   - When a community-based exercise is not possible, a facility-based, functional exercise

   The second annual exercise includes, but is not limited to, one of the following:
   - A second full-scale, community-based exercise
   - A second facility-based, functional exercise
   - Mock disaster drill
   - Tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan

   Note 1: If the critical access hospital experiences an actual emergency (natural or man-made) that requires activation of the emergency plan, the critical access hospital is exempt from engaging in its next required full-scale, community-based exercise or facility-based, functional exercise following the onset of the emergency event.
   Note 2: See the Glossary for the definitions of community-based exercise, full-scale exercise, and functional exercise.

4. For each site of the critical access hospital with a defined role in its community’s response plan, at least one of the two emergency response exercises includes participation in a communitywide exercise.
   Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 3.
   Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.

**EM.04.01.01**

If the critical access hospital is part of a health care system that has an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the critical access hospital participates in planning, preparedness, and response activities with the system.

**Element(s) of Performance for EM.04.01.01**
1. **The critical access hospital demonstrates its participation in the development of its system’s integrated emergency preparedness program through the following:**
   - Designation of a staff member(s) who will collaborate with the system in developing the program
   - Documentation that the critical access hospital has reviewed the community-based risk assessment developed by the system’s integrated all-hazards emergency management program
   - Documentation that the critical access hospital’s individual risk assessment is incorporated into the system’s integrated program
   - Documentation that the critical access hospital’s patient population, services offered, and any unique circumstances of the hospital are reflected in the system’s integrated program
   - Documentation of an integrated communication plan, including information on key contacts in the system’s integrated program
   - Documentation that the critical access hospital participates in the annual review of the system’s integrated program

**Human Resources (HR) Chapter**

**HR.01.01.01**

The critical access hospital defines and verifies staff qualifications.

**Element(s) of Performance for HR.01.01.01**
17. For swing beds in critical access hospitals: The activities program is directed by a professional who meets one of the following criteria:

- Is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which he or she practices and 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
- Has two years of experience in a social or recreational program within the last five years, one year of which was full-time in a patient activities program in a health care setting
- Is a qualified occupational therapist or occupational therapy assistant
- Has completed a training course approved by the state

Note: The services described in the CoP from 42 CFR 485.15(f) may be directed either by a qualified professional meeting the requirements of 42 CFR 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.

Infection Prevention and Control (IC) Chapter

IC.01.01.01

The critical access hospital identifies the individual(s) responsible for the infection prevention and control program.

Element(s) of Performance for IC.01.01.01

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The individual with clinical authority over the infection prevention and control program is responsible for the following:

- Developing policies governing control of infections and communicable diseases
- Implementing policies governing control of infections and communicable diseases
- Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases

4. The individual with clinical authority over the infection prevention and control program is responsible for the following:

- Developing and implementing hospital-wide infection surveillance, prevention and control policies and procedures that adhere to nationally recognized guidelines
- Documenting the infection prevention and control program surveillance, prevention, and control activities
- Communicating and collaborating with the quality assessment and performance improvement program on infection prevention and control issues
- Training and educating staff, including medical staff, on the practical applications of infection prevention and control guidelines, policies, and procedures
- Preventing and controlling health care–associated infections, including auditing of adherence to infection prevention and control policies and procedures by hospital staff, including medical staff
- Communicating and collaborating with the antibiotic stewardship program

6. An individual(s) who is qualified through education, training, experience, or certification in infection, prevention, and control is appointed by the governing body to be responsible for the infection, prevention, and control program. The appointment is based on recommendations of medical staff leadership and nursing leadership.

Key: ☐ indicates that documentation is required; ☐ indicates an identified risk area;
Leadership (LD) Chapter

LD.01.02.01

The critical access hospital identifies the responsibilities of its leaders.

**Element(s) of Performance for LD.01.02.01**

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The chief executive officer, medical staff, and nurse executive make certain that the critical access hospitalwide quality assessment and performance improvement and training programs address problems identified by the individual responsible for infection prevention and control and that corrective action plans are successfully implemented. (See also IC.03.01.01, EP 7)

LD.04.01.07

The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.

**Element(s) of Performance for LD.04.01.07**

7. The critical access hospital’s policies are reviewed at least annually by the group of professional personnel required under LD.04.01.07, EP 6, and reviewed as necessary by the critical access hospital.

LD.04.02.03

Ethical principles guide the critical access hospital’s business practices.

**Element(s) of Performance for LD.04.02.03**

23. The critical access hospital discloses the names and addresses of the following:
   - Its owners, or those with controlling interest in the critical access hospital, or in any subcontractor in which the critical access hospital directly or indirectly has a 5% or more ownership interest, in accordance with subpart C of 42 CFR Part 420
   - The person principally responsible for the operation of the critical access hospital
   - The person responsible for medical direction of the critical access hospital

23. The critical access hospital discloses the names and addresses of the following:
   - The person principally responsible for the operation of the critical access hospital
   - The person responsible for medical direction of the critical access hospital

Medication Management (MM) Chapter

MM.05.01.07

The critical access hospital safely prepares medications.

**Element(s) of Performance for MM.05.01.07**

Key: ☑ indicates that documentation is required; ☑ ☐ indicates an identified risk area;
5. For rehabilitation and psychiatric distinct part units in critical access hospitals: Medications are prepared and administered in accordance with the orders of a licensed independent practitioner or other practitioner responsible for the patient’s care, and in accordance with critical access hospital policies; medical staff bylaws, rules, and regulations; and law and regulation. * Footnote *: For law and regulation guidance pertaining to those responsible for the care of patients, refer to 42 CFR 482.12(e).

MM.09.01.01

The critical access hospital has an antimicrobial stewardship program based on current scientific literature.

Element(s) of Performance for MM.09.01.01

7. The critical access hospital collects, analyzes, and reports data on its antimicrobial stewardship program. Note: Examples of topics on which to collect and analyze data may include evaluation of the antimicrobial stewardship program, antimicrobial prescribing patterns, and antimicrobial resistance patterns.

7. The critical access hospital collects, analyzes, and reports data on its antimicrobial stewardship program. Note 1: Examples of topics on which to collect and analyze data may include evaluation of the antimicrobial stewardship program, antimicrobial prescribing patterns, and antimicrobial resistance patterns. Note 2: The antibiotic stewardship program documents the evidence-based use of antibiotics in all departments and services of the critical access hospital.

9. An individual(s) who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program. The appointment is based on recommendations of medical staff leadership and pharmacy leadership.

10. The antibiotic stewardship program demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.
11. The leader of the antibiotic stewardship program is responsible for the following:
- Developing and implementing a hospitalwide antibiotic stewardship program, based on
  nationally recognized guidelines, to monitor and improve the use of antibiotics
- Documenting antibiotic stewardship activities
- Communicating and collaborating with the medical staff, nursing, and pharmacy leadership, as
  well as with the critical access hospital’s infection prevention and control and quality
  assessment and performance improvement programs on antibiotic use issues
- Training and educating staff, including medical staff, on the practical applications of antibiotic
  stewardship guidelines, policies, and procedures

Medical Staff (MS) Chapter

**MS.01.01.01**

Medical staff bylaws address self-governance and accountability to the governing body.

**Element(s) of Performance for MS.01.01.01**

16. For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff bylaws
include the following requirements, in accordance with Element of Performance 3: The requirements for
completing and documenting medical histories and physical examinations. The medical history and
physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or
other qualified licensed individual in accordance with state law and hospital policy. (For more
information on performing the medical history and physical examination, refer to MS.03.01.01, EPs
6–10.)

Note 1: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid
Services (CMS) (refer to the Glossary).

Note 2: The requirements referred to in this element of performance are, at a minimum, those described
in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

38. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the
medical staff has chosen to allow an assessment, in lieu of a comprehensive medical history
and physical examination, for patients receiving specific outpatient surgical or procedural
services, the medical staff bylaws specify that an assessment of the patient is completed and
documented after registration, but prior to surgery or a procedure requiring anesthesia services,
when the patient is receiving specific outpatient surgical or procedural services.

Note: For law and regulation guidance pertaining to the medical history and physical
examination, refer to 42 CFR 482.22(c)(5)(i), (ii), (iii), and (v). Refer to “Appendix A: Medicare
Requirements for Hospitals” (AXA) for full text.
MS.03.01.01
The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

**Element(s) of Performance for MS.03.01.01**

19. For rehabilitation and psychiatric distinct part units in critical access hospitals: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following:
- Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure
- Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures
- Applicable state and local health and safety laws
Note: For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text.

MS.05.01.01
The organized medical staff has a leadership role in organization performance improvement activities to improve patient safety and the quality of care, treatment, and services.

**Element(s) of Performance for MS.05.01.01**

17. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the critical access hospital intends to perform.
Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Nursing (NR) Chapter

NR.02.03.01
The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).

**Element(s) of Performance for NR.02.03.01**

7. For rehabilitation and psychiatric distinct part units in critical access hospitals: A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week.
Note: A registered nurse is immediately available for the provision of bedside care of any patient.

7. For rehabilitation and psychiatric distinct part units in critical access hospitals: A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week.
Note: A registered nurse is immediately available for the provision of care of any patient.

Key: □ indicates that documentation is required; R indicates an identified risk area;
Provision of Care, Treatment, and Services (PC) Chapter

**PC.01.02.03**

The critical access hospital assesses and reassesses the patient and his or her condition according to defined time frames.

**Element(s) of Performance for PC.01.02.03**

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

**Note 1:** For rehabilitation and psychiatric distinct part units in critical access hospitals: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.

**Note 2:** For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(ii) and 482.51(b)(1)(iii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text.

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient’s condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient’s condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

**Note 1:** For rehabilitation and psychiatric distinct part units in critical access hospitals: Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.

**Note 2:** For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(ii). Refer to “Appendix A: Medicare Requirements for Hospitals” (AXA) for full text.

**PC.02.01.03**

The critical access hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

**Element(s) of Performance for PC.02.01.03**

**Key:** ☐ indicates that documentation is required; ☒ indicates an identified risk area;
1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Prior to providing care, treatment, and services, the critical access hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; critical access hospital policies; and medical staff bylaws, rules, and regulations. 
Note 1: Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:
- Responsible for the care of the patient
- Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
- Acting within his or her scope of practice under state law
- Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services
Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: Patient diets, including therapeutic diets, are ordered by the practitioner responsible for the patient’s care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.
Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

PC.02.02.01

The critical access hospital coordinates the patient’s care, treatment, and services based on the patient’s needs.

Element(s) of Performance for PC.02.02.01

8. For swing beds in critical access hospitals: The critical access hospital provides activity services directly or through referral for ambulatory and nonambulatory residents at various functional levels.
12. For swing beds in critical access hospitals: The critical access hospital provides 24-hour emergency dental services directly or through arrangement with an external provider.

Note 1: The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.

Note 2: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan.

12. For swing beds in critical access hospitals: The critical access hospital assists residents who are eligible and wish to apply for reimbursement of dental services as an incurred medical expense under the state plan. The critical access hospital may charge a Medicare resident an additional amount for routine and emergency dental services.

PC.03.05.05

For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.

Element(s) of Performance for PC.03.05.05

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care orders the use of restraint or seclusion in accordance with critical access hospital policy and law and regulation.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician or other authorized licensed practitioner responsible for the patient’s care orders the use of restraint or seclusion in accordance with critical access hospital policy and law and regulation.

5. For rehabilitation and psychiatric distinct part units in critical access hospitals: Unless state law is more restrictive, every 24 hours, a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with critical access hospital policy and law and regulation.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

5. For rehabilitation and psychiatric distinct part units in critical access hospitals: Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed practitioner responsible for the patient’s care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with critical access hospital policy and law and regulation.

PC.03.05.07

For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital monitors patients who are restrained or secluded.

Key:  indicates that documentation is required;  indicates an identified risk area;
Element(s) of Performance for PC.03.05.07

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians, clinical psychologists, or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EPs 2 and 3)

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians, other licensed practitioners, or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EPs 2 and 3)

PC.03.05.09

For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has written policies and procedures that guide the use of restraint or seclusion.

Element(s) of Performance for PC.03.05.09

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital’s policies and procedures regarding restraint or seclusion include the following:
   - Physician, clinical psychologist, and other authorized licensed independent practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
   - The requirement that restraint or seclusion is discontinued as soon as is safely possible
   - A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C)
   - A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii)
   - A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B)
   - A determination of who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion

Note 1: The definition of restraint per 42 CFR 482.13(e)(1)(i)(A–C) is as follows:
42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is— ) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.
42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Note 2: The definition of seclusion per 42 CFR 482.13(e)(1)(ii) is as follows:
Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

Key: indicates that documentation is required; indicates an identified risk area;
Note 3: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital's policies and procedures regarding restraint or seclusion include the following:
   - Physician and other licensed practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
   - The requirement that restraint or seclusion is discontinued as soon as is safely possible
   - A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C)
   - A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii)
   - A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B)
   - A determination of who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion

Note 1: The definition of restraint per 42 CFR 482.13(e)(1)(i)(A–C) is as follows:
42 CFR 482.13(e)(1) Definitions. (i) A restraint is—(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is—) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Note 2: The definition of seclusion per 42 CFR 482.13(e)(1)(ii) is as follows:
Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through critical access hospital policy in accordance with law and regulation) have a working knowledge of the critical access hospital policy regarding the use of restraint and seclusion.

Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians and other licensed practitioners authorized to order restraint or seclusion (through critical access hospital policy in accordance with law and regulation) have a working knowledge of the critical access hospital policy regarding the use of restraint and seclusion.

PC.03.05.11

Key: [D] indicates that documentation is required; [R] indicates an identified risk area;
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.

**Element(s) of Performance for PC.03.05.11**

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.

   Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

   Note 1: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

   1. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician or other licensed practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.

   Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

   2. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or physician assistant, he or she consults with the attending physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by critical access hospital policy.

   Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

   2. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse, he or she consults with the attending physician or other licensed practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by critical access hospital policy.

**PC.03.05.19**

For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital reports deaths associated with the use of restraint and seclusion.

**Element(s) of Performance for PC.03.05.19**
3. For rehabilitation and psychiatric distinct part units in critical access hospitals: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the critical access hospital does the following:
- Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
- Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
- Documents in the patient record the date and time that the death was recorded in the log or other system
- Documents in the log or other system the patient’s name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es)
- Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request

Footnote *: For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).

PC.04.01.01

The critical access hospital follows a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

**Element(s) of Performance for PC.04.01.01**

Key: ③ indicates that documentation is required; ④ indicates an identified risk area;
22. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient or the patient’s family of his or her freedom to choose among participating Medicare providers and, when possible, respects the patient’s and family’s preferences when they are expressed. The critical access hospital does not limit the qualified providers that are available to the patient.

22. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient or the patient’s representative of his or her freedom to choose among participating Medicare providers and suppliers of post-discharge services and, when possible, respects the patient’s or patient representative’s goals of care and treatment preferences, as well as other preferences when they are expressed. The critical access hospital does not limit the qualified providers who are available to the patient.

23. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the discharge planning evaluation indicates a need for home health care, the critical access hospital includes in the discharge plan a list of participating Medicare home health agencies (which have requested to be on the list) that are available and serve the patient’s geographic area. For patients enrolled in managed care organizations, the critical access hospital lists home health agencies that have a contract with the managed care organization.

24. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the discharge planning evaluation indicates a need for posthospital extended care services, the critical access hospital includes in the discharge plan a list of participating Medicare skilled nursing facilities that are available and in the geographic area requested by the patient. For patients enrolled in managed care organizations, the critical access hospital lists skilled nursing facilities that have a contract with the managed care organization.

25. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents in the patient’s medical record that the list of home health agencies or skilled nursing facilities was presented to the patient or to the individual acting on the patient’s behalf. The discharge plan identifies disclosable financial interests between the critical access hospital and any home health agency or skilled nursing facility on the list.

Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420.206.

25. For rehabilitation and psychiatric distinct part units in critical access hospitals: The discharge plan identifies any home health agency or skilled nursing facility in which the critical access hospital has a disclosable financial interest, and any home health agency or skilled nursing facility that has a disclosable financial interest in a critical access hospital.

Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420, subpart C and section 1861 of the Social Security Act.

26. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has written discharge planning policies and procedures applicable to all patients.

26. The critical access hospital has written discharge planning policies and procedures applicable to all patients.
31. The critical access hospital assists patients, their families, or the patient’s representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, home health agency, skilled nursing facility, inpatient rehabilitation facility, and long term care hospital data on quality measures and resource-use measures. The critical access hospital makes certain that the post-acute care data on quality measures and resource-use measures is relevant and applicable to the patient’s goals of care and treatment preferences.

33. For rehabilitation and psychiatric distinct part units in critical access hospitals: For patients enrolled in managed care organizations, the critical access hospital makes patients aware of the need to verify with their managed care organization which practitioners, providers, or certified suppliers are in the managed care organization’s network. If the critical access hospital has information on which practitioners, providers, or certified suppliers are in the network of the patient’s managed care organization, it shares this information with the patient or the patient’s representative.

PC.04.01.03

The critical access hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.

Element(s) of Performance for PC.04.01.03

7. The critical access hospital has an effective discharge planning process that focuses on the patient’s goals and treatment preferences and includes the patient and his or her caregiver or support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process is consistent with the patient’s goals for care and his or her treatment preferences, makes certain that there is an effective transition of the patient from the hospital to post-discharge care, and reduces the factors leading to preventable critical access hospital readmissions.

10. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital conducts reassessments of its discharge planning process within its established time frames for reassessment.

10. The critical access hospital assesses its discharge planning process within its established time frames. The assessment includes ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to make certain that the plans are responsive to patient post-discharge needs.

11. For rehabilitation and psychiatric distinct part units in critical access hospitals: The reassessment of the discharge planning process includes an audit of discharge plans to determine if the discharge plans meet the needs of patients.

Record of Care, Treatment, and Services (RC) Chapter

RC.02.01.01

The medical record contains information that reflects the patient’s care, treatment, and services.

Element(s) of Performance for RC.02.01.01

Key: D indicates that documentation is required; R indicates an identified risk area;
7. For psychiatric distinct part units in critical access hospitals: Progress notes are recorded by the following individuals involved in the active treatment of the patient:
   - The doctor of medicine or osteopathy responsible for the care of the inpatient
   - A nurse
   - A social worker
   - Others involved in active treatment modalities
   The above individuals record progress notes at least weekly for the first two months of a patient’s stay and at least monthly thereafter.

7. For psychiatric distinct part units in critical access hospitals: Progress notes are recorded by the following individuals involved in the active treatment of the patient:
   - The physician(s), psychologist(s), or other licensed practitioner(s) responsible for the care of the inpatient
   - A nurse
   - A social worker
   - Others involved in active treatment modalities
   The above individuals record progress notes at least weekly for the first two months of a patient’s stay and at least monthly thereafter.

Rights and Responsibilities of the Individual (RI) Chapter

RI.01.07.07

For swing beds in critical access hospitals: The critical access hospital protects the rights of residents who work for or on behalf of the critical access hospital.

Element(s) of Performance for RI.01.07.07

1. For swing beds in critical access hospitals: The critical access hospital follows a written policy that addresses situations in which residents work for or on behalf of the critical access hospital.

3. For swing beds in critical access hospitals: Wages paid to residents who work for or on behalf of the critical access hospital are in accordance with law and regulation.

4. For swing beds in critical access hospitals: The critical access hospital incorporates work performed by the resident for or on behalf of the critical access hospital into the plan of care.

5. For swing beds in critical access hospitals: Residents have the right to refuse to work for or on behalf of the critical access hospital.

Key: 📝 indicates that documentation is required; 🟥 indicates an identified risk area;