Self-Audit Tool for Application as a Critical Access Hospital

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Revised February, 2000

Self-Audit Tool for Application as a Critical Access Hospital

The enclosed *Self-Audit Tool for Application as a Critical Access Hospital* is designed for use by hospital staffs to ensure that they are as prepared as possible for the initial survey their hospital will undergo as part of the CAH application process. The tool is structured to conform to the interpretive guidelines which surveyors will use in evaluating CAH applicant hospitals.

The self-audit tool is meant to be a "checklist" which hospital staff can use to see if the required standards are met or whether corrective action is needed. It is suggested that the tool be parceled out to the appropriate departments which can then report on their status in terms of meeting the outlined requirements.

The tool is divided into four columns, as follows:

- The first column (*Tag #*) provides the number of the specific interpretive guideline which the surveyors use for this section.
- The second column (*Regulation*) lists the specific regulation which applies to that area.
- The third column (*Elements to Consider*) is our interpretation of the items the hospital must assess to ensure that the standards for that regulation are met. These "elements" were derived from the guidance to surveyors. In most cases, the context of the guidance was altered to make it read more appropriately for a "self check." Notes or cautionary language was added in areas which may present problems.
- The fourth column (*Notes*) is for notations which may be as simple as "OK" or may be more detailed, e.g., outlining corrective action which needs to be taken prior to the survey.

Although not specifically addressed in CAH regulations, nor in this tool, it is noted that hospitals also must be in compliance at the initial survey with

federal regulations pertaining to:

- advance directives,
- criminal background checks,
- organ procurement and
- EMTALA.

Finally, please note that this tool does *not* cover:

- physical plant requirements, such as distances, space per patient, etc., as it is presumed that CAH requirements are no more demanding in this regard than the requirements under which hospitals currently operate;
- CAH requirements regarding geographical location, length of stay, population mix, numbers of beds, etc., as those elements will have been considered and disposed of in the initial application process;
- life safety or construction requirements, again as it is presumed the hospitals is meeting current requirements and the requirements under CAH status are no more demanding; and
- the specifics of governing body oversight and medical staff credentialling, although both are areas which *will* be looked at in the survey process.

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January 1999
revised July 1999

SELF-AUDIT TOOL FOR APPLICATION AS A CRITICAL ACCESS HOSPITAL[1]

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C150	§485.608 Condition of participation: Compliance with Federal, State, and local laws and regulation. The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.	EMTALA, PSDA, SMDA, Organ Procurement policies? **(Note: as a CAH you are not subject to Organ Procurement Regulations, but if you are a hospital applying for status as CAH surveyors may take the position that on date of survey you must meet all then existing conditions.)** See tag 170	
C151	(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.		
C152	(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.	**(Note: as a CAH you are not subject to a lot of hospital regulations , but if you are a hospital applying for status as CAH surveyors may take the position that on date of survey you must meet all then existing conditions.)** **See sample policy C152 Appendix A** See tag 170 Are all state mandated policies and procedures in place?	

[1] Basic physical and geographic requirements (distance, numbers of beds, etc.) have been omitted as these criteria would winnow out ineligible applicants prior to the survey process.

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C153	(c) Standard: Licensure of CAH. The CAH jis licensed in accordance with applicable Federal, State and local lasw and regulations.	There are no state licensing regulations specific to CAH's in Idaho.	
C154	(d) Standard; Licensure, certification or registration of personnel. Staff of the CAH are licensed, certified, or registered in accordance with applicable Stae and local laws and regulations.	Do we have current licenses or verification of current licenses in personnel files for all licensed personnel; **See sample policy C154 Appendix A**	

C165	(4) 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 the CAH is certified by the State as being a necessary provider of health care services to residents in the area.	Interpretive Guidelines §485.610(b)(4) One may reasonably consider a road "secondary" if it is not an Interstate, U.S., or State highway.	

C170	§485.612 Condition of participation: Compliance with hospital requirements at time of application. The hospital has a provider agreement to participate in the Medicare program as a hospital applies for designation as a CAH.	This is a BIG one. Be sure that you can demonstrate corrective action has been taken with regards to any deficiencies under old Condition of particiations. Get out your last survey report and be sure you don't have the smae deficiencies	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C190	§485.616 Condition of participation: Agreements.	What kind of agreement/system is set up to handle commuications with transfer hospital? What about "back-up" systems? **See Sample Transfer Agreement Appendix A**	
C191	(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--	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 communications delays. What evidence demonstrates that CAH staff can operate communications equipment? How does the network's communications system compare with any online and available communications equipment in the CAH? When the network communications system is down how does the CAH communicate and share patient data with networkhospital? **See Sample Transfer Agreement Appendix A**	
C192	(1) Patient referral and transfer;	**See sample Agreement A192 Appendix A**	
193	(2) The development and use of communication 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		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C194	(3) The provision of emergency and non-emergency transportation among the facility and the hospital.		
C195	[2](b) Standard: Agreement 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 -- (i) One hospital that is a member of the network; or (ii) One PRO or equivalent entity; or (iii) One other appropriate and qualified entity identified in the State rural health care plan.	Do you have an agreement with another network hospital or with another "qualified entity" with respect to QA and credentialing? 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 procedures and policies for how information is to be utilized, obtained, and how confidentiality of information will be maintained. **NOTE: IHA could be that "qualified entity" but simply being a member of IHA will not meet this requirement. There must be a written agreement regarding QA and credentialing.** **NOTE: Participating with the PRO in a quality improvement project will not satisfy this requirement.** **See Sample Policies C195A, and C195b and Sample Quality Asurance Agreement, and Sample Credentialing Agreement Appendix A**	

[2]Elements in this tag under (a) have been ommitted from this tool as they refer to base requirements which will have been met as part of the initial application process.

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C200	§485.618 Condition of participation: Emergency services. The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.	Review all policies and procedures for emergency services. Review a sample of patient records for the emergency department. Is hospital able to demonstrate appropriate care following emergency department policies and procedures? Are all the regulatorily required policies and procedures in place? (IHA can provide you with these policies if they are not in place.)	
C201 C202	(a) Standard: Availability. Emergency services are available on a 24-hour basis. (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 availble must include the following:	Is there a qualified practitioner available 24-hours a day? Can that person be at the hospital within 30 minutes? Are required equipment, supplies and medications always readily available? Qualified practitioner need not be an M.D. or D.O. Could be NP or PA but your hospital's governing body must have agreed to this. EMTALA is still a requirement for CAH's **See sample policy C201 Appendix A**	
C203	(1) Drugs and biologicals commonly used in life saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics,	Are appropriate drugs and biologicals available to the staff at all times? Is an inventory maintained? Do all staff know how to access required drugs and biologicals 24 hours a day?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C203 Cont.	serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.		
C204	(2) Equipment and supplies commonly used in life saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquet, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.	Are equipment and supplies required at §485.618(b)(2) readily available? Does the staff know where emergency equipment and supplies are kept? 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)? Are pediatric equipment and supplies available?	
C205	(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	Blood is either stored on-site under appropriate conditions or the facility has a process in place to get a patient to a site where blood is available. Blood and blood products are accessible to staff in time to effectively treat emergency patients. There is in place an effective system of making blood products available to its emergency patients 24-hours-a-day. Either type and cross match are available 24-hours-a-day or there is always on hand four units of OB packed red cells. If universal donor is stored on site, is there an arrangement with blood bank to rotate and replace? **See sample policy C205 Appendix A**	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C205 Cont.	of blood products needed for emergencies on a 24-hour-a-day basis.		
C206	(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 person directly responsible for the operation of the facility.	If bloodbanking services are provided on-site, is the blood facility under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy? If bloodbanking services are provided under arrangement, what evidence shows that medical staff and administration operations have approved the arrangement? Be sure you have a signed agreement with pathologist and it details his or her responsibilities	
C207	<u>(d) Standard: Personnel</u> (1) There must be a practitioner with training or experience in emergency care on-call and immediately available by telephone or radio contact, and available on-site within 30 minutes on a 24-hour-a-day basis.	How does staff ensure that a practitioner described in §485.618(d)(1) is on call 24-hours-a-day and available on-site at the CAH within 30 minutes? Could any staff person at any time determine who the on-call person is? Is there evidence from documentation reviews that the 30 minute on-call requirement has been met? (You might expect the surveyors to show up at the hospital at any hour of the day to test this requirement.) The person at the hospital makes the determination as to whether or not practitioner must come in. T<u>he "on call" practitioner does not.</u> **See sample policy C207 Appendix A**	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C208	(2) The practitioner referred to in paragraph (d)(1) must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner.	There is a process in place for scheduling or call-back, for practitioners referred to in §485.618(d)(1). Staff in the professional categories at left can get to the hospital within 30 minutes of being called back.	
C209	<u>(e) Standard: Coordination with emergency response systems.</u> 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-hour-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.	The hospital has in place a system to immediately put a doctor of medicine or osteopathy in communication with emergency responders. **Note: This is a requirement for the hospital, not the ambulance service. This requirement contemplates that the doctor from his residence or from someplace outside the hospital could make this contact as well as from the hospital** What records will demonstrate that the procedures are followed and evaluated? **See sample policy C209 Appendix A**	
C212	<u>(b) Standard Length of stay.</u> The CAH discharges or transfers each inpatient within 96 hours after admission,	96 hour rule is now an “average” not per individual patient. You need no longer seek waiver from the PRO for patients whose expected length of stay will be over 96 hours. Be prepared to demonstrate at you next survey that your average length of stay was not over 96 hours.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C212 Cont.	unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions. However, a PRO or equivalent entity may, on request, waive the 96 hour restriction on a case-by-case basis.	PRO approval is not required if inclement weather or "other emergency" is the reason for not transferring within 96 hours. Have documentation in the record for any length of stay greater than 96 hours.	
C220	§485.623 Condition of participation: Physical plant and environment.		
C222	(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;	Are there maintenance records on any unsafe mechanical equipment (e.g., boiler equipment, kitchen refrigerator/freezer, laundry equipment) in evidence? Does the hospital meet 1985 Life Safety Codes?	
C223	(2) There is proper routine storage and prompt disposal of trash;	Is trash, including contaminated materials, stored and disposed of promptly and properly?	
C224	(3) Drugs and biologicals are appropriately stored;		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C225	(4) The premises are clean and orderly; and		
C226	(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	There is an uncluttered physical environment where patients and staff can function safely (e.g., equipment and supplies stored in proper spaces, not in corridors, spills not left unattended or identified, no floor obstructions) and is neat and well-kept (e.g., no peeling paint, visible water leaks, plumbing problems). Will maintenance records show repeated difficulties in ventilation, lighting, and temperature control without effective resolution? What are the standards used to determine appropriate levels of light, ventilation, etc.?	
C227	(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;	Are fire and emergency drills conducted regularly? Do all staff know what they are supposed to do in case of an emergency such as a tornado or a blizzard?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C228	(2) Providing for emergency power and lighting in the emergency room and for battery lamps and flashlights in other areas;	<u>Survey Procedures and Probes §485.623(c)(2)</u> Does the emergency generator have adequate capacity to provide power for emergency equipment and lighting in the emergency room? Are there maintenance records and facility specific policies and procedures or test runs and frequency of test runs on emergency equipment?	
C229	(3) Providing for an emergency fuel and water supply; and	<u>Survey Procedures and Probes §485.623(c)(3) and (4)</u> What arrangements have been made for fuel and water in the event normal sources are degraded? If hospital is heated with oil have a signed agreement from supplier that hospital will be considered "priority" customer in emergencies or shortage situations.	
C230	(4) Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.		
C241	<u>(a) Standard: Governing body or responsible individual.</u> 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.	Have the facility's operating policies been updated to fully reflect its responsibilities as a CAH,? Is there evidence that the governing body is fully responsible for the operations? Is there evidence that the governing body has approved the effort to become a CAH ?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C244	(3) The person responsible for medical direction.	Is there a designated medical director for the hospital? Are the duties and responsibilites of the medical director clearly spelled out.	
C250	§485.631 Condition of participation: Staffing and staff responsibilities.		
C251	(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.	Is there either a doctor of medicine or osteopathy on staff with a PA, NP or CNS? Is there an organizational chart, showing staff physicians,mid-levels and nursing staff	
C252	(2) Any ancillary personnel are supervised by the professional staff.	All ancillary personnel are supervised by the professional staff. Have organizational charts been kept current?	
C253	(3) The staff is sufficient to provide the services essential to the operation of the CAH.	Staff coverage is sufficient to provide essential services at the facility (e.g., emergency services described at §485.618, direct services described at §485.635(b), and nursing services described at §485.631(d)? Are staffing records and census records compatible?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C254	(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.	If the hospital operates outpatient clinics, a doctor of medicine or osteopathy, PA, NP, or CNS is physically present and prepared to treat patients. Outpatient clinics have specific, posted operating hours. You cannot staff a clinic with a receptionist whose job it is to call a practitioner to come in when a patient shows up	
C255	(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.	NOTE: If a nurse practitioner is on duty in the CAH, both requirements at §485.631(a)(4) and (5) are met. However, if a physician assistant is on duty, §485.631 (a)(4) is met, but §485.631(a)(5) is not met unless a registered nurse, clinical nurse specialist or licensed practical nurse is also on duty. We do not recommended staffing with only an LPN although the regulations do allow such. **See sample policy C255 Appendix A**	
C256	(b) Standard: Responsibilities of the doctor of medicine or osteopathy. (1) The doctor of medicine or osteopath --		
C257	(i) Provides medical direction for the CAH's health care activities and consultation for the medical supervision of the health care staff;	There is a doctor of medicine or osteopathy on staff. That individual must perform all of the medical oversight functions described in §485.631(b).	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C258	(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.	Does a doctor of medicine or osteopathy participate in the development of policies governing services? Are these policies periodically reviewed by the doctor of medicine or osteopathy? **See sample policy C258 Appendix A**	
C259	(iii) In conjunction with the physician assistant and/or nurse practitioner member(s), periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; and	Does the doctor of medicine or osteopathy periodically review patient records in conjunction with staff mid-level practitioners? Is there evidence of a periodic review of patient records by the physician? **See sample policy C259 Appendix A**	
C260	(iv) Periodically reviews and signs the records of patients cared for by nurse practitioners, clinical nurse specialists, or physician assistants.	NOTE: The CAH physician must review and sign all inpatient records for patients cared for by mid-level practitioners. The CAH physician is not required to review and sign all outpatient records for patients cared for by mid-level practitioners.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C261	(2) A doctor of medicine or osteopathy is present for sufficient periods of time, at least once in every two 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	Does a physician visit patients at least every two weeks? Will the records show that the physician visits the facility at east once every two weeks?	
C261 Cont.	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 last site visit.		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C262	(c) Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities. (1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH's staff --		
C263	(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and	Are NPs, CNSs, and/or PAs involved in the policy development, execution, and periodic review? Are policies updated regularly?	
C264	(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patient's health records.	Do PAs, NPs, and/or CNSs participate with a doctor of medicine or osteopathy in the review of their patients' health records?	
C265	(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:		
C266	(i) Provides services in accordance with the CAH's policies; and	Are all mid-levels knowledgeable regarding the hospitals policies and procedures? Do they understand the unique status of CAH?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C267	(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.	Are there referral arrangements in place with higher level facilities, particularly with reference to OB, cardiac and trauma? Are all staff aware of referral agreements? Are all staff aware of EMTALA requirements? Are there policies that address transfer of records when patient is transferred. **See sample policy C267 Appendix A** **See sample transfer agreement Appendix A**	
C268	(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.	Does a policy require notification of a doctor of medicine or osteopathy when inpatients are admitted? **See sample policy C268 Appendix A**	
C270	§485.635 Condition of participation: Provision of services.		
C271	(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.	Would observance of staff in daily duties support adherence to policies and procedures. Do they reflect current thinking/literature in procedures? Are all of the regulatory required policies and procedures in place?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C272	(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.	Physician is involved in and approves all clinical policies. Policies and procedures have been approved by clinical staff of CAH and at least one non-staff professional.	
C273	(3) The policies include the following: (i) A description of the services the CAH furnished directly and those furnished through agreement or arrangement.	Do policies clearly explain what type of health care services are available by staff, which are furnished through agreements or arrangements and which are not? Do they reflect current thinking/literature in procedures? Are there copies of arrangements and/or agreements, and contracts? Are informal agreements understood? An exemplary policy would be one such as “arrangements have been made with hospital X for patients to receive the following services” (with a specific list of specialized diagnostic and laboratory testing, specialized therapy).	
C274	(ii) Policies and procedures for emergency medical services.	Do policies show what emergency services requirements are provided by staff, by contract, by consultant, by transfer? Do policies define an “appropriate medical screening examination” and who can do it?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C275	(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.	Are all practitioners credentialed? Have protocols been developed for mid-levels? Are privileges detailed and specific? Are policies clear on which mid-level practices require direct “over the shoulder” supervision, which require adherence to specific protocols and which allow independent judgement?	
C276	(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	There are policies (and practices) ensuring that storage handling, dispensing and administration of drugs and biologicals are in accordance with accepted professional principles. Are there inventory records and records of receipt and disposition? Is the key to controlled substances maintained by one and only one nurse? (state pharmacy requirement) Are there procedures in place for handling of outdated, mislabeled or degraded drugs and biologicals?	
C276 Cont.	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.		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C277	(v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.	There are written procedures which require that medication errors and adverse drug reactions be reported immediately to the practitioner who ordered the drug. Medication errors are to be entered into the patient's medical record.	
C278	(vi) A system for identifying, reporting, investigating and controlling infectious and communicable diseases of patients and personnel.	What is the hospitals nosocomial infection rate? Is there an active surveillance program of specific measures for prevention, early detection, control, education and investigation of infections and communicable disease? Is there a mechanism to evaluate the program(s) and take corrective action? Does the hospital follow the current recommendations of the Centers for Disease Control and Prevention (CDC) relative to specific infection(s) and communicable disease(s)? Are there systems in place to identify, report, investigate and control infectious and communicable diseases? Is the infection control program incorporated into the facility-wide QA program? Are there procedures to resolve identified problems involving infections and communicable diseases within the facility? Are there current minutes showing ongoing and current activity by the infection control committee?	
C279	(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 §485.625(i) is met with respect to inpatients receiving post-hospital SNF care.	Are policies and procedures in place to govern the delivery of dietary services? Is there a registered dietitian on staff or under contract with the hospital? Is there a dietary manual?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C280	(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.	Are patient care policies reviewed on an annual basis by the professional group described in §485.635(a)(2)? Note: Annual review is a new standard as a CAH.	
C281	(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	Which diagnostic and therapeutic services are delivered by staff? Which are provided indirectly (i.e., by contractual arrangement). Are specific, written, and current contracts on file in the hospital? Do contracts show level and frequency of service to be provided? Do contracts address peripheral issues of arrangement (i.e., inservice education for staff, liability, etc.)?	
C281 Cont.	another entry point into the health care delivery system, such as a low intensity hospital 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.		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES

C282	(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. 236(a)) (See the laboratory requirements specified in Part 493 of this Chapter). (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.	Does the laboratory have a current CLIA certificate? Does the laboratory provide at least: (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.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C283	(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) Are radiologic services available as needed to meet the needs of patients? Does the hospital have a contract with a radiologist to provide direction to radiology department? Are there procedures in place providing for adequate shielding for patients, personnel and facilities? Are there policies for adequate storage, use, and disposal of radioactive materials? Are there periodic inspections, and prompt identification and correction of hazards? Is patient and staff exposure to radioactive hazards monitored?	
C284	(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 illnesses.	Is one person responsible for ensuring the availability of emergency equipment and supplies?	
C285	(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	Are contractual services well defined? Is there evidence in the agreement or arrangement that the governing body is responsible for these services provided under agreement or arrangement? Do agreements change as scope of services changes?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C285 Cont.	its patients, including --		
C286	(i) Inpatient hospital care;	Is there an arrangement or agreement with one or more hospitals to provide inpatient care to patients the hospital cannot handle (i.e., greater than 96 hours or acuity level beyond capabilities of CAH)? **See sample Transfer Agreement Appendix A**	
C287	(ii) Services of doctors of medicine or osteopathy; and	Are there arrangements or agreements with one or more doctors of medicine or osteopathy to meet its requirements at §485.631(b)?	
C288	(iii) Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH.	Interpretive Guideline §485.635(c)(iii) Are contracting or referring laboratories in conformance with CLIA requirements in 42 CFR Part 493 of this chapter? Are there arrangements or agreements for specialized diagnostic and clinical laboratory services (in addition to those required in §485.635(b)(2)) that are necessary to provide care for its patients (i.e., MRI, etc.)?	
C289	(iv) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.	If dietary services are contracted, does the contract allow for the provision of nutritional services that meet requirements in §485.635(a)(3)(vii) and (if it has swing-bed patients) §485.25(i)?	
C290	(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.	Do you have documentation which shows that: " Transferred patients were accepted and provided with inpatient care, as needed, at hospitals 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? " Physicians and/or suppliers of services are providing services in the manner described in the arrangement or agreement?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C290 Cont.		This will require that your transfer agreement with other hospital allows you to at least periodically check these items after you transfer a patient. **See Sample Transfer Agreement Apendix A**	
C291	(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.	Is there a listing of all services which are provided under contract?	
C292	(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; and	Is the hospital administrator/CEO responsible for all services provided through arrangements or agreements?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C293	(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	Do all contracted services meet all of the appropriate Conditions of Participation and standards for contracted services? NOTE: Your contractors must meet all Medicare conditions of participation (i.e., non-discrimination compliance, etc.)	
C293 Cont.	standards for the contracted services.		
C294	(d) <u>Standard: Nursing services.</u> Nursing services must meet the needs of patients.		
C295	(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.	Does an RN have overall responsibility for patient care services? Are specialized needs of patients considered and documented? Are staff assigned appropriately given census and acuity? Does care provided meet the needs of each patient? Are temporary nursing staff oriented and supervised?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C296	(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each SNF level of care in a swing-bed CAH.	Does a registered nurse supervise the nursing care for each patient? Are staffing schedules current? Do staffing schedules correlate to the number and acuity of patients, including swing-bed patients? Will staffing schedules demonstrate that acuity and numbers of patients are considered in staffing?	
C297	(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a	Drugs, biologicals, and intravenous medications are administered only with a proper order. How does the CAH ensure that its policies and procedures for the administration of drugs, biologicals and intravenous medications are followed? Standing orders are reviewed, updated and signed by the current medical staff. Is the administration of drugs, biologicals and intravenous medications	
C297 Cont.	doctor of medicine or osteopathy or, where permitted by State law, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.	regularly monitored for quality assurance purposes?	
C298	(4) A nursing care plan must be developed and kept current for each patient.	Is there a complete and current nursing care plan for each patient? Is discharge planning consideration part of every patient evaluation?	
C300	§485.638 Condition of participation: Clinical records.		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C301	(a) Standard: Records system. (1) The CAH maintains a clinical records system in accordance with written policies and procedures.		
C302	(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.	Are records prepared and maintained in accordance with the requirements of §485.638(2) and (4)?	
C303	(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.	Is there an ART or RRA on staff or under contract who oversees medical records?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C304	(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;	Are there properly executed informed consent forms, medical history health status and care needs assessments, and summary in each record, as needed?	
C305	(ii) Reports of physical examinations, diagnostic and laboratory test results, including	Are reports of physical examinations, diagnostic and laboratory test results, and consultative findings signed by the appropriate practitioner?	
C305 Cont.	laboratory services, and consultative findings;		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C306	(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 treatments; and	Is "other pertinent information" at §485.638(a)(4)(iii), in appropriate records?	
C307	(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.	If rubber stamp or auto authenticated signatures are allowed, do policies and procedures provide for appropriate sanctions for unauthorized or improper use of computer codes or signature stamps? Are medical records signed as required by State law? Is there a list of authorized signatures (doctors and mid-levels) for medical record?	
C308	(b) <u>Standard: Protection of record information.</u> (1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.	Are medical records physically secure? Are there policies to prevent unauthorized persons from gaining access to patient records? **See sample policy C308 attached**	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C309	(2) Written policies and procedures govern the use and removal of records from the CAH and the condition for the release of information.	Are there policies addressing the removal of medical records from the hospital? Is it allowed? Is it disallowed? If allowed, under what circumstances? **See sample policy C309 Appendix A**	
C310	(3) The patient's consent is required for release of information not required by law.	No records are released without the patients consent or under appropriate legal authority.	
C311	(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 preceding.	Are medical records retained in their original or legally reproduced form, for a period of at least 6 years? Facsimiles received on thermal sensitive paper is reproduced on to regular paper. Is there a policy which states all medical records will be retained at least six years? NOTE: IHA recommends 10 years **See sample policy C311 Appendix A** .	
C320	§485.639 Condition of participation: Surgical services. Surgical procedure 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.	For surgical services the hospital has: " Equipment and supplies sufficient so that the type of surgery conducted can be preformed in a manner that will not endanger the health and safety of the patient; " Operative and recovery areas limited in access; " Appropriate aseptic techniques in place; " Appropriate cleaning between surgical cases; " Suitable equipment available for rapid and routine sterilization of operating room materials; " Sterilized materials properly labeled, and stored in a manner to ensure sterility; and " Operating room attire suitable for the kind of surgical cases performed. (Persons working in the operating suite must wear clean surgical costumes in lieu of their ordinary clothing.) Surgical costumes are to be designed for maximum skin and hair coverage.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C320 Cont.		Does the surgical department have policies and procedures which address at a minimum: " Resuscitative techniques; " Aseptic technique and scrub procedures; " Care of surgical specimens; " Appropriate protocols for all surgical procedures, specific or general in nature, and include a list of equipment, materials, and supplies to properly carry out job assignments; " The cleaning of operating rooms after each use; " Sterilization and disinfection procedures; " Acceptable operating room attire; " Care of anesthesia equipment; and " Special provision for infected or contaminated patients.	
C321	(a) 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 osteopathy practitioner recognized under section 1101(a)(7) of the Act;	Are physicians or others performing surgical techniques appropriately credentialed? Does the operating room supervisor have a current list of approved procedures for each practitioner?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C321 Cont.	(2) A doctor of dental surgery or dental medicine; or (3) A doctor of podiatric medicine.		
C322	(b) Anesthetic risk and evaluation. A qualified practitioner, as described in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner as described in paragraph (a) of this section.	Will surgical medical records confirm and acceptable pre-anesthesia evaluation done by the practitioner administering the anesthetic agent is in the chart? " If laboratory studies were ordered as part of patient evaluation the lab work is should be part of the medical record. For general anesthesia, the evaluation should contain, at a minimum, a brief note regarding the heart and lung findings the day of surgery; <u>and</u> depending on the type of anesthesia and length of surgery, the postoperative check should include some or all of the following: - Level of activity; - Respirations; - Blood pressure; - Level of consciousness; - Patient color; and - Wound/dressing assessment, when appropriate.	
C323	(c) Administration of anesthesia. The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and	Credentialing covers those persons qualified to administer anesthesia.	
C323 Cont.	procedures and with State scope of practice laws.		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C324	(1) Anesthetics must be administered only by -- (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, as defined in §410.69(b) of this chapter; or (vi) An anesthesiologist's assistant, as defined in §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.		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C325	(2) In those cases in which a certified registered nurse anesthetist administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner. An anesthesiologist's assistant must be under the supervision of an anesthesiologist.	In all procedures where a CRNA administers anesthesia, the operating practitioner understands and agrees to supervise the anesthetist when applicable. **NOTE**: This is an area in which CAH regulations appear to be in conflict with state licensing regulations. State licensing regulations for CRNA's allow *"the prescribing and dispensing of pharmacologic agents"* and call for "collaboration with a physician" Further the regulations define Collaboration as: *"The cooperative working relationship with another health care provider, each contributing his respective expertise in the provision of patient care, and such collaborative practic includes the discussion of patient treatment and cooperation in the management and delivery of health care.*" It is our guess that this regulation does not contemplate that a physician, who may be less trained than a CRNA in the administration of anesthetic agents would oversee the administration of anesthesia by a CRNA. What we think is contemplated is that there is only one "captain" in the OR, and that person is the surgeon, not the CRNA.	
C326	(d) Discharge. All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure.	All patients are discharged in the company of a responsible adult, except those exempted by the practitioner who performed the surgical procedure. The medical record reflects all such exemptions. There are policies regarding discharge instructions for post-anesthetic patients.	
C330	§485.641 Condition of participation: Periodic evaluation and quality assurance review.	NOTE: The following conditions regarding "yearly evaluation" would not be applicable at initial survey but the hospital must have a process to show that yearly evaluation will be done annually, as a CAH. **See sample policy C330 Appendix A**	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C331	(a) <u>Standard: Periodic evaluation.</u> (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 --	**NOTE: As a CAH there must be an annual evaluation of services.** Are there QA surveys and patient satisfaction surveys in place? **See sample policy C330 Appendix A**	
C332	(i) The utilization of CAH services, including at least the number of patients served and the volume of services;	NOTE: Does yearly evaluation of service include a consideration of volume, numbers and utilization?	
C333	(ii) A representative sample of both active and closed clinical records; and	Yearly evaluation includes review of 10 percent of records.	
C334	(iii) The CAH's health care policies.	Yearly evaluation and review includes health care policies of the hospital. **See sample policy C330 Appendix A**	
C335	(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.	Can it be demonstrated that yearly evaluation results in follow-up and action where necessary?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C336	(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 --	The QA program must be facility-wide, including all departments and all services provided under contract. There is an effective quality assurance program which 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. QA includes peer review by outside sources.	
C337	(1) All patient care services and other services affecting patient health and safety, are evaluated;	There is a designated QA Coordinator. Patient care services and patient health and safety are part of the QA program.	
C338	(2) Nosocomial infections and medication therapy are evaluated;	There is an infection control officer, infection control committee and documented infection control processes.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C339	(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;	Does a doctor of medicine or osteopathy evaluate the quality of care provided by mid-level practitioners? Is clinical performance of mid-level practitioners part of the QA program? Is there provision for action if quality of care concerns are raised with regards to mid-levels? Consider "outside" peer review for mid-levels. **See Sample Agreement to Exchange Peer Review Services Appendix A**	
C340	(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by the PRO for the State in which the CAH is located; and	The hospital has a Memorandum of Understanding with the PRO. There is an agreement with another hospital for peer review.	
C341	(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the PRO, and takes corrective action if necessary.	There is a person designated as PRO liaison who can go forward with the PRO's findings and recommendations.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C342	(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.	Can the QA program demonstrate follow-up action, remedial and corrective?	
C343	(iii) The CAH documents the outcome of all remedial action.	Remedial action, once taken, is further monitored until positive outcomes are demonstrated.	
C350	§485.645 Special requirements for CAH provides of long-term care services (swing-bed). A CAH must meet the following requirements in order to be granted an approval from HCFA to provide post-hospital SNF care, and to be paid for SNF-level services, in accordance with paragraph (b) of this section.	**NOTE: MDS is a requirement for all swing-beds in critical access hospitals.**	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C360	(c) 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), (j)(i)(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 requirement of §485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a	THIS ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. **NOTE: Most hospitals applying for CAH status probably do not meet these requirements at present. These requirements must be met for approval as a CAH.**	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C360 Cont.	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), (d), and (e) 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).		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C361	§483.10 Residents 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: §483.10(b) Nature of rights and services. (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;	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. What are the hospital's capabilities regarding communicating with physically impaired patients? Hospital minimizes use of technical jargon in communicating with the resident or cognitively impaired person. What are the foreign language skills of hospital personnel? **See Sample Policy C361 Appendix A**	
C362	(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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Is patients' informed consent to all treatments always demonstrated? Is information regarding advance directives and living wills or durable powers of attorney given to all patients over the age of 18? Is it understood that the right to consent includes the right to refuse? Services will not be denied because of refusal of specific treatments in cases of refusal. Staff understands Idaho law regarding surrogate consent. When refusal of treatment brings about a significant change, the facility reassess the resident and institutes care planning changes.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C363	(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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Residents are told in advance when changes will occur in their bills. Hospital informs the resident of services and related changes. Are patients advised on admission that certain services may not be covered and that they are personally responsible?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C363 Cont.	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's per diem rate.		
C364	(d) Free Choice -- The resident has the right to -- (1) Choose a personal attending physician;	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. The facility may seek alternative physicians for patients if physician of record is not in compliance with Conditions of Participation. The facility will not place barriers in the way of residents choosing their own physicians. For example, if a resident does not have a physician, or if the resident's physician becomes unable or unwilling to continue providing care to the resident, the facility must assist the resident in exercising his or her choice in finding another physician.	
C365	(2) Be fully informed in advance about the care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Do patients receive information about their medical condition and changes in medical condition, about the benefits and reasonable risks of the treatment, and about reasonable available alternatives?	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C366	(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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. **NOTE: Incompetency is a legal not a medical determination.** Residents are involved in decisions about care and treatment. If there are conflicts between a resident's right and the resident's health or safety, the facility must attempt 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 participates.	
C367	(e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality for 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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Right to privacy is respected with whomever the resident wishes to be private. 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 treats 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.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C367 Cont.	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.		
C368	(h) <u>Work.</u> 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--	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. All resident work, whether of a voluntary or paid nature, is part of the plan of care. A resident's desire for work is subject to discussion of medical appropriateness. As part of the plan of care, a therapeutic work assignment must be agreed to by the resident. 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. Residents who are paid for work are paid the prevailing rate in the community for similar work.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C368 Cont.	(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.		
C369	(i) <u>Mail.</u> 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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Delivery of mail or other materials is made to the resident within 24 hours of delivery by the postal service. Delivery of outgoing mail to the postal service is made within 24 hours.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C370	(j) Access and Visitation Rights. (1) The resident has the right and the facility must provide immediate access to any resident by the following: (i) Any representative of the Secretary; (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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. **NOTE: Existing visiting hours limitations may conflict with this provision. Immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident. Non-family visitors are also granted "immediate access" to the resident.** An individual or representative of an agency that provides health, social, legal or other services to the resident has the right of "reasonable access" to the resident.	
C371	(1) Personal Property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. 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. All residents' possessions,	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C371 Cont.	do so would infringe upon the rights or health and safety of other residents.	regardless of their apparent value to others, are treated with respect, for what they are and for what they may represent to the resident.	
C372	(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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. The right of residents who are married to each other to share a room does not give a resident the right, or the facility the responsibility, to compel another resident to relocate to accommodate a spouse. When a room is available for a married couple to share, the facility must permit them to share it if they choose.	
C373	§483.12 Admission, transfer and discharge rights. (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 plan or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Transfer and discharge provisions significantly restrict a facility's ability to transfer or discharge a resident once that resident has been admitted to the facility. The facility will not transfer or discharge the resident unless: 1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility. 2. 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; 3. The safety of individuals in the facility is endangered; 4. The health of individuals in the facility would otherwise be endangered;	
C373 Cont.		5. The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; or 6. The facility ceases to operate.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES

C374	(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;	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. If transfer is due to a significant change in the resident's condition, but not an emergency requiring an immediate transfer, the facility conducts the appropriate assessment to determine if a new care plan would allow the facility to meet the resident's needs. Refusal of treatment will not constitute grounds for transfer, unless the facility is unable to meet the needs of the resident or protect the health and safety of others. If transfer is due to the fact that the resident's health improved to the extent that the transferred/ discharged resident no longer needed the services of the facility. " Did a physician document the record if residents were transferred because the health of individuals in the facility is endangered? " Do the records of residents transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? If so, determine differences between these residents and those who were transferred or discharged.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C374 Cont.	(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.		
C376	(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 --	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C376 Cont.	(i) The resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and (ii) A physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.		
C377	(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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C377 Cont.	(iii) Include in the notice the items described in paragraph (a)(6) of this section.		
C378	(5) <u>Timing of the notice.</u> (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;	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C378 Cont.	(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.		
C379	(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;	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C379 Cont.	(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 Individals Act.for		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C379 Cont.	for Mentally Ill Individuals Act.		
C380	(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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. The facility informs the resident where he or she is going and takes steps under its control to assure safe transportation. The facility should actively involve, to the extent possible, the resident and the resident's family in selecting the new residence.	
C381	§483.13 Resident behavior and facility practices. (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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. **NOTE: Guidelines for restraints are significantly more restrictive than under hospital regulations.** Restraints will not be used for discipline or convenience and restraint use will be limited 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 which 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.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C381 Cont.		“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 must be reflected in the comprehensive assessment and care planning. For those residents whose care plans indicate the need for restraints the facility engages in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities.) In the case of a resident who is incapable of making a decision, the surrogate or representative exercises this right based on the same information that would have been provided to the resident. The surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident’s medical symptoms. That is, because a surrogate or representative has approved or requested them the facility will not use restraints in violation of the regulation solely. “Physical restraints” include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove. Also included as restraints are facility practices that meet the definition of a restraint, such as: " Using bed rails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; " Tucking in a sheet so tightly that a bed bound resident cannot move; " Using wheel chair safety bars to prevent a resident from rising out of a chair; " Placing a resident in a chair that prevents rising; and " Placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails may be used to restrain residents or to assist in mobility and transfer of residents. The use of bed rails as restraints is	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C381 Cont.		Orthotic body devices may be used solely for therapeutic purposes to improve overall functional capacity of the resident. Bed rails may be used to restrain residents or to assist in mobility and transfer of residents. The use of bed rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Bed rails used as restraints add risk to the resident. They potentially increase the risk of more significant injury from a fall from a bed with raised bed rails than from a fall from a bed without bed rails. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from bed. Other interventions that the facility might incorporate in care planning include: the resident will spend more time in bed and fall when attempting to transfer from bed. Other interventions that the facility might incorporate in care planning include: " Providing restorative care to enhance abilities to stand safely and to walk; " A trapeze to increase bed mobility; " Placing the bed lower to the floor and surrounding the bed with a soft mat; " Equipping the resident with a device that monitors attempts to arise; " Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom; and/or " Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information. When used for mobility or transfer, assessment should include a review of the resident's:	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C381 Cont.		" Bed mobility (e.g., would the use of the bed rail assist the resident to turn from side to side? Or, is the resident totally immobile and cannot shift without assistance?): and " Ability to transfer between positions, to and from bed or chair, to stand and toilet (e.g., does the raised bed rail add risk to the resident's ability to transfer?). However, as with other restraints, for residents who have been restrained by bed rails, it is expected that the process facilities employ to reduce the use of bed rails as restraints is systematic and gradual (e.g., lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell.) Before a resident is restrained, the facility must demonstrate the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the cause of the symptom and assist the resident in reaching his or her highest level of physical and psychosocial well-being. Appropriate exercise, therapeutic interventions such as orthotic devices, pillows, pads, or lap trays often assist in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use.effects effects associated with restraint use. Restraints may not be used to permit staff to administer treatment to which the resident has not consented. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C382	(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Residents are not 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 inflection 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; 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. "Mental abuse" includes, but is not limited to, humiliation, harassment, 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	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C382 Cont.		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.	
C383	(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;	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. The facility will do whatever is within its control to prevent mistreatment, neglect, and abuse of resident or misappropriation of their property. Facility policies include, but are not limited to, identification of residents whose personal histories render them at risk for abusing other residents. Assessment of appropriate intervention strategies to prevent occurrences. Monitoring resident for any changes that would trigger abusive behavior. Reassessment of the strategies on a regular basis. Facility policies call for disciplining up to discharge and/or filing of criminal complaints for staff abuse.	
C384	(ii) Not employ individuals who have been -- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PPATIENTSIN SWING-BEDS.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C384 Cont.	(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or mis-appropriation 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 officials in accordance with State law through established procedures (including the State survey and certification agency).	Facility does a thorough investigation of the past histories of individuals they are considering hiring. In addition to inquiry of the State nurse aide registry or other licensing authorities, the facility will check all references and make reasonable efforts to uncover information about any past criminal prosecutions. An aide or other facility staff found guilty of neglect, abuse , or mistreating residents or misappropriation of property by a court of law, will have his or her name entered into the nurse aide registry, or reported to the licensing authority, if applicable. Further, if actions by a court of law against an employee are such that they indicate that the individual is unsuited to work in a nursing home (e.g., felony conviction of child abuse, sexual assault, or assault with a deadly weapon), the hospital will report that individual to the nurse aide registry (if a nurse aide) or to the State licensing authority (if a licensed staff member). Such a determination is not limited to mistreatment, neglect and abuse of residents and misappropriation of their property, but to any treatment of residents or others inside or outside the facility which the facility determines to be such that the individual should not work in a nursing home environment.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C384 Cont.	(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 designed representative and to other officials in accordance with Sate 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.		
C385	§483.15 Quality of Life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of Life.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. There is an activities program which provides stimulation or solace; promotes physical, cognitive and/or emotional health; enhances to the extent practicable, each resident's physical and mental status; and promote each resident's self-respect by providing activities that support self-expression and choice. There is a designated activities director.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C385 Cont.	(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		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C385 Cont.	(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.		
C386	(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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. The facility provides for the medically-related social services needs of each resident. The facility will aggressively identify the need for medically-related social services, and pursue the provision of these services. "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 might include, for example:	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C386 Cont.		" 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 and their ramifications; " 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; " Providing or arranging provision of needed counseling services; " Through assessment and care planning process, identifying and seeking ways to support residents' individual needs and preferences, customary routines, concerns and choices; " Building relationships between residents and staff and teaching staff how to understand and support residents' individual needs; " Promoting actions by staff that maintain or enhance each resident's dignity in full recognition of each resident's individuality; " 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 decision; " Providing alternatives to drug therapy or restraints by understanding and communicating to staff the way residents act as they do, what they are attempting to communicate, and what needs the staff must meet; " Meeting the needs of residents who are grieving; and " Finding options that most meet the physical and emotional needs.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C386 Cont.		Factors with a potentially negative effect on physical, mental, and psychosocial well-being include an unmet need for: " Dental/denture care; " Podiatric care; " Eye care; " Hearing services; " Equipment for mobility or assistive eating devices; and " Need for home-like environment, control, dignity, privacy. Where needed services are not covered by the Medicaid State Plan, the facility still attempts to obtain these services. For example, if a resident requires transportation services that are not covered under a Medicaid State Plan, the facility is required to arrange these services. This could be achieved, for example, through obtaining volunteer assistance. Types of conditions to which the facility should respond with social services by staff or referral include: " Lack of an effective family/social support system; " Behavioral symptoms; " If a resident with dementia strikes out at another resident, the facility should evaluate the resident's behavior. For example, a resident may be re-enacting an activity he or she used to perform at the same time everyday. If that resident senses that another is in the way of his or her re-enactment, the resident may strike out at the resident impeding his or her progress. The facility is responsible for the safety of any potential resident victim while it assesses the circumstances of the resident's behavior); " Presence of a chronic disabling medical or psychological condition (e.g., multiple schizophrenia); " Depression;	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C386 Cont.		" Chronic or acute pain; " Difficulty with personal interaction and socialization skills; " Presence of legal or financial problems; " Abuse of alcohol or other drugs; " Inability to cope with loss of function; " Need for emotional support; " Changes in family relationships, living arrangements, and/or resident's condition or functioning; and " A physical or chemical restraint.	
C388	§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) The facility must make a comprehensive assessment of a resident's needs which -- (i) Is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the State and approved by the Secretary; and	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. State specified RAI (which includes both the MDS and utilization guidelines which include the RAPs) are to assess newly admitted residents. There is an annual review of those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or RAPS. The scope of the RAI does not limit the facility's's responsibility to assess and address all care needed by the resident. Furthermore, the facility is responsible for addressing the resident's needs from the moment of admission.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C388 Cont.	(ii) Describes the resident's capability to perform daily life functions and significant impairments in functional capacity. (2) The comprehensive assessment must include at least the following information: (i) Medically defined conditions and prior medical history; (ii) Medical status measurement; (iii) Physical and mental functional status; (iv) Sensory and physical impairments; (v) Nutritional status and requirements; (vi) Special treatments or procedures; (vii) Mental and psychosocial status; (viii) Discharge potential; (ix) Dental condition;		

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C388 Cont.	(x) Activities potential; (xi) Rehabilitation potential; (xii) Cognitive status; and (xiii) Drug therapy.		
C389	(4) Frequency. Assessments must be conducted -- (i) No later than 14 days after the date of admission; (ii) For current NF residents not later than October 1, 1991; (iii) For current SNF residents, not later than January 1, 1991; (iv) Promptly after a significant change in the resident's physical or mental condition; and (v) In no case less often than once every 12 months.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Patients are assessed not later than 14 days after admission. "Admission" to be 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. A resident who is readmitted and for whom there is a prior RAI on file does not require a new assessment unless a significant change in status has occurred (see below), and should remain on the same schedule as if there had been no temporary absence. An MDS/RAI need not be completed for residents discharged in less than 14 days, although the facility is to provide care appropriate to the resident's needs from admission to discharge. If the resident experiences a significant change in status, the next annual assessment is not due until 365 days after the significant change reassessment. Facilities may correct errors on the MDS per HCFA policy within 7 days of its completion.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C389 Cont.		The following guidance concerning significant change is applicable until the State respecifies its RAI for version 2.0. A "significant change" may include, but is not limited to, any of the following, or may be determined by a physician's decision if uncertainty exists: " Deterioration in two or more ADLs, or any combination of deterioration in two or more areas of ADLs, communication, or cognitive abilities that appears 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 status, where this change places the resident's life in danger, (e.g., stroke, heart disease, metastatic cancer); 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 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 last 30 days, 10% in last 180 days); or " Improvement in behavior, mood or functional status to the extent that the plan of care no longer addresses the needs of the resident. Comprehensive resident assessment is not required if declines in physical, mental or psychosocial well-being are short-term or insignificant (i.e., do not require a change in the resident's care plan). This may include:	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C389 Cont.		" Discrete and easily reversible symptoms documented in the resident's record and for which facility staff can initiate corrective action. For example, an anticipated side effect of introducing a psychotropic medication while attempting to establish a clinically effective dose level; " Short-term acute illness such as a mild fever secondary to a cold from which facility staff expect a full recovery of the resident's pre-morbid functional abilities and health status; " Well-established symptoms associated with previously diagnosed cyclical conditions. For example, depressive symptoms in a resident previously diagnosed with bipolar disease; or " If the resident continues to make steady progress under the current course of care, reassessment is required only when the condition has stabilized. "Promptly" means that once it is determined that the resident's change in status is significant or likely to be permanent, a full assessment must be completed within 14 days of this determination. The following definition of a criteria for significant change are effective when the State respecifies its RAI: assessment must be completed within 14 days of this determination. The following definition of a criteria for significant change are effective when the State respecifies its RAI: A "significant change" is a major change in the resident's status that is not self-limiting, impacts on more than one area of the resident's health status, and requires interdisciplinary review and/or revision of the care plan. According to this definition, a significant change reassessment would be indicated if decline or improvement is consistently noted in 2 or more areas of decline or 2 or more areas of improvement. Following are examples which could indicate a significant change.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C389 Cont.		<u>Decline:</u> " Any decline in ADL physical functioning where a resident is newly coded as 3, 4 or 8 (Extensive assistance, Total dependancy, Activity did not occur); " Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered" (i.e., an increase in the number of code "1s" for E4B); " Resident's decision-making changes from 0 or 1, to 2 or 3; " Resident's incontinence pattern changes from 0 or 1 to 2, 3 or 4, or placement of an indwelling catheter; " Emergence of sad or anxious mood as a problem that is not easily altered; " Emergence of an unplanned weight loss problem (5% change in 30 days or 10% change in 180 days); " Begin to use trunk restraint or a chair that prevents rising for a resident when it was not used before; " Emergence of a condition/disease in which a resident is judged to be unstable; " Emergence of a pressure ulcer at stage II or higher, when no ulcers were previously present at Stage II or higher; or " Overall deterioration of resident's condition; resident received more support (e.g., in ADLs or decision-making). <u>Improvement:</u> " Any improvement in ADL physical functioning where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4 or 8; " Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered"; " Resident's decision-making changes from 2 or 3, to 0 or 1; " Resident's incontinence pattern changes from 2, 3 or 4 to 0 or 1; or " Overall improvement of resident's condition; resident receives fewer supports.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C389 Cont.		Sad or Anxious Mood are coded as "not easily altered"; " Resident's decision-making changes from 2 or 3, to 0 or 1; " Resident's incontinence pattern changes from 2, 3 or 4 to 0 or 1; or " Overall improvement of resident's condition; resident receives fewer supports. If the resident experiences a significant change in status, the next annual assessment is not due until 365 days after the significant change reassessment.	
C392	(5) <u>Review of Assessments.</u> The nursing facility must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. <u>Intent: §483.20(b)(5)</u> To assure that the resident's assessment is accurate and reflects the resident's current status. At least each quarter, the facility reviews each resident with respect to those MDS items specified under the State's quarterly review requirement. At a minimum, this would include all items contained in HCFA's quarterly review form. Until the State respecifies its RAI for version 2.0, facilities are not required to use HCFA's form unless specified by the State. However, when the State respecifies its RAI, the quarterly review form will be required. If the resident has experienced a significant change in status, the next quarterly review is due no later than 3 months after the significant change reassessment. Until the State respecifies its RAI, review at least quarterly; " Cognitive patterns, especially memory and daily decision-making ability; " Communication/hearing ability, especially the ability to make one's self understood and to understand others; " Physical functioning and ADL abilities;	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C392 Cont.		" Continence; " Mood and behavior patterns; " New disease diagnoses that have a relationship to current ADL status, behavior status, medical treatments, or risk of death; " Weight loss; " Medication use, particularly psychotropic medications; and " Special treatments and procedures, including restraints. **NOTE: These quarterly assessment domains will no longer apply when the State respecifies its RAI.**	
C393	(6) Use. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care, under paragraph (d) of this section.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	
C394	(7) Coordination. The facility must coordinate assessments with any State-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	
C395	(d) Comprehensive care plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. An interdisciplinary team, in conjunction with the resident, resident's family, surrogate or representative, as appropriate, develops quantifiable objectives for the highest level of functioning the resident may be expected to maintain, based on the comprehensive assessment. The interdisciplinary team shows evidence in the RAP Summary or clinical record of the resident's	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C395 Cont.	and timetables to meet a resident's medical, nursing and 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 psycho-social 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).	status in triggered RAP areas and their rationale for deciding whether to proceed with care planning and that they considered the development of care planning interventions for 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 or 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.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C396	(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 physician, 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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. " 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? A comprehensive care plan is developed within 7 days of the completion of the assessment.	
C397	(3) The services provided or arranged by the facility must -- (i) Meet professional standards of quality and	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C398	(ii) Be provided by qualified persons in accordance with each resident's written plan of care.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. The hospital has recommended practices to achieve desired resident outcomes. These may include: " Current manuals or textbooks on nursing, social work, physical therapy, etc. " Standards published by professional organizations such as the American Nurses' Association, the National Association of Social Work, the American Dietetic Association, the National Association of Activity Professionals, the American Medical Association, etc. " Clinical practice guidelines published by the Agency for Health Care Policy and Research. " Current professional journal articles.	
C399	(e) <u>Discharge summary.</u> 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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. A post-discharge plan of care for an anticipated discharge is done for each resident whom the facility discharges to a private residence, to another NF or SNF, or to another type of residential facility such as a board and care home or an intermediate care facility for mentally retarded individuals. A "post-discharge plan of care" means the discharge planning process which includes: assessing continuing care needs and developing a plan designed to ensure the individual's needs will be met after discharge from the facility into the community. "Anticipates" means that the discharge was not an emergency discharge (e.g., hospitalization for an acute condition) or due to the resident's death. "Adjust to his or her living environment" means that the post-discharge plan, as appropriate, should describe the resident's and family's preferences for care, how the resident and family will	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C399 Cont.	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.	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.	
C400	(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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Parameters of nutritional status are monitored by staff. 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 be examined in light of the individuals former life style as well as the current diagnosis.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C401	(2) Receive a therapeutic diet when there is a nutritional problem.	Suggested parameters for evaluating significance of unplanned and undesired weight loss are: <u>Interval</u> <u>Significant Loss</u> <u>Severe Loss</u> 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: % of body weight loss = $\frac{\text{usual weight - actual weight}}{\text{usual weight}} \times 100$ 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? <u>Suggested laboratory values are</u>: 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	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES

C401 Cont.		normal values. **NOTE: These is no requirement that facilities order the tests references above.** <u>Clinical Observations</u>: Potential indicators of malnutrition are pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting. Risk factors for malnutrition are: 1. Drug therapy that may contribute to nutritional deficiencies such as: a. Cardiac glycosides; b. Diuretics; c. Anti-inflammatory drugs; d. Antacids (antacid overuse); e. Laxatives (laxative overuse); f. Psychotropic drug overuse; g. Anticonvulsants; h. Antineoplastic drugs; i. Phenoathiazines; j. Oral hypoglycemics; 2. Poor oral health status or hygiene, eyesight, motor coordination, or taste alterations; 3. Depression or dementia; 4. Therapeutic or mechanically altered diet; 5. Lack of access to culturally acceptable foods; 6. Slow eating pace resulting in food becoming unpalatable, or in staff removing the tray before resident has finished eating; and 7. 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	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C401 Cont.		hypothyroidism; " 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 physician 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).	
C402	§483.45 Specialized rehabilitative services. (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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. "Specialized rehabilitative services" are differentiated from restorative services which are provided by nursing staff. Specialized rehabilitative services are provided by or coordinated by qualified personnel. Specialized rehabilitative services provided to residents who need them even when the services are not specifically enumerated is the State plan. No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C402 Cont.	(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.		
C403	(b) <u>Qualifications.</u> Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. Specialized rehabilitative services are provided for individual's under a physician's order by a qualified professional.	
C404	<u>§483.55 Dental services.</u> The facility must assist residents in obtaining routine and 24-hour emergency dental care.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. The facility is directly responsible for the dental care needs of its residents. The facility must ensure that a dentist is available for residents (i.e., employ a staff dentist or have 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. 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.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C405	(a) <u>Skilled nursing facilities.</u> 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;	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	
C406	(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.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS. "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 prosthodonic 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, appropriately treated by a dentist that requires immediate attention.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C406 Cont.		"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.	
C407	(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 services (to the extent covered under the State plan); and (ii) Emergency dental services.	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	
C408	(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	ITEM IS A NECESSARY ELEMENT OF APPROVAL AS A CAH FOR PATIENTS IN SWING-BEDS.	

TAG #	REGULATION	ELEMENTS TO CONSIDER	NOTES
C408 Cont.	(3) Must promptly refer residents with lost or damaged dentures to a dentist.		

___________________HOSPITAL

Subject: PROVISION OF PATIENT CARE SERVICES

Policy: CI52

All patient care services at ____________ hospital are supervised by physicians. Direct patient care may be initiated and ordered by a physician, physician assistant, or advanced practice nurse.

Patient care services provided by a physician assistant will be provided under physician supervision as provided by Sections 22.01.03 and 22.01.04 Idaho Administrative Practices Act.

Patient care services provided by advanced practice nurses will be provided under physician supervision as provided by Section 22.01.04 Idaho Administrative Practices Act.

___________________HOSPITAL

Subject: LICENSED DISCIPLINES

Policy: C154

The state of Idaho by legislative mandate licenses the following health care providers: physicians, chiropractors, podiatrists, pharmacists, dentists, physician assistants, advanced practice nurses (nurse midwives, certified registered nurse anesthetists, clinical nurse specialists, family nurse practitioners), registered nurses, licensed practical nurses, respiratory therapists, physical therapists, physical therapy assistants, occupational therapists, occupational therapist assistants, dieticians, psychologists, acupuncturists and social workers.

All persons employed by or providing services at _______________hospital in any of the above listed disciplines will have in their personnel files a current copy of the appropriate license. It is the responsibility of persons in the above listed categories to provide ___________ hospital with a copy of their current license. As a condition of providing patient services, it is the responsibility of persons in the above listed categories to renew their license at the appropriate time. Finally, it is the responsibility of persons in the above listed categories to advise _______________ hospital of any change in their licensure status.

___________________**HOSPITAL**

Subject: CREDENTIALING

Policy: C195A

As a critical access hospital, ______________ hospital has entered into an agreement for credentialing with __________________. _________________ will conduct an initial evaluation of ______________ hospital's credentialing system. This evaluation will consist of a 100 percent review of credentialing files at _____________ hospital to verify that:

1. There is a credentialing file maintained on each practitioner on the medical staff of ___________ hospital.

2. Each practitioner has been approved for specific privileges listed in the file.

3. The medical staff and governing board of _______________ hospital have approved the appointment of all practitioners granted privileges.

4. The National Practitioners Data Bank has been queried for all practitioners.

Biennially, after initial evaluation, ________________ will review 100 percent of the credentialing files at ____________ hospital and verify each of the elements above.

__________________HOSPITAL

Subject: QUALITY IMPROVEMENT AGREEMENT

Policy: C195b

A condition of participation as a Critical Access Hospital (CAH) is that the hospital has *"An agreement with respect to quality assurance . . . with . . . one other appropriate and qualified entity in the State rural health care plan."* It is recognized that quality assurance is an ongoing, objective process of monitoring and evaluating that must include identification and correction of problems.

To meet this requirement __________________ hospital has entered into an agreement with ________________. As part of that agreement _______________ will oversee the following activities at ___________ hospital.

(For hospitals with a quality assurance agreement with IHA the following language is suggested.)

________________ hospital will become a member of the Maryland Quality Indicator Project (MQIP) and provide IHA access to their MQIP data and permission to share that data with appropriate state and federal agencies. To ensure an effective QUALITY ASSURANCE effort, the following process will be undertaken.

1. Initially and on an annual basis thereafter, IHA, the State Office of Rural Health (SORH) and each individual CAH will review the various MQIP indicators and select one or two QIP indicators for which that individual participating CAH will be required to report to IHA for the next calendar year.

2. In addition to at least one MQIP indicator, participating CAHs will track by 12 hour increments and report to IHA quarterly the length of stay for each admission.

3. IHA will make available to the SORH or designee, e.g., the Bureau of Facility Standards, information on tracked indicators on an annual or more frequent basis, as dictated by the SORH.

IHA will serve as a resource to all CAHs in establishing, implementing and maintaining total quality assurance programs. However, IHA will not receive reports on quality assurance activities nor forward information to other entities, with the exception of those enumerated above for participating CAHs.

(For hospitals with agreements with other entities the following language is suggested.)

_________________ will serve as a resource to ________________ hospital in establishing,

implementing, and maintaining total quality assurance programs.

(Enter here the elements of your agreement with the other entity which will demonstrate meaningful oversight.)

_____________ hospital may also use IHA as a resource to in establishing, implementing and maintaining total quality assurance programs. However, IHA will not receive reports on quality assurance activities nor forward information to other entities, with the exception of those agreed upon for participating CAHs.

__________________**HOSPITAL**

Subject: EMERGENCY ROOM SERVICES

Policy: C201

All emergency room services at _______________ are physician directed. All patients presenting to ______________ hospital seeking services or on whose behalf services are sought will receive an appropriate medical screening examination. An appropriate medical screening examination will not be denied to any patient no matter what the potential payment source nor for lack of an apparent payment source. An appropriate medical screening examination will not be delayed to inquire as to payment source nor to seek the approval or authorization from any third party.

(Recommend a statement such as one of the following.)

At _____________ hospital all medical screening examinations will be performed by a physician.

(OR)

At _______________ hospital a medical screening examination may be performed by ___________ as detailed in Policy #_______ approved by the Governing Board. The emergency department physician on call remains ultimately responsible for medical screening examinations performed by _______________.

If the medical screening examination reveals the existence of an emergency medical condition, the patient will be stabilized before transfer or discharge unless:

1. the patient requests the transfer or discharge in writing or

2. a physician has decided that the transfer is medically necessary and he/she will sign a certificate to that effect and that the benefits of the transfer outweigh the risks of the transfer.

__________________HOSPITAL

Subject: TRANSFUSION OF NON-CROSS MATCHED BLOOD

Policy: C205

As a critical access hospital, _______________ hospital does not maintain type and cross matching abilities at all times. Emergency blood supplies may be met by administering O-negative packed red blood supplies.

If O-negative blood is required, before administration to the patient a physician will sign an acknowledgment that the blood to be administered in not cross matched for the patient.

The patient or appropriate surrogate will also sign a consent acknowledging that the blood is not cross matched.

__________________HOSPITAL

Subject: ON CALL AVAILABILITY TO EMERGENCY DEPARTMENT

Policy: C207

Call schedules for response to the emergency department of _____________ hospital will be prepared _____ days in advance.

The call schedule will list the name of the primary provider responsible for emergency department coverage for each day the schedule covers. If the primary provider is a physician assistant or advanced practice nurse, the call schedule will also list the name of the physician available for "back up."

A copy of the call schedule will be posted and readily available in the emergency department. Changes to the published call schedule will not be considered in effect until they have been communicated to ___________ hospital and are reflected on the published schedule maintained in the emergency department.

Primary provider must be able to respond to the emergency department within 30 minutes of notification.

(Editorial note: The new standard suggested for CAHs in frontier areas is 60 minutes, as published in the July 30, 1999 Federal Register Volume 64 No. 146 at page 41537. However, the recommendation of IHA and of most liability carriers is 30 minutes.)

___________________HOSPITAL

Subject: COORDINATION/COMMUNICATION WITH EMERGENCY RESPONSE SYSTEM

Policy: C209

_____________ hospital has ongoing, 24 communication capability with ____________________ (emergency first responders) via ______________.

In the event of failure of that system, _____________ hospital would utilize _____________ or _______________ to communicate with first responders.
The medical staff at ______________ hospital has access to this system when not on site by relay communications on _______________.

___________________HOSPITAL

Subject: LENGTH OF STAY

Policy: C212

As mandated in CFR Sec. 485.620(b), ______________________ hospital will discharge or transfer each inpatient within 96 hours after admission unless:

a. a longer period is required because a transfer to another hospital is precluded due to inclement weather or other emergency conditions or

b. upon waiver of the 96 hour restriction by the PRO when a Medicare beneficiary's medical condition warrants further acute care.

Inclement Weather or Other Emergency Conditions

In the event of inclement weather or other emergency conditions, __________ ____________________ (department/position, e.g., billing office) will so indicate on the uniform billing claim form or as otherwise specified by the fiscal intermediary.

The inclement weather or other emergency conditions necessitating the extended stay will be documented in the patient record by _______________ ____________ (department/position, e.g., nurse/discharge planner).

Medical Conditions

Weekdays: On weekdays, in the event that the beneficiary's medical condition warrants continued acute care services beyond 96 hours, __________________ ________________ (department/ position, e.g., discharge planner) will contact the PRO by 5:00 p.m. on Thursday to request a waiver by telephone and concurrently provide the PRO (either by fax or express mail) a copy of the patient's medical record (or those portions of the record requested by the PRO).

Weekends/Holidays: For Medicare beneficiaries whose 96 hour stay limit will occur when the PRO staff is unavailable during weekend hours or holidays and whose need for extended acute care services is anticipated by ______________ _________________________ (department/position, e.g. utilization review personnel/discharge planner), the hospital will contact the PRO by 5:00 p.m. two days prior to the weekend/holiday.

The PRO will instruct the hospital as to its requirements in order to review the case (e.g., submitting all or part of the medical record) and will notify the hospital by 6:00 p.m. (PST) of its approval or denial of the extension and the length of the extension (e.g., one day, two day) in the event an anticipated extension becomes necessary over the weekend/holiday.

Denial

In the event of an extension denial by the PRO, ______________________ ___________________ (hospital staff) will request an expedited reconsideration by telephoning or faxing a written request to the PRO, if deemed necessary by the hospital, and make appropriate arrangements to address the continued needs of the patient. If an expedited reconsideration is not filed timely, ___________________________ (hospital personnel) will seek a non-expedited reconsideration as deemed necessary.

___________________HOSPITAL

Subject: LICENSED NURSE STAFFING

Policy: C255

At any time there is one or more inpatient at _______________ hospital there will be one or more licensed nurse on duty.

Licensed nurse means a “clinical nurse specialist,” a “registered nurse,” or a “licensed practical nurse” licensed by the State of Idaho.

(Editorial Note: It is <u>not</u> recommended that a CAH ever meet this requirement by staffing with only an LPN.)

___________________HOSPITAL

Subject: PRACTITIONER REVIEW OF POLICIES AND PROCEDURES

Policy: C258

Annually all patient care policies of __________ hospital will be reviewed by the chief of the medical staff or a physician designated by the chief of the medical staff.

In addition, all physicians, physician assistants, and nurse practitioner members of the medical staff will review all patient care policies on their appointment.

Changes to or additions to the patient care policies of ___________ hospital will be made only on approval of the medical staff.

___________________HOSPITAL

Subject: REVIEW OF MEDICAL RECORDS BY PHYSICIAN

Policy: C259

All patients at _____________ hospital are under the care of a physician. Each physician is responsible for signing those orders which he makes.

A physician may turn direct care of any of his patients over to either a physician assistant or an advanced practice nurse. The physician remains responsible under Idaho law for supervision of physician assistants and nurse practitioners to whom he has delegated patient care.

If direct patient care is being handled by a physician assistant or advanced practice nurse, that provider is authorized to issue orders to hospital personnel for care of that patient. It is not necessary that orders issued by physician assistants or nurse practitioners be counter-signed nor approved by a physician.

Review of patient records is an integral part of the quality assurance process at ___________ hospital. However, in addition to the normal quality assurance screens used, each physician who has delegated patient care to a physician assistant or nurse practitioner is required to review no less than 10 percent of those patient records per quarter. Physicians engaged in this review are expected to bring items of concern to the hospital peer review and quality assurance committees.

Physicians at ____________ hospital will, as part of their biennial recredentialing certify that they have reviewed medical records of those physician assistants and advanced practice nurses whom they supervise.

__________________HOSPITAL

Subject: REMOVAL OF PATIENT CARE RECORDS

Policy: C309

No original patient care records will be removed from ____________ hospital for any purpose, unless by specific judicial order.

Patients will be provided access to their own records on request and copies of their own records on payment of copying fees of ___________________.

Patients who wish copies of their medical records to be provided to any third party must file a request in writing with the medical records department and pay appropriate copying fees.

___________________HOSPITAL

Subject: RETENTION OF MEDICAL RECORDS

Policy: C311

All patient care records at ______________ hospital will be maintained for ____________ years.

At the end of ___________ years after the last patient encounter all patient care records will be destroyed by shredding, in keeping with their confidential nature.

(Editorial note: The statutory requirement is at least 6 years; IHA recommends ten years. Contrary to popular belief, there is no requirement under Idaho law for hospitals to keep records of a minor until they reach the age of majority. Nor is there any right of a minor to sue upon reaching the age of majority if rights existent during minority were not asserted. Under Idaho law, the statute of limitations is tolled for a period of "not more than six years on account of minority" [Section 5-230 Idaho Code], thus the longest a minor would have to initiate a lawsuit would be eight years.)

__________________HOSPITAL

Subject: ANNUAL EVALUATION OF SERVICES

Policy: C330

Annually _______________ hospital will evaluate its services and total program. The purpose of this evaluation will be to insure that suitable services are being delivered to the community and that critical access hospital designation remains the most appropriate service level for ______________ hospital.

This will include an annual review of:

1. utilization of services including number of patients served and volume of services,

2. a review of a representative sample of both active and closed clinical records, and

3. a review of all clinical care policies.

___________________ HOSPITAL

Subject: PATIENT RIGHTS

Policy: C361

Patients transferred to "swing bed status" have the following rights, which will be provided to the patient or appropriate patient surrogate in writing upon transfer to a "swing bed."

1. The right to be fully informed of his or her total health status.

2. The right to refuse treatment or to refuse to participate in experimental research.

3. The right to formulate an advance directive.

4. The right to choose a personal attending physician.

5. The right to be fully informed in advance of any changes in care planned.

6. The right to personal privacy and confidentiality.

7. The right to refuse to perform services for the facility or, if he/she chooses to perform services, to have the need or desire for work documented in the care plan, to know whether the services are voluntary or paid, and, if paid, to be paid at the prevailing rate.

8. The right to send and receive mail and telephone communications without interference.

9. The right to access any representative of the Director of the Department of Health and Welfare.

10. The right to retain and use personal property.

11. The right to share a room with his/her spouse.

12. The right to be free from restraints of any kind.

13. The rigth to be notified in advance of any planned transfer.

14. The right to be free from verbal, sexual, physical and mental abuse, and corporal punishment or involuntary seclusion.

___________________ **HOSPITAL**

Subject: MINIMUM DATA SETS FOR RESIDENTS IN SWING BED STATUS

Policy: C388

Patients at ____________ hospital transferred to "swing bed status" must have a comprehensive assessment of their needs made as follows:

1. A comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI), will be conducted within 14 calendar days of admission to a swing bed.

2. A comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI), will be conducted with 14 calendar days of a significant change in the patient's physical or mental condition.

3. A comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI), will be conducted at least once every 12 months thereafter.

Patients in swing bed status in CAHs are <u>not</u> subject to the requirements of 413.343(b) which requires assessments on the 5th, 14th, 30th, 60th, and 90th days following admission.

_____________________ HOSPITAL

Subject: Mid-Level review of patient records

Policy: C264

Each mid level practitioner at _________________ hospital will participate with a doctor of medicine or osteopathy in on going, and periodic review of patient records. This review will consist of a selection of no less than 10% of the mid-level's inpatient records per quarter, to be selected by the doctor of medicine or osteopathy.

The doctor of medicine or osteopathy will review the patient records and discuss findings and conclusions, positive or negative with the mid-level. Questions of quality of care or patient safety will be referred to a peer committee for further review.

In addition, any patient cared for by a mid-level practitioner who "falls out" in the hospitals normal Q.A. process will, after review by the hospital Q.A. committee, be referred for peer review.

______________________ HOSPITAL

Subject: Transfer of patient records

Policy: C267

When any patient is transferred from this facility to any other hospital appropriate patient records will be sent. Copies of all patient records, including laboratory and diagnostic information available will be sent with the patient.

A discharge summary by the attending practitioner will also accompany the patient. Clinical records not available at discharge, but which later become available will be sent by fax or other forms of electronic transfer as appropriate.

Original patient records will never be sent but will be maintained by this hospital.

______________________ HOSPITAL

Subject: Notification on admission of patient

Policy: C268

Mid-level practitioners are authorized to admit patients to __________________ hospital. As soon as practical after admission the admitting practitioner must notify a physician member of the staff of __________________ hospital.

At notification the physician will be given the patients admitting diagnosis, summary of the patients condition, a report of all laboratory and diagnostic work and the findings and conclusions of the admitting practitioner. The physician may order additional, supplemental or alternative regimens for the patient, including an order to transfer the patient which orders shall be followed by staff.

If the physician disagrees with any of the admitting practitioners to the extent that admitting orders are contravened, the physician must, within the next 12 hours see the patient or arrange for the patient to be seen by a physician within the next 12 hours.

______________________ HOSPITAL

Subject: Security of Medical Records

Policy: C308

All medical records of all patients are deemed to be confidential.All hospital personnel are charged with maintaining confidentiality of medical records in their custody. The medical records department will be locked when medical records personnel are not present. The charge nurse will have a key for “after hours” access.

Any access to the medical records department “after hours” will be entered into a log kept in the medical records deparment.

Records which are removed from the medical records department for any reason will be logged out” by the person taking them with information as to date, time, location and person taking them.

SAMPLE NETWORK AGREEMENT

THIS NETWORK AGREEMENT, (Agreement), entered into this _____ day of __________________,by____________________________________ a General Acute Care Hospital and______________________ a Critical Access Hospit (CAH), collectivley referred to as the parties

WHEREAS$_1$ the purpose of the Critical Access Hospital Program is to create options for redesigning the health care delivery system to cope with and prosper in the rural health environment.

WHEREAS$_1$_______________________ a CAH and______________________________ wish to maintain and promote the availability of a range of high-quality and cost-effective healthcare services in the CAH's service area and to assure the delivery of those healthcare services at a level most appropriate to a patient's identified need;

ThEREFORE, in consideration of the following mutual covenants,

___________________________ a CAH and

_________________________________ agree as follows:

PATIENT REFERRAL AND TRANSFERS:

Patient Transfers. To comply with the requirements of Public law 105-33, § 4201, the CAH will identify for transfer, patients which require services not offered by the CAH. Such patients will be tnansferred to _____________________ or to another hospital that provides the needed services. ______________________ is required to accept the patients referred by CA; however, this requirement is no greater than that required by the Emergency Medical Treatment and Active Labor Act 42 U.S.C. § 13954d, (EMTALA/COBRA).

Referral protocols. The decision to transfer or refer between the parties' facilities shall be in accord with the established policies and procedures of the transferring facility. The transfer or referral protocol shall be initiated and followed by the patient's attending physician, the emergency room physician on-duty, or the physician assistant or nurse practitioner$_7$ in consultation with the supervising physician, as the case may be$_7$ in deterrnining whether a transfer should be made.

Prior Consultations:. The referring practitioner will determihe if a telephone or other consultation with the potential attending physician is appropriate prior to transfer. Records from the transferring facility will be transmitted to the receiving facility as needed for purposes of the consultation. If a prior consultation between the referring physician and receiving physician is not appropriate or necessary, the referring physician will contact the receiving physician prior to transfer and will provide the receiving physician copies of clinical information appropriate to the

patient and the patient's course ot treatment.

Effecting Transfers. The parties agree to abide by the requirements of EMTALA/ COBRA in effecting transfers between the two facilities. Consequently, EMTALA/ COBRA's requirements for obtaining patient consents, prior notice and acceptance of the transfer by the receiving facility, records to be transmitted, and other requirements for effecting appropriate transfers shall be followed.

Transfers to Other Facilities: . The parties recognize that at times ____________________ may be unable to accept a patient via transfer from the CAH. Consistent with EMTALA/COBRA,_______________may refuse to accept a patient whose
transfer has been requested. After consultation with a _____________________ physician, a decision may be made by the referring physician to transfer the patient to another facility. The referring physician will contact another facility to provide the required care to the patient and will follow the policies and protocols of the transferring facility.

Communication After Transfer and During and After hospitalization: Following transfer to __________________________,________________________
agrees to send the CAH notice that the patient has been admitted and a confirmation as to the physician who is attending the patient. During a transferred patient's hospitalization, the attending physician will provide updates to the referring physician concerning the patient's diagnosis, treatment, and disposition.If the patient is transferred to another facility for treatment other than back to the CAH ____________________ will contact the CAH as soon as practical. To the extent possible, patients from the CAH's community whose care needs can be provided by the CAH will be offered the opportunity to return to the CAH for such services;

At the time of discharge, the attending physician will send a copy of the Discharge Surimary to the referring physician.

COMMUNICATION SYSTEMS:

The parties agree that they may utilize the following technologies for purposes of transrnitting patient information and other data between their twofacilities:

____
____
____
______
____

and other technologies as agreed by the parties. The policies and protocols of the respective facilities as amended from time to time will specify the personnel responsible at each facility for the operation of the equipment involved in the technologies listed above. All voice telephonic or radio communications between the facilities shall be documented by the parties in a cornrnnications log and

medical record as appropriate, and permanent copies of all transmissions by facsimile, electronic medical record, and/or other technologies shall be retained in the patient's medical record to ensure proper documentation of the parties' communications. Additionally, a back-up plan in the event of failure of the priority communications system shall be established and agreed to by the CAH and ___________________________.

OTHER PROVISIONS:

Term. This Agreement shall be effective on ______________________ and shalt continue for a period of one year, and thereafter it shall be renewed automatically for successive one- (1) year terms, unless sooner terminated as provided below.

Liability. Each facility shall be responsible for its own acts and omissions and shall not be responsible for the acts and omissions of the other

Termination. This Agreement may be terminated by either party for any reason, by giving thirty (30) days' written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved m the transfer process. To this end, the terminating party will be required to meet its commitments under the Agreement to all patients for whom the other party has begun the transfer process in good faith.

IN WITNESS WHEROF , the parties have caused this agreement to be executed as of:

This __________________ day of ___________________________ 00

Signed:__________________________________ For the Critical Access Hospital

Signed:___________________________________For ________________________ Hospital

AGREEMENT

QUALITY ASSURANCE

I. PARTIES

This is an agreement between ________________________Hospital and the Idaho Hospital Association (IHA) regarding oversight of the quality assurance activities of ____________________ hospital.

II. TERM OF AGREEMENT

This agreement is effective upon status as a Critical Access Hospital being granted to _____________ hospital and will remain in effect until it is terminated by either of the parties. Either party may terminate this agreement on thirty days written notice being provided to the other party.

III. CONDITIONS OF AGREEMENT

1. ______________hospital as a Critical Access Hospital is required to have *" An agreement with respect to quality assurance . . . with . . . one other appropriate and qualified entity identified in the State rural health care plan."*

2. IHA has been identified as such a qualified entity.

3. At initial granting of Critical Access Hospital status ________________ hospital will agree to become a participant in the Maryland Quality Improvement Project(MQIP) sponsored by IHA.

   a.______________ hospital will quarterly report to MQIP on indicators which _________ hospital will select

   b._____________ hospital will agree to give IHA staff access to data collected from _____________ hospital as a member of MQIP.

   c. IHA may periodically make written recommendations to _______________regarding reported data and possible corrective action which should be considered.

4. Within 90 days of __________________ hospital being granted status as CAH IHA staff will do an on-site review of _________________ hospitals Quality Assurance program.

5. Within 30 days of the on-site review IHA will send a written report to ____________ hospital outlining the findings of the review and making recommendations for corrections of any deficiencies noted.

6. ________________ hospital will within 90 days of receiving IHA staff report, demonstrate to the satisfaction of IHA staff that deficiencies have been corrected.

7. No less than annually thereafter and as deemed necessary by IHA staff, IHA staff will do on site surveys of ________________hospitals Quality Assurance activities to insure continued performance.

IV. NOT COVERED BY THIS AGREEMENT

1. IHA will not play any role in the Quality Assurance process of ___________ hospital other than those outlined above.

2. IHA will not play any role in the Peer Review process of _______________ hospital nor in recommending changes in clinical practices at ________________hospital

Dated this _____ day of _______, 20____

____
Hospital

____
Idaho Hospital Association

AGREEMENT

CREDENTIALING SERVICES

I. PARTIES

This is an agreement between ________________________Hospital and the Idaho Hospital Association (IHA) regarding CREDENTIALING of the medical staff of ____________________ hospital.

II. TERM OF AGREEMENT

This agreement is effective upon status as a Critical Access Hospital being granted to _____________ hospital and will remain in effect until it is terminated by either of the parties. Either party may terminate this agreement on thirty days written notice being provided to the other party.

III. CONDITIONS OF AGREEMENT

1. ______________hospital as a Critical Access Hospital is required to have *" An agreement with respect to CREDENTIALING . . . with . . . one other appropriate and qualified entity identified in the State rural health care plan."*

2. IHA has been identified as such a qualified entity.

3. At initial granting of Critical Access Hospital status ________________ hospital will so notify IHA. IHA will within 90 days of such notification do an on-site review of ____________ hospital's medical staff CREDENTIALING files. This review will be limited to:

   a. A determination that there is a CREDENTIALING file maintained for each member of the medical staff

   b. A review of individual files to insure that all required documentation is present

   c. Written recommendations to _______________regarding any observed deficiencies

4. __________________ hospital will make available to IHA staff files and supporting documentation to conduct such review.

5. Within 90 days of initial review __________________ hospital will provide IHA staff with evidence that any deficiencies identified in initial review have been corrected

6. After initial review IHA will bi- annually re-survey _____________ hospitals CREDENTIALING files to insure that appropriate CREDENTIALING files and processes are maintained.

IV. NOT COVERED BY THIS AGREEMENT

1. IHA will not play any role in the CREDENTIALING process, nor in CREDENTIALING decisions. IHA will not consider questions of clinical competence, nor suitability for appointment to the medical staff of ___________________

2. Decisions regarding appointment, or removal from the medical staff, or of levels of privileges extended to any member of the medical staff of ___________________hospital are solely and exclusively within the purview of the administration, medical staff and governing body of _____________________ hospital.

Dated this _____ day of _______, 20____

____
Hospital

____
Idaho Hospital Association

AGREEMENT TO EXCHANGE PEER REVIEW SERVICES

PRELIMINARY PROVISIONS

1.This is an agreement between __________________ hospital and ____________________ hospital to engage in a mutual exchange of physician peer review services.

2. Every Hospital in Idaho is statutorily required to have a peer review process in place.

3. Hospitals seeking designation as a Critical Access Hospital are specifically required to have a *" physician peer review process provided by an outside source."*

4. Since both ______________ hospital and _______________ hospital have applied for designation as Critical Access Hospitals it would be to their mutual advantage to exchange services for peer review.

TERMS OF THIS AGREEMENT

1. This agreement is effective on the date of designation as a Critical Access Hospital for each of the above named hospitals. This agreement will continue in force until terminated in writing by either party.

2. This agreement may be terminated by either party by sending written notice of the effective date of the termination to the other party.

3. Each of the hospitals will determine internally those items which it will include in it's peer review process. Once a month a representative sample (10%) of that hospitals peer review charts will be sent to the other hospital. Copies only of these charts will be sent, and original medical records will never be sent. The hospital sending charts for review will bear all the costs associated with copying, mailing etc. The hospital reviewing charts will incur no costs.

4. Charts sent for review will be considered as part of the normal peer review process as detailed in section 39-1392 et. seq. of the Idaho Code and will have all of the protections of confidentiality and exemption from discovery as contemplated by those sections.

5. It is contemplated that this process will be a mutually beneficial one to each hospital and that exchange of charts for review will be an equitable exchange of labor. Neither hospital will charge the other for this service.

6. The hospital performing the review will:

A. Prepare a written report of its findings in a format to be agreed upon by the parties and forward that report to the peer review committee of the other hospital

b. Not maintain a copy of that report.

c. Immediately on transmission of it's report, destroy all copies of any medical records it

has received for review in that case.

7. Each hospital entering into this arrangement agrees to hold harmless and indemnify the other for any action arising from services performed under this Peer Review exchange.

Dated this: day of _____________, 20____

____

Administrator ______________________ Hospital

Dated this day of ______________, 20____

Administrator ____________________ Hospital

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