



Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-18-26- Hospital/CAH

DATE: August 31, 2018

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group (*formerly Survey & Certification Group*)

SUBJECT: Guidance to Hospitals and Critical Access Hospital (CAH) Surveyors Addressing Revisions to Swing-Bed Requirements

Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) is providing updated guidance to surveyors for the special requirements for Hospital and CAH providers of long-term care services (LTC), also known as “swing beds”.
- ***For Hospitals:*** Appendix T has been deleted and will no longer be used for the special requirements for hospital providers of LTC services (“swing beds”). The guidance for the special requirements for hospital providers of LTC services are now located in Appendix A under §482.58.
- ***For CAHs:*** The special requirements for CAH providers of LTC services (“swing beds”) in Appendix W at §485.645 have been revised to reflect the provisions of the final rule that revised the requirements for LTC facilities in 2017. The CAH Survey Protocol has also been significantly revised.

Background

On October 4, 2016, CMS published a final rule that revised the requirements for LTC facilities (81 FR 68871) which also included revisions to the special requirements for Hospitals and CAHs with swing beds at 42 CFR 482.58 and 485.645, respectively. On July 13, 2017, CMS published technical corrections to that final rule (82 FR 32260).

Revisions were made to the Appendices in the CMS State Operations Manual (SOM). Specifically, in Appendix A, *Survey Protocol, Regulations and Interpretive Guidelines for Hospitals*, Tags A-1500 through A-1576, are revised to reflect the recent revisions to the regulations and to update the interpretive guidelines and survey procedures for hospitals. Appendix A is also revised to include the guidance for Swing Beds that is found Appendix T,

Regulations and Interpretive Guidelines for Swing Beds in Hospitals. Therefore, Appendix T is being deleted.

Also, Appendix W, *Survey Protocol, Regulations and Interpretive Guidelines for CAHs and Swing Beds in CAHs* is similarly being revised at Tags C-0350 through C-0410 to include the recent regulatory changes as well as to update the interpretive guidelines and survey procedures, with significant revisions to the Survey Protocol section. These revisions are not exclusive to surveying swing bed services in CAHs.

As stated previously, Appendix T for Swing Bed Services is deleted. All content is now located in Appendix A.

Contact: Questions concerning this memorandum should be addressed to the appropriate provider type as follows:

- Hospitals: HospitalSGC@cms.hhs.gov;
- CAH: CAHSCG@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment - Advanced Copy Appendices A and W

cc: Survey and Certification Regional Office Management

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health &
Human Services (HHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal-Advanced Copy

Date:

SUBJECT: Revisions to Medicare State Operations Manual (SOM) Table of Contents, Medicare SOM Appendix, SOM Appendix A – *Survey Protocol, Regulations and Interpretive Guidelines for Hospitals*, SOM Appendix T- *Regulations and Interpretive Guidelines for Swing Beds in Hospitals*, SOM Appendix W- *Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs*

I. SUMMARY OF CHANGES: Revisions are being made to SOM Appendix A for Hospitals and Appendix W for Critical Access Hospitals (CAHs) to address new and revised regulations and interpretive guidelines related to Swing Bed Services. Content currently found in SOM Appendix T for Swing Bed Services in Hospitals will be relocated to SOM Appendix A since Swing Bed Services are an optional service for hospitals. SOM Appendix T will be deleted.

NEW/REVISED MATERIAL –

EFFECTIVE DATE*:

IMPLEMENTATION DATE:

Or

MANUALIZATION/CLARIFICATION –

EFFECTIVE/IMPLEMENTATION DATES: Not Applicable.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)

(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Medicare State Operations Manual Table of Contents
R	Medicare State Operations Manual Appendix
R	Appendix A/Table of Contents
R	Appendix A/A-1500/§482.58 Special requirements for hospital providers of long-term care services (“swing-beds”)
R	Appendix A/A-1501
N	Appendix A/A-1562
N	Appendix A/A-1564
N	Appendix A/A-1566

N	Appendix A/A-1568
N	Appendix A/A-1570
N	Appendix A/A-1572
N	Appendix A/A-1574
N	Appendix A/A-1576
D	Appendix T Regulations and Interpretive Guidelines for Swing Beds in Hospitals
R	Appendix W/Table of Contents
R	Appendix W/Survey Protocol
R	Appendix W/C-0350
R	Appendix W/C-0351
D	Appendix W/C-0360
R	Appendix W/C-0361
D	Appendix W/C-0362
D	Appendix W/C-0363
D	Appendix W/C-0364
D	Appendix W/C-0365
D	Appendix W/C-0366
D	Appendix W/C-0367
D	Appendix W/C-0368
D	Appendix W/C-0369
D	Appendix W/C-0370
D	Appendix W/C-0371
D	Appendix W/C-0372
R	Appendix W/C-0373
D	Appendix W/C-0374
D	Appendix W/C-0376
D	Appendix W/C-0377
D	Appendix W/C-0378
D	Appendix W/C-0379
D	Appendix W/C-0380
R	Appendix W/C-0381
D	Appendix W/C-0382
D	Appendix W/C-0383
D	Appendix W/C-0384
R	Appendix W/C-0385
R	Appendix W/C-0386
R	Appendix W/C-0388
D	Appendix W/C-0389
D	Appendix W/C-0390
D	Appendix W/C-0395
D	Appendix W/C-0396
D	Appendix W/C-0397

D	Appendix W/C-0398
D	Appendix W/C-0399
D	Appendix W/C-0400
D	Appendix W/C-0401
R	Appendix W/C-0402
D	Appendix W/C-0403
R	Appendix W/C-0404
D	Appendix W/C-0405
D	Appendix W/C-0406
D	Appendix W/C-0407
D	Appendix W/C-0408
R	Appendix W/C-0410

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2018 operating budgets.

Or

Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. **Click on the corresponding letter in the “Appendix Letter” column to see any available file in PDF.**
- To return to this page after opening a PDF file on your desktop. Use the browser "back" button. This is because closing the file usually will also close most browsers

Appendix Letter	Description
<u>A</u>	Hospitals
<u>AA</u>	Psychiatric Hospitals
<u>B</u>	Home Health Agencies
<u>C</u>	Laboratories and Laboratory Services
<u>D</u>	Portable X-Ray Service
<u>E</u>	Outpatient Physical Therapy or Speech Pathology Services-Interpretive Guidelines
F	Physical Therapists in Independent Practice - Deleted
<u>G</u>	Rural Health Clinics (RHCs)
<u>H</u>	End-Stage Renal Disease Facilities
<u>I</u>	Life Safety Code
<u>J</u>	Intermediate Care Facilities for Individuals with Intellectual Disabilities
<u>K</u>	Comprehensive Outpatient Rehabilitation Facilities
<u>L</u>	Ambulatory Surgical Services Interpretive Guidelines and Survey Procedures
<u>M</u>	Hospice
<u>N</u>	Psychiatric Residential Treatment Facilities (PRTF) Interpretive Guidance
<u>P</u>	Survey Protocol for Long-Term Care Facilities
<u>PP</u>	Interpretive Guidelines for Long-Term Care Facilities

Appendix Letter	Description
<u>Q</u>	Determining Immediate Jeopardy
<u>R</u>	Resident Assessment Instrument for Long-Term Care Facilities
S	Mammography Suppliers - Deleted
<u>T</u>	Swing-Beds - <i>Deleted</i>
<u>U</u>	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
<u>V</u>	Responsibilities of Medicare Participating Hospitals In Emergency Cases
<u>W</u>	Critical Access Hospitals (CAHs)
<u>Y</u>	Organ Procurement Organization (OPO)
Z	Emergency Preparedness for All Provider and Certified Supplier Types

State Operations Manual

Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents (Rev.)

Transmittals for Appendix A

Regulations and Interpretive Guidelines

A-1500 (Rev.)

Condition of Participation: §482.58 Special requirements for hospital providers of long-term care services (“swing-beds”).

A hospital that has a Medicare provider agreement must meet the following requirements in order to be granted an approval from CMS to provide post-hospital extended care services, as specified in §409.30 of this chapter, and be reimbursed as a swing-bed hospital, as specified in §413.114 of this chapter:

Interpretive Guidelines §482.58

Swing-bed services are an optional service. The swing-bed concept allows a hospital to use their beds interchangeably for either acute-care or post-acute care. A “swing-bed” is a change in reimbursement status. The patient swings from receiving acute-care *hospital inpatient* services and reimbursement to receiving *post-acute care* skilled nursing facility (SNF) services and reimbursement. *A psychiatric hospital is not allowed to have swing-bed approval.*

Allowing a hospital to operate swing-beds is done by issuing a “swing-bed approval”. If the *hospital* fails to meet the swing-bed requirements (not the same as the *hospital* conditions of participation (CoPs)), and the *hospital* does not *implement* a plan of correction, they lose the approval to operate swing-beds and receive swing-bed reimbursement. However, in such a situation, the *hospital* does not go on a termination track. If the hospital continues to meet *all other applicable* hospital CoPs, it continues to participate in Medicare, but loses its swing-bed approval.

Swing-beds do not have to be located in a special section of the hospital *although a hospital may choose to do so*. The patient does not have to change locations in the hospital merely because their admission status changes unless the hospital requires it. The change in status from acute care to swing-bed status can occur within the same part of the hospital or the patient can be moved to another part of the hospital for swing-bed admission. Likewise, a patient may be

discharged from one hospital and admitted in swing bed status to another hospital that has swing bed approval.

Beds in a hospital IPPS-excluded rehabilitation or psychiatric unit, or a separately certified co-located Medicare participating entity (e.g., a distinct part SNF/NF, another hospital, or an inpatient hospice) cannot be used by the hospital for providing swing-bed services.

There must be discharge orders from acute care hospital inpatient services and subsequent admission orders for swing-bed services, the same as if the patient had been transferred to a separately certified skilled nursing facility. The same clinical record may be used for a swing-bed patient, but it must include discharge orders from acute care hospital inpatient services and admission orders to swing-bed services, and the swing-bed services (which may be SNF or NF level services) must be clearly delineated within the clinical record.

There is no length of stay restriction for any hospital swing-bed patient. There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between hospitals and nursing homes. While there is no length of stay limit for patients in swing-bed status, the intended use for swing beds is for a transitional time period to allow the patient to fully recover to return home or while awaiting placement into a nursing facility.

The Medicare statute and regulations require that, in order to be eligible for Medicare coverage of post-hospital skilled nursing facility (SNF) or swing-bed care, a beneficiary must have a qualifying 3-day inpatient stay in a participating or qualified hospital or participating CAH prior to admission to a swing bed in a hospital, or admission to a SNF. This requirement applies only to patients who are Medicare beneficiaries who seek Medicare coverage of their SNF services. It is not evaluated or enforced through the survey and certification process, since it is a coverage requirement.

In accordance with SOM Section 2037 hospitals seeking swing-bed approval are screened prior to survey for their eligibility for swing beds. However, the CMS Regional Office makes the determination whether the hospital has satisfied the eligibility criteria, regardless of whether the State Survey Agency or Accrediting Organization, as applicable, recommends approval of swing bed status.

NOTE: *Swing-beds must not be confused with beds in a skilled nursing facility (SNF) or nursing facility (NF), including a distinct part SNF/NF, that shares the same building/campus as the hospital but is a separately certified provider with its own Medicare provider agreement.*

*An onsite survey must be conducted and the hospital must meet all the requirements of 42 CFR 482.58 before the hospital can obtain swing bed approval. Surveyors assess the manner and degree of non-compliance with the swing bed standards in determining whether there is condition-level compliance or *standard-level* non-compliance.*

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(Rev.)

§482.58 (a) Eligibility. A hospital must meet the following eligibility requirements:

- (1) The facility has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care type inpatient units (for eligibility of hospitals with distinct parts electing the optional reimbursement method, see §413.24(d)(5) of this chapter).**
- (2) The hospital is located in a rural area. This includes all areas not delineated as “urbanized” areas by the Census Bureau, based on the most recent census.**
- (3) The hospital does not have in effect a 24-hour nursing waiver granted under §488.54(c) of this chapter.**
- (4) The hospital has not had a swing-bed approval terminated within the two years previous to application.**

Interpretive Guidelines §482.58(a)

Hospitals seeking swing-bed approval are screened prior to survey for their eligibility for swing-beds. However, the CMS RO makes the determination whether the hospital has satisfied the eligibility criteria, regardless of whether the SA or AO, as applicable, recommends approval of swing-bed status (this responsibility may not be delegated to the SA).

The eligibility criteria at 42 CFR 482.58(a) requires:

- *The hospital has a Medicare provider agreement;*
 - *An initial applicant hospital may seek swing-bed approval. If the applicant hospital meets all Federal requirements for participation, including those for swing-bed approval, the applicant hospital’s approval for swing-bed services will be effective with the effective date of the hospital’s Medicare participation agreement;*
- *The hospital has fewer than 100 maintained hospital beds, including any beds in IPPS-excluded units, but excluding beds for newborns and beds in intensive care type inpatient units;*
 - *The bed-count will be evaluated by surveyors during the survey;*
 - *Even though beds within a hospital’s IPPS-excluded psychiatric or rehabilitation unit may not be used for the provision of swing bed services, the beds maintained within those units are included with the number of maintained beds within the hospital (that is because the §482.58(a)(1) does not exclude those beds from the count);*
 - *The bed-count is not based on the number of licensed or certified beds, but rather*

the bed-count is based on maintained beds;

- *Maintained beds are those patient beds within the Medicare certified hospital that are present for use in providing inpatient services, observation services, and/or swing-bed services.*
 - *Maintained beds would include:*
 - *Patient beds that are that located within nursing units of the hospital;*
 - *Established bed locations in patient rooms where the bed is temporarily out of service or temporarily absent from the location it routinely occupies; and*
 - *Those beds that are located within nursing units that are temporarily closed but are still included on the hospital's license and which can be brought into service when the hospital chooses.*
 - *Maintained beds would not include:*
 - *Examination or procedure tables or stretchers located in procedure rooms that are exclusively used for conducting examinations or procedures; and*
 - *Stretchers maintained in nursing units that are solely used for patient transport;*
- Note: Maintained beds that are located within intensive care type units and those beds that are maintained solely for the use of newborns would not be included in the bed count.*
- *If a Medicare certified hospital has multiple inpatient locations such as remote locations or satellites, all maintained beds at each location must be combined into a single bed-count. The total count of maintained beds for the Medicare certified hospital must be less than 100.*
 - *The hospital is located in a rural area. This includes all areas not delineated as "urbanized" areas by the Census Bureau, based on the most recent census;*
 - *The CMS RO Division of Survey and Certification (DSC) is responsible for conducting the evaluation as to whether the hospital is located outside of an urbanized area;*

- *The hospital must be located outside an urbanized area but may be located in an urban cluster (the terms “urbanized area” and “urban cluster” are two distinct classifications of population size used by the U.S. Census Bureau. An urban cluster is not an “urbanized area”);*
- *The RO will utilize the U.S. Census Bureau’s most current edition of American Factfinder to determine if the hospital is located outside of an area designated as urbanized. See SOM §2037E for additional instructions;*
- *In a situation where a hospital has multiple inpatient locations, such as a multi-campus hospital (a hospital with remote locations), or a hospital with satellites, each inpatient location must be individually evaluated to determine if it is located outside an urbanized area. When any inpatient location of the Medicare certified hospital is located within an urbanized area the hospital does not qualify for swing-bed approval.*
- *A hospital’s swing bed approval must be terminated if the U.S. Census Bureau delineates the hospital, or any inpatient location of the hospital, as being located within an urbanized area.*
- *The hospital does not have in effect a 24-hour nursing waiver granted under 42 CFR 488.54(c);*
 - *The RO must review the hospital’s ASPEN file to determine if the hospital has in effect a 24-hour nursing waiver. A hospital with this waiver cannot have swing-bed approval;*
 - *A hospital that currently has swing-bed approval that seeks and is granted a 24-hour nursing waiver under 42 CFR 488.54(c) must have its swing-bed approval terminated;*
- *The hospital has not had a swing-bed approval terminated within the two years previous to application;*
 - *When a hospital is seeking initial swing-bed approval, the RO will review the hospital’s ASPEN file to determine if the hospital previously had swing-bed approval that was terminated within the two years previous to the application; and*
 - *A request for swing-bed approval will be denied if the hospital has had swing-bed approval terminated within the previous two years. It does not matter whether the termination was voluntary or involuntary.*

Survey Procedures §482.58(a)

In conducting the survey, verify that the hospital has fewer than 100 hospital beds, excluding beds for newborns and beds in intensive care units. A hospital licensed for more than 100 beds may be eligible for swing-bed approval if it utilizes and staffs for fewer than 100 beds. Surveyors are to count the beds in each nursing unit. Do not count beds in recovery rooms, intensive care units, operating rooms, newborn nurseries, or stretchers in emergency departments. However, do count the beds within IPPS-excluded Rehabilitation and Psychiatric Units.

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(Rev.)

§482.58(b) Skilled nursing facility services. The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter.

§482.58(b)(1) Resident rights (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2), (e)(4), (f)(4)(ii), (f)(4)(iii), (f)(9), (h), (g)(8), (g)(17), and (g)(18) introductory text.

- ***§483.10(b)(7): In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.***
 - (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decision outside the representative's authority.***
 - (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.***
 - (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.***
- ***§483.10(c)(1): The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.***
- ***§483.10(c)(2)(iii): The right to be informed, in advance, of changes to the plan of care.***
- ***§483.10(c)(6): The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.***

- *§483.10(d): Choice of attending physician. The resident has the right to choose his or her attending physician.*
 - (1) *The physician must be licensed to practice, and*
 - (2) *If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.*
 - (3) *The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.*
 - (4) *The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.*
 - (5) *If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.*
- *§483.10(e)(2): The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.*
- *§483.10(e)(4): The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.*
- *§483.10(f)(4)(ii): The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.*
- *§483.10(f)(4)(iii): The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time.*
- *§483.10(f)(9): The resident has a right to choose to or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when—*
 - (i) *The facility has documented the resident's 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.*
- *§483.10(g)(8): The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:*
 - (i) *Privacy of such communications consistent with this section; and*
 - (ii) *Access to stationery, postage, and writing implements at the resident's own expense.*
- *§483.10(g)(17): The facility must—*
 - (i) *Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—*
 - (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 Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.*
- *§483.10(g)(18):[introductory text]: The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.*
- *§483.10(h): Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.*

Interpretive Guidelines §482.58(b)(1)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(1)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

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§482.58(b)(2) Admission, transfer, and discharge rights (§483.5 definition of transfer and discharge, §483.15(c)(1), (c)(2)(i), (c)(2)(ii), (c)(3), (c)(4), (c)(5), and (c)(7)).

- ***§483.5: definition of transfer and discharge: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.***
- ***§483.15(c)(1): Facility requirements—***
 - (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—***
 - (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;***
 - (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;***
 - (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;***
 - (D) The health of individuals in the facility would otherwise be endangered;***
 - (E) 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. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or***
 - (F) The facility ceases to operate.***

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

- *§483.15(c)(2)(i) Documentation in the resident's medical record must include:*
 - (A) The basis for the transfer per paragraph (c)(1)(i) of this section.*
 - (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).*
- *§483.15(c)(2)(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—*
 - (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and*
 - (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.*
- *§483.15(c)(3): Notice before transfer. Before a facility transfers or discharges a resident, the facility must—*
 - (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.*
 - (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and*
 - (iii) Include in the notice the items described in paragraph (c)(5) of this section.*
- *§483.15(c)(4): Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.*
 - (ii) Notice must be made as soon as practicable before transfer or discharge when—*

- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;*
 - (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;*
 - (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;*
 - (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or*
 - (E) A resident has not resided in the facility for 30 days.*
- *§483.15(c)(5): Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:*
 - (i) The reason for transfer or discharge;*
 - (ii) The effective date of transfer or discharge;*
 - (iii) The location to which the resident is transferred or discharged;*
 - (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;*
 - (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;*
 - (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and*
 - (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.*

- ***§483.15(c)(7): Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.***

Interpretive Guidelines §482.58(b)(2)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(2)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

A-1566

(Rev.)

§482.58(b)(3) Freedom from abuse, neglect, and exploitation (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)).

- ***§483.12(a)(1): The facility must (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.***
- ***§483.12(a)(2): Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.***
- ***§483.12(a)(3)(i): Not employ or otherwise engage individuals who (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.***
- ***§483.12(a)(3)(ii): Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.***
- ***§483.12(a)(4): Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.***
- ***§483.12(b)(1): The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.***
- ***§483.12(b)(2): Establish policies and procedures to investigate any such allegations.***

- **§483.12(c): In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:**

- (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.**
- (2) Have evidence that all alleged violations are thoroughly investigated**
- (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.**
- (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.**

Interpretive Guidelines §482.58(b)(3)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(3)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

A-1568

(Rev.)

§482.58(b)(4) Patient activities (§483.24(c)).

- **§483.24(c): Activities.**
 - (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of**

each resident, encouraging both independence and interaction in the community.

(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who—

(i) Is licensed or registered, if applicable, by the State in which practicing; and

(ii) Is:

(A) 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

(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or

(C) Is a qualified occupational therapist or occupational therapy assistant; or

(D) Has completed a training course approved by the State.

Interpretive Guidelines §482.58(b)(4)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(4)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

A-1570

(Rev.)

§482.58(b)(5) Social services (§483.40(d) and 483.70(p)).

- §483.40 (d): The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.***
- §483.70 (p): Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:***

- (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and*
- (2) One year of supervised social work experience in a health care setting working directly with individuals.*

Interpretive Guidelines §482.58(b)(5)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(5)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

A-1572

(Rev.)

§482.58(b)(6) Discharge planning (§483.20(e)).

- *§483.20(e) Coordination. A facility must coordinate assessments with the preadmission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes—*
 - (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.*
 - (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.*

Interpretive Guidelines §482.58(b)(6)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(6)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

A-1574

(Rev.)

§482.58(b)(7) Specialized rehabilitative services (§483.65).

- **§483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must—**
 - (1) **Provide the required services; or**
 - (2) **In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.**
- **§483.65(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.**

Interpretive Guidelines §482.58(b)(7)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(7)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

A-1576

(Rev.)

§482.58(b)(8) Dental services (§483.55).

- **§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.**
 - (a) **Skilled nursing facilities. A facility**
 - (1) **Must provide or obtain from an outside resource, in accordance with §483.70(g), 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;**
 - (3) **Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for**

the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;

(4) Must if necessary or if requested, assist the resident—

(i) In making appointments; and

(ii) By arranging for transportation to and from the dental services location; and

(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

(b) Nursing facilities. The facility-

(1) Must provide or obtain from an outside resource, in accordance with §483.70(g), 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;

(2) Must, if necessary or if requested, assist the resident—

(i) In making appointments; and

(ii) By arranging for transportation to and from the dental services locations;

(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;

(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and

(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.

Interpretive Guidelines §482.58(b)(8)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §482.58(b)(8)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

State Operations Manual

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

(Rev.)

Transmittals for Appendix W

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Survey Protocol

Introduction

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

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

Regulatory and Policy Reference

- The Medicare Conditions of Participation for CAHs are found at [42 CFR Part 485 Subpart F](#).
- Survey authority and compliance regulations can be found at [42 CFR Part 488 Subpart A](#).
- If an individual or entity (CAH) refuses to allow immediate access to either a State *Survey Agency (SA)* or CMS surveyor, the Office of Inspector General (OIG) may terminate the CAH from participation in the Medicare/Medicaid programs in accordance with [42 CFR 1001.1301](#).
- *If a CAH fails to grant immediate access upon a reasonable request to an SA or other CMS-authorized entity for the purpose of determining, in accordance with 42 CFR 488.3, whether the CAH meets the applicable CoP, CMS may terminate the CAH Medicare provider agreement in accordance with 42 CFR 489.53(a)(18).*
- *If a CAH refuses to permit copying of any records or other information by, or on behalf of, CMS, as necessary to determine or verify compliance with participation requirements, CMS may terminate the CAH's Medicare provider agreement in accordance with 42 CFR 489.53(a)(13).*
- The CMS State Operations Manual (SOM) provides CMS policy regarding survey and certification activities.

Surveyors assess CAH compliance with the CoPs for all services, areas and locations in which the provider receives reimbursement for patient care services billed under its *CMS Certification Number (CCN)*, *as well as certain entities that provide services to the CAH on a contractual basis*. *These areas include all inpatient and outpatient services and practice locations, buildings and facilities (including, but not limited to, generators, electrical rooms, food services, HVAC,*

supply areas, sterilization areas, etc.).

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

All CAH surveys are unannounced. Do not provide CAHs with advance notice of the survey. *The SAs, Accreditation Organizations (AOs), and CMS may not make any communications or requests to a CAH that would amount to advance notice of a survey (with the exception of providing resurvey timeframes as stated in the SOM).*

Tasks in the Survey Protocol

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

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

Survey Modules for Specialized CAH services

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

Survey Team

Size and Composition

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

- Size of the facility to be surveyed, based on average daily census;

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

Qualifications for CAH Surveyors

Minimum qualifications. Surveys must be conducted by individuals who meet minimum qualifications prescribed by CMS. In addition, before any State or Federal surveyor may serve on a CAH survey team (except as a trainee), he/she must have successfully completed the relevant CMS-sponsored basic CAH surveyor training courses and any associated prerequisites. New surveyors may accompany the team as part of their training prior to completing the basic training courses.

Team Coordinator

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

Responsibilities of the **Team Coordinator** include:

- Scheduling the date and time of survey activities;
- Acting as the spokesperson for the team;
- Assigning staff to areas of the CAH or tasks for the survey;
- Facilitating time management;
- Encouraging *and facilitating* on-going communication among team members;
- Evaluating team progress;
- Coordinating daily team meetings;
- Coordinating any ongoing *discussions* with CAH leadership (as determined appropriate by the circumstances and SA/RO policy) and providing on-going feedback, as appropriate, to CAH leadership on the status of the survey;

- Coordinating Task 2 Entrance Conference;
- Facilitating Task 4 Preliminary Decision Making;
- Coordinating Task 5 Exit Conference;
- *Ensuring that all survey team activities are conducted in accordance with CMS procedures;*
- *Ensuring that the team completes all applicable forms prescribed by CMS, including Form CMS-2567.*

Task 1 - Off-Site Survey Preparation

General Objective

The objective of this task is to analyze information about the *CAH* in order to identify areas of potential concern to be investigated during the survey and to determine if those areas, or any special features of the *CAH* (e.g., provider-based clinics, specialty units, services offered, etc.) require the addition of any specialty surveyors to the team. Information obtained about the *CAH* will also allow the SA (or the RO for Federal teams) to determine survey team size and composition, and to develop a preliminary survey plan. The type of *CAH* information needed includes:

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

Off-Site Survey Preparation Team Meeting

The team should prepare for the survey off-site so they are ready to begin the survey

immediately upon entering the *CAH*. The *Team C* Coordinator should arrange an off-site preparation meeting with as many team members as possible, including specialty surveyors. This meeting may be a conference call if necessary.

During the meeting, discuss at least the following:

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

Gather copies of *or have access to* resources that may be needed. These may include:

- CAH Regulations and Interpretive Guidelines (Appendix W);
- Survey protocol and modules;
- Immediate Jeopardy ([Appendix Q](#));
- Responsibilities of Medicare Participating Hospitals in Emergency Cases ([Appendix V](#));
- Hospital/CAH Medicare Database Worksheet ([Exhibit 286](#));
- *Authorization by Deemed Provider/Supplier Selected for Accreditation Organization Validation Survey* ([Exhibit 287](#)); and
- Worksheets, *as applicable*, for swing bed and CAH distinct part rehabilitation and psychiatric units.

Task 2 - Entrance Activities

General Objectives

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

General Procedures

Arrival

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

Entrance Conference

The entrance conference sets the tone for the entire survey. Be prepared and courteous, and make requests, not demands. The entrance conference should be informative, concise, and brief; it should not utilize a significant amount of time. Conduct the entrance conference with administrative staff available at the time of entrance (*do not delay the survey to wait for additional management staff to arrive*). During the entrance conference, the Team Coordinator should address the following:

- Explain the purpose and scope of the survey;
- Briefly explain the survey process;
- Introduce survey team members, including any additional surveyors who may join the team at a later time. Discuss the general area that each will be responsible for, and the various documents that they may request;
- Clarify that all CAH areas and locations, departments, and patient care settings under the CAH CCN may be surveyed, including any contracted patient care activities or patient services;
- Explain that all interviews will be conducted privately with patients, staff, and visitors, unless requested otherwise by the interviewee;
- Discuss and determine how the **CAH** will ensure that surveyors are able to obtain the photocopies of material, records, and other information as they are needed;
 - *Explain that surveyors will need to have access to one or more copying machines so they can personally make copies as needed;*
 - *If the CAH uses electronic medical records or uses electronic documents for its policies, procedures, or other activities, explain that surveyors will need access to*

one or more printers so they can personally print documents as needed;

- *Explain that if the CAH wishes, surveyors will make the CAH an additional copy of every document that surveyors copy;*
- Obtain the names, locations, and telephone numbers of key staff to whom questions should be addressed;
- *Explain that the survey team will not be providing the hospital with a list of all patients, staff, or visitors interviewed or records reviewed during the survey;*
- Discuss the approximate time, location, and possible attendees of any meetings to be held during the survey. The *Team C*oordinator should coordinate any meetings with facility leadership; and
- Propose a date and time for the exit conference.

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

- A location (e.g., conference room) where the team may meet privately during the survey;
- A telephone for team communications, preferably in the team meeting location;
- A list of *current* inpatients, providing each patient's name, room number, diagnosis (es), admission date, age, attending physician, and other significant information as it applies to that patient. The *Team C*oordinator will explain to the CAH representative that in order to complete the survey within the allotted time it is important the survey team is given this information as soon as possible, and request that it be no later than 3 hours after the request is made. SAs may develop a worksheet to give to the *CAH* for obtaining this information;
- A list of department heads with their locations and telephone numbers;
- A copy of the *CAH*'s organizational chart;
- The names and addresses of all off-site locations operating under the same CCN;
- The CAH's infection control plan;
- A list of employees;
- The medical staff bylaws and rules and regulations;
- A list of contracted services; and

- A copy of the **CAH's** floor plan, indicating the location of patient care and treatment areas.
- *The Team Coordinator will inform the CAH that this is not an all-inclusive list and other documents/manuals may be requested throughout the survey depending on potential issues that may be identified.*

During the entrance conference the Team Coordinator will inquire whether the CAH wishes to have CAH personnel accompany surveyors during their survey activities. The Team Coordinator must explain that this is allowed as long as the CAH personnel do not interfere or delay the survey. For example:

- *When a patient or another CAH staff person is interviewed, the accompanying CAH staff must not provide the answers or interject information,*
- *The surveyor will inform the accompanying CAH staff when an interview with a patient, patient family member, or CAH staff person is confidential and they cannot be present,*
- *When the surveyor is to go to another unit, department or survey location and the CAH guide is not present, the surveyor is never to delay while waiting for the arrival of the CAH staff person. The survey must be conducted whether or not those personnel are present.*
- *The CAH personnel must never be allowed to be present during discussions of findings. If a CAH staff person enters the conference area during discussions, the discussions must stop until the CAH staff person departs.*

During the entrance conference for a validation survey, the survey team presents to the hospital a letter signed by the SA Director announcing the validation survey (SOM Exhibit 37), as well as an "Authorization by Deemed Provider/Supplier Selected for Accreditation Organization Validation Survey," (SOM Exhibit 287). The SA requires the signature of the provider/supplier CEO or other authorized individual on the authorization document, acknowledging that the provider/supplier must permit the validation survey by the SA to take place, as well as SA monitoring of the correction of any substantial noncompliance identified during the validation survey.

Surveying CAHs with electronic health records (EHR) and other documents, such as, policies, procedures, or data related to compliance efforts.

During the entrance conference surveyors will establish with the CAH the process they will follow in order to have unrestricted access to the medical record. Inform the CAH as to whether the team will use one or a combination of the following:

- *Surveyors will directly access the CAH's EHR or other electronic documents. If this is the case, inform the CAH that it must provide surveyor(s) with passcodes that will*

provide sufficient system access permissions that ensure the surveyor's ability to retrieve complete medical records, including, when requested, information from built-in audit features that enable identification of the date, time, and author for entries or changes made to the record. Inform the CAH that the surveyor(s) must have sufficient access to review any CAH documents needed to evaluate the CAH's compliance with the CoPs (for example policies, procedures, schedules, Infection Control information, etc.) Whenever possible, the CAH must provide surveyors electronic access to records in a read-only format or other secure format to avoid any inadvertent changes to the record. The provider is solely responsible for ensuring that all necessary back up of data and security measures are in place.

- Surveyors will utilize staff, such as nurses assigned to patient care units to review medical records, or Infection Control staff to review those activities. If this is the case, inform the CAH that staff will be requested to access and display medical records for review by the surveyor. In other situations the surveyor may request CAH staff to access policies, procedures, Infection Control information, committee minutes, etc.*
- Surveyors will request that experienced CAH EHR users with appropriate system permissions be assigned as "navigators" to assist surveyors with retrieval of medical record information and other electronically stored information as needed for evaluation of the CAH's compliance. If this is the case, an EHR navigator would assist a surveyor in retrieving medical records and other electronically stored information that the surveyor has identified as needed to evaluate compliance. The navigator is expected to have sufficient system access permissions that ensure the navigator's ability to retrieve electronically stored CAH records such as policies, committee minutes, and complete medical records. In addition, when requested, information from built-in audit features that enable identification of the date, time and author of entries or changes made to the record.*

In CAHs that use hybrid mixes of electronic and paper medical record systems, CAH staff are expected to know which portions of the medical record are not captured in the EHR, to inform the surveyor of this, and to be able to retrieve those paper-based portions of the records as well.

***Note:** If a CAH declines to provide the requested means of access to the surveyor when requested, the surveyor will first remind the CAH that failure to provide access to records may, in accordance with 42 CFR 489.53(a)(5), be grounds for terminating the Medicare provider agreement. In a situation where the survey team requests a method of access other than surveyor direct access, and the CAH offers to furnish only direct surveyor access to the EHR system, the SA must determine whether it is willing and able to continue the survey with the surveyor directly accessing the EHR system.*

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

CAH Tours

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

Initial On-Site Team Meeting

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

- Review the scope of services;
- Identify all locations to be surveyed, including all off-site locations;
- Adjust surveyor assignments, as necessary, based on new information;
- Discuss issues such as change of ownership, sentinel events, construction activities, and disasters, if they have been reported;
- *Discuss any issues that have been observed or reported while surveyors have been at the CAH;*
- Make an initial patient sample selection (the patient list may not be available immediately after the entrance conference, therefore the team may delay patients completing the initial patient sample selection a few hours as meets the needs of the survey team); and
- Set the next meeting time and date.

Sample Size and Selection

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

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

Note:

- *Open records are medical records of inpatients who are current inpatients of the hospital.*
- *Closed records are medical records of inpatients who have been discharged, transferred, or are deceased.*

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

To conduct an initial survey of a CAH there must be enough inpatients currently in the CAH and patient records (open and closed) for surveyors to determine whether the CAH can demonstrate compliance with all the applicable CoPs. The number of current and discharged inpatients and outpatients in relation to the complexity of care provided to patients and the length of stay of those patients needs to be large enough for surveyors to evaluate the manner and degree to which the CAH satisfies all the standards within each CoP. Utilize the same sample size and selection methods as previously discussed.

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

Task 3 - Information Gathering/Investigation

General Objective

The objective of this task is to determine the *CAH's* compliance with the Medicare *CoPs* through observations, interviews, and documentation review.

Guiding Principles

- Focus attention on actual and potential patient outcomes, as well as required processes.

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

General Procedures

During the Survey

- Visit as many patient care settings as possible, including all on campus and off-campus patient care locations that bill for services under the CAH's *CCN*. Because the CAH's compliance with the requirements is being assessed, all patient care locations should be part of the total CAH survey. A surveyor should observe what activities are taking place and assess the CoP that represent the scope and complexity of the patient care services located at each location, as well as, any other CoP that apply to those locations. *Observation of the care environment must include assessing for safety risks in the patient care setting.* The depth of assessment of the CoPs will be determined by what the surveyor observes at each location. The surveyor expands the survey activities as necessary.
- On any Medicare survey, contracted patient care activities or patient services (such as dietary services, treatment services, diagnostic services, etc.) located on the CAH campus or at CAH provider based locations should be included in the survey.
- The SA and surveyors have discretion whether to allow, or to refuse to allow, facility personnel to accompany the surveyors during a survey. Sometimes facility personnel may be helpful and may answer questions or point out concerns to the survey team. Conversely, facility personnel may sometimes hinder the surveyor, and argue about observed problems. Surveyors should make a decision whether to allow facility personnel to accompany them based on the circumstances at the time of the survey.
- The team *must* meet at least daily in order to assess the status of the survey, *to discuss each surveyor's findings*, progress of completion of assigned tasks, areas of concern, and to identify areas for additional investigations. *All issues must be discussed at the next available team meeting. Surveyors must not withhold their findings or areas of concern while individually attempting to make a final conclusion or while attempting to obtain*

conclusive evidence. The team meetings should include a *briefing*/update by each surveyor *to the entire team* that addresses findings and areas of concern that have been identified. *It is important to note that team meetings are not to be individual briefings to the Team Coordinator; rather they must be briefings to the entire team so that the entire team is aware of all findings and the entire team can discuss how the presented findings are impacting their own findings.* If areas of concern are identified in the discussion, the team should coordinate efforts to obtain additional information. Additional team meetings can be called at any time during the survey to discuss crucial problems or issues. *The format for the daily team meetings is:*

- *In an organized manner, each surveyor, in turn, will report their compliance concerns and identified or potential deficient practices to the entire team,*
 - *Other team members will add any of their own observations related to the issues brought up.*
 - *The Team Coordinator and other team members will suggest other ideas as to where to look or other survey methods to evaluate identified concerns,*
- *The Team Coordinator will maintain organized notes of the discussions for future follow-up.*
 - *Note: As needed, members of the team may participate by conference calls. This method works well with surveys of multi-location hospitals.*
- All significant issues or significant adverse events must be brought to the *Team Coordinator's* attention immediately.
- Maintain open and ongoing dialogue with the *CAH* staff throughout the survey process. *Informal discussions* with *CAH* staff may be held in order to inform them of survey findings. This affords *CAH* staff the opportunity to present additional information or to offer explanations concerning identified issues. Survey information must not be discussed unless the investigation process and data collection for the specific concerns is completed. *Regular meetings with CAH leadership are not encouraged, but a meeting may be needed when a problem conducting the survey has arisen and the Team Coordinator needs to explain procedures to CAH leadership. Additionally, CAH leadership may request a meeting with the Team Coordinator to address any concerns with the survey. If meetings with CAH leadership are held, the Team Coordinator must be the spokesperson for the team.*
- Surveyors should always maintain a professional working relationship with *CAH* staff.
- Surveyors need to respect patient privacy and maintain patient confidentiality at all times during the survey.
- Surveyors should maintain their role as representatives of a regulatory agency. Although non-consultative information may be provided upon request, the surveyor is not a

consultant.

Patient Review

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

Observations

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

- Patient care, including treatments and therapies in all patient care settings;
- Staff member activities, equipment, documentation, building structure, sounds and smells;
- People, care, activities, processes, documentation, policies, equipment, etc., that are present that should not be present, as well as, those that are not present that should be present;
- Integration of all services, such that the *CAH* is functioning as one integrated whole;
- Whether quality assurance (QA) is a *CAH*-wide activity, incorporating every service and activity of the provider and whether every facility department and activity reports to, and receives reports from, the *CAH's* central organized body managing the facility-wide QA program; and
- Storage, security, and confidentiality of medical records.
- Environmental risks. Examples may include, but are not limited to, unattended cleaning carts, unattended hazardous cleaning solutions, unlocked medications, and ligature risks in areas where psychiatric patients may have care provided.

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

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

A surveyor must not *touch or* examine patients by themselves. *However*, in certain circumstances, *it is permissible and necessary to determine the physical condition of patients. Whenever a surveyor views it necessary to determine the physical condition of the patient, the surveyor must request that a staff member* examine the patient in the surveyor's presence. The health and dignity of the patient is always of paramount concern. *Additionally, if the surveyor believes that blankets or clothing are hiding bedsores, bruises, or incontinence, and with the patient's permission, they may remove the coverings and make a determination based on observation.*

In all situations, surveyor's must obtain the patient's (or authorized representative's) permission prior to making any examination. The health and dignity of the patient is always of paramount concern. A surveyor must respect the patient's right to refuse to be examined.

Interviews

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

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

patient or family interview may include advanced directives and the *CAH*'s grievance/complaint procedure.

- Interviews with patients must be conducted in privacy and with the patient's prior permission.
- Use open-ended questions during your interview.
- Validate all information obtained.
- Telephone interviews may be conducted if necessary, but a preference should be made for in-person interviews.
- Integrate the data from interviews with data gathered through observations and document reviews.

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

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

Document Review

Document review focuses on a *CAH*'s compliance with the CoPs. When conducting a document review, document the source and date of the information obtained. When making document copies identify the original date of the document and indicate the date and time the copies were made. Once a document review is completed, integrate the data obtained with data gathered through observations and interviews to decide if the CAH is in compliance with the CoP.

Documents reviewed may be both written and electronic and include the following:

- Patient's clinical records, to validate information gained during the interviews, as well as for evidence of advanced directives, discharge planning instructions, and patient teaching. This review will provide a broad picture of the patient's care. Plans of care and discharge plans should be initiated immediately upon admission, and be modified, as patient care needs change. The record review for that patient who has undergone surgery would include a review of the pre-surgical assessment, informed consent, operative report, and pre-, inter-, and post-operative anesthesia notes. Although team members may have a specific area assigned during the survey, the team should avoid duplication of efforts during review of medical records and each surveyor should review the record as a whole instead of targeting the assigned area of concern. Surveyors should use open

patient records rather than closed records, whenever practical.

- Closed medical records may be used to determine past practice, and the scope or frequency of a deficient practice. Closed records should also be reviewed to provide information about services that are not being provided by the CAH at the time of the survey. For example, if there are no obstetrical patients in the facility at the time of the survey, review closed OB records to determine care practices, or to evaluate past activities that cannot be evaluated using open records. In the review of closed clinical records, review all selected medical records for an integrated plan of care, timelines of implementation of the plan of care, and the patient responses to the interventions.
- Personnel files to determine if staff members have the appropriate *qualifications including* educational requirements, have had the necessary training required, and are licensed, if it is required (*the sample selection, both numbers and types of personnel files to be reviewed, will be based on individual CoPs and issues being investigated*);
- *Privileging* files to determine if the *CAH* complies with CMS requirements and State law, as well as, follows its own written policies for medical staff privileges and credentialing;
- Maintenance records to determine if equipment is periodically examined and to determine if it is in good working order and if environmental requirements have been met;
- Staffing documents to determine if adequate numbers *and types* of staff are provided according to the number and acuity of patients;
- Policy and procedure manuals. When reviewing policy and procedure manuals, verify with the person in charge of an area that the policy and procedure manuals are current;
- Contracts, if applicable, to what requirements are provided under arrangements or agreements.
- Diet menus to ensure they meet the needs of the sample patients.

Electronic Documents Including EHR

Electronic access to records will not eliminate the need for a surveyor to print a paper copy or to request a paper copy of certain parts of certain records. However, the surveyor shall make reasonable efforts to avoid, where possible, the printing of entire records. It is neither expected nor advisable to ask that all requested records be printed out for the surveyor to review. Surveyors will request print-outs or screen shots selectively, based on their preliminary survey findings. The surveyor should print or request a paper copy of only those parts of records that are needed to support findings of noncompliance.

The goal of the surveyor's observation of how the EHR is used by CAH staff is to determine

whether staff can enter into and retrieve the information necessary for their patient's care in a timely fashion.

- *Healthcare staff must be able to demonstrate their ability to access parts of the record necessary for the provision of care for their patients.*
- *The focus of the review is determining staff competence in using the EHR system as opposed to the surveyor's ability to navigate the system.*

Surveyors must investigate what happens when the computer is unavailable or offline, whether planned or unplanned. Some examples might include:

- *How to register, admit, transfer, move, or discharge patients.*
- *How to order, determine, and record medications and administration of medications.*
- *How to order or determine diets.*
- *How to order, determine, and record treatments.*
- *How to obtain laboratory reports and other testing results.*

Photocopies

Surveyors *must* make photocopies of all documents needed to support survey findings.

Photocopies support survey findings, and therefore in order to ensure accurate copies of the documents needed, the survey team must either make their own copies or hand carry the material to the copy machine where they directly observe hospital staff make the requested copies and then take immediate possession of the copies. If requested by the **CAH**, the surveyor should make the **CAH** a copy of all items photocopied. All photocopies need to be dated and timed as to when photocopied, and identified such as “CAH IV management policy-12/05/17 page 3” or “Patient # 6, progress note –12/05/17.”

Completion of Hospital/CAH Medicare Database Worksheet

Interview a member of the administrative staff to update and clarify information from the provider file. The Hospital/CAH Medicare Database worksheet will be used to collect information about the CAH services, locations, and staffing by the Medicare CAH surveyors during the CAH survey. The worksheet will be completed by the surveyors using observation, staff interviews, and document review. **The worksheet will not be given to the CAH staff to complete.** The worksheet is used to collect information that will later be entered into the Medicare Database.

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

Task 4 - Preliminary Decision Making and Analysis of Findings

General Objectives

The general objectives of this task are to integrate findings, review and analyze all information collected from observations, interviews, and record reviews, and to determine whether or not the

CAH meets the Conditions of Participation found at [42 CFR Part 485](#). The team's preliminary decision-making and analysis of findings assist it in preparing the exit conference report. Based on the team's decisions, additional activities may need to be initiated.

General Procedures

Preparation

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

Discussion Meeting

Prior to the preliminary decision-making meeting all members of the team should review their findings and concerns regarding the CAH's compliance and be prepared to present their findings during the meeting. Each team member should be familiar with the team's findings as discussed during the daily team meetings.

The preliminary decision-making meeting is not organized or conducted in the same manner as daily team meetings. The meeting will be conducted as a team.

- *The entire survey team that is at the CAH must be present. Additionally:*
 - *Survey team members who are off-site must join the meeting by conference call,*
 - *Survey team members who have already departed the survey should join the meeting by conference call when possible,*
- *The Team Coordinator will sequentially discuss the regulations in order as they appear in the regulations, CoP, Standard, or Tag, depending on what issues have been identified during the survey,*
- *Surveyors will share their findings, evaluate the evidence, and make team decisions regarding compliance with each requirement when that requirement is discussed,*
 - *Team discussion is to include the official interpretation of the regulation as put forth in the interpretive guidelines for each regulation (Note: citations of non-compliance must be based on non-compliance with regulation; citations of non-compliance cannot be based on non-compliance with the interpretive guidelines),*
 - *The discussion must address potential outcomes (Note that actual adverse outcomes are not needed to identify or cite a deficient practice),*
 - *The Team Coordinator must verify with the team whether all evidence has been collected to support any citations (this must be done at the time each requirement*

is discussed). If not, the Team Coordinator must direct someone to collect that evidence prior to the exit conference,

- *The Team Coordinator must take accurate notes for later reference and to assist him/her in preparation for the exit conference.*

Decisions about deficiencies are to be team decisions, with each member having input. The team should document their decisions, the substance of the evidence, and the numbers of patients impacted, in order to identify the extent of **CAH's** noncompliance. The team must ensure that their findings are supported by adequate documentation of observations, interviews, and document reviews, and includes any needed evidence such as photocopies. Any additional documentation or evidence needed to support identified noncompliance should be gathered prior to the exit conference but at a minimum prior to exiting the **CAH**.

Determining the Severity of Deficiencies

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

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

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

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

- Is the corrective action superficial or inadequate, or is the corrective action adequate and systemic?
- *Is the deficient practice still present?*
- Has the CAH implemented the corrective intervention(s) or action(s)?

- Has the CAH taken a QA approach to the corrective action to ensure monitoring, tracking and sustainability?
- *Have the CAH's corrective actions made it unlikely for the deficient practice to recur?*

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

All noted noncompliance must be cited even when corrected on site during the survey. *Identified non-compliance must be cited at either Immediate Jeopardy, Condition level or Standard level.* Citing noncompliance at the appropriate level is important to the integrity of the survey process. Citing too high a level is unfair to the CAH. Citing noncompliance at a level below the noted degree and manner of the noncompliance does not ensure that the CAH will develop acceptable plans of correction and implement corrective actions, does not depict whether the care provided adversely affects the health and safety of patients, and whether continued deficient practices may lead to adverse patient outcomes such as injury or death.

Gathering Additional Information

If it is determined that the survey team needs additional information to determine *CAH's* compliance or noncompliance, the *Team C*oordinator should decide the best way to conduct the additional review.

Task 5 - Exit Conference

General Objective

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

Prior to the Exit Conference

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

Discontinuation of an Exit Conference

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

conference. For example:

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

Recording the Exit Conference

If the **CAH** wishes to audio *record* the conference, it must provide two tapes and tape recorders, recording the meeting simultaneously. *In order for this to occur, the CAH must be able to supply a copy of the recording, or transmit a copy in a format the survey team can utilize (or if the survey team has the capability to record the discussion, the team can use its own recording device for its purposes).*

General Principles

The following general principles apply when conducting an exit conference:

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

Exit Conference Sequence

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

A - Introductory Remarks:

- Thank everyone for cooperation during the survey.
- Introduce all team members, mentioning any that have concluded their portion of the survey and have left the **CAH**.
- Briefly mention the reason for the survey.

- Explain that the exit conference is an informal meeting to discuss preliminary findings.
- Indicate that official findings are presented in writing on the [Form CMS-2567](#).

B - Ground Rules

- Explain how the team will conduct the exit conference and any ground rules.
- Ground rules may include waiting until the surveyor finishes discussing each deficiency before accepting comments from **CAH** staff.
- State that the **CAH staff** will have an opportunity to present new information *or evidence of compliance* after the exit conference for consideration after the survey.

C - Presentation of Findings

- Avoid referring to data tag numbers.
- Present the *preliminary* findings of noncompliance, explaining why the findings are a violation. If the provider asks for the regulatory basis, provide it.
- Refrain from making any general comments (e.g., “Overall the **CAH** is very good”). Stick to the facts. Do not rank findings. Treat requirements as equal as possible.
- *Refrain from making global statements, such as, “The CAH does not have any Condition level citations”, or “The CAH only has lower level citations”. Except in citations of Immediate Jeopardy, the survey team does not discuss citation levels for individual citations or for the overall survey.*
- Do not identify unmet requirements as condition or standard level. Avoid statements such as, “the condition was not met” or “the standard was not met.” It is better to state, “the requirement is not met.”
- If immediate jeopardy was identified, explain the significance and the need for immediate correction. Follow instructions in Appendix Q.
- Assure that all findings are discussed at the exit conference.

D - Closure

- Explain that a statement of deficiencies (Form CMS-2567) will be mailed within 10 *business* days to the CAH.
- Explain that the Form CMS-2567 is the document disclosed to the public about the **CAH's** deficiencies and what is being done to remedy them. The Form CMS-2567 is made public no later than 90 calendar days following completion of the survey. It

documents specific deficiencies cited, the *CAH*'s plans for correction and timeframes, and it provides an opportunity for the *CAH* to refute survey findings and furnish documentation that requirements are met.

- Inform the *CAH* that a written plan of correction (*POC*) must be submitted to the survey agency within 10 *business* days following receipt of the written statement of deficiencies.
- Explain the required characteristics of a plan of correction. The characteristics *of an acceptable POC* include:
 - *Separately addressing each citation;*
 - *A Quality Assessment and Performance Improvement (QAPI) methodology for each citation and address improvements in the hospital's systems in order to prevent the likelihood of the cited deficient practice from recurring;*
 - *A procedure for implementing each corrective action taken;*
 - *A procedure for monitoring the corrective actions taken for each citation Providing the identity or position of the person who will monitor the corrective action and the frequency of monitoring;*
 - Dates each corrective action *for each citation was/will* be completed;
 - The administrator or appropriate individual must sign and date the Form CMS-2567 before returning it to the survey agency.
- The submitted plan of correction must meet the approval of the State agency, or in some cases the CMS Regional Office for it to be acceptable.

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

Task 6 - Post-Survey Activities

General Objective

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

General Procedures

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

- Timelines for completing each step of the process;
- Responsibilities of the *Team Coordinator* and other team members to complete the Form CMS-2567, Statement of Deficiencies, using the **Principles of Documentation** as reference;
- Notification to the *CAH* staff regarding survey results;
- Additional survey activities based on the survey results (e.g., revisit, forwarding documents to the Regional Office for further action/direction);
- Compilation of documents for the provider file;
- *Signed “Authorization by Deemed Provider/Supplier Selected for Accreditation Organization Validation Survey,” ([Exhibit 287](#)) is forwarded to RO; and*
- Enter the information collected on the Hospital/CAH Medicare Database Worksheet into the Medicare database.

Plan of Correction

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

CAH Swing-Bed Survey Module

An onsite survey must be conducted and the CAH must meet all the requirements of 42 CFR 485.645 before the CAH can obtain swing-bed approval.

Additionally, a survey of the CAH swing-bed CoP at 42 CFR 485.645 will be conducted:

- When conducting a full survey of a CAH that has swing-bed approval;*
- When conducting a complaint survey of the swing-bed CoP; or*
- When a CAH without current swing-bed approval, that has been determined to meet the eligibility criteria, is requesting swing-bed approval.*

These requirements, as well as interpretive guidelines, are found in Appendix W of the State Operations Manual (SOM).

Background

Swing-bed services are an optional services that may be provided in CAHs that meet the eligibility criteria in 42 CFR 485.645(a). Swing-bed patients are CAH patients who are situated in the CAH but for whom the CAH is receiving reimbursement for *post-acute CAH extended care* (skilled nursing services), as opposed to acute-care reimbursement. The reference to swing-bed is a patient care and reimbursement status and has no relationship to geographic location in the CAH. The patient may be in acute-care status one day and change to swing-bed status the next day. It is not necessary for the patient to change location in the CAH when the reimbursement status changes, but moving to a different location is allowed. A qualifying 3-day *inpatient* stay in a participating or qualified hospital or participating CAH is required prior to admission to swing-bed status in order for a beneficiary to be eligible for Medicare coverage of post-hospital swing-bed care. The 3-day qualifying stay does not need to be in the same CAH as the swing-bed admission.

***NOTE:** Surveyors do not evaluate compliance with the 3-day qualifying stay requirement.*

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

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

Section 1883 of the Act authorizes payment under Medicare for post-hospital SNF services provided by any CAH that meets *the requirements found in the swing-bed CoP at 42 CFR 482.645*. By regulation, the Secretary has specified these requirements at 42 CFR 485.645 *as the following:*

- The CAH has a Medicare provider agreement;
- The total number of beds that may be used at any time for furnishing swing-bed services or acute inpatient services does not exceed 25 beds; *and*
- The CAH meets the swing-bed CoP on Resident Rights; Admission, Transfer, and Discharge Rights; *Freedom from Abuse, Neglect and Exploitation*; Patients Activities; Social Services; *Comprehensive Assessment, Comprehensive Care Plan, and Discharge Planning*; Specialized Rehabilitative Services; Dental Services; *and Nutrition. Use the interpretive guidelines from SOM Appendix PP to evaluate compliance with the individual referenced requirements from 42 CFR 483.*

Activities Conducted Prior to Swing-Bed Survey

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

- The *CAH's* swing-bed approval is in effect; *and*
- *The CAH meets distance/location requirements (confirm with RO).*

Survey Procedures

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

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

Evaluate the CAH's compliance with the swing-bed requirements at 42 CFR 485.645 found in appendix W of the SOM *and for those requirements referenced from 42 CFR 483 use Appendix PP*. Swing-bed requirements apply to any patient discharged from a hospital or CAH and admitted to a swing-bed for skilled nursing services. The requirements for acute-care CAHs also apply to swing-bed patients.

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

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

Exit Conference

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

Post-Survey Activities

As is the case for any CAH CoPs, the findings for swing-bed deficiencies must be documented on *the same* Form CMS-2567.

C-0350
(Rev.)

§485.645 Special Requirements for CAH Providers of Long-Term Care Services (“Swing-Beds”)

A CAH must meet the following requirements in order to be granted an approval from CMS to provide post-CAH SNF care, as specified in §409.30 of this chapter, and to be paid for SNF-level services, in accordance with paragraph (c) of this section.

Interpretive Guidelines §485.645

The swing-bed concept allows a CAH to use their beds interchangeably for either acute-care or post-acute care. A “swing-bed” is a change in reimbursement status. The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.

Medicare allows a CAH to operate swing-beds through the issuance of a “swing-bed approval.” If the facility fails to meet the swing-bed requirements, and the facility does not develop and implement an accepted plan of correction, the facility loses the approval to operate swing-beds and receive swing-bed reimbursement. The facility does not go on a termination track. If the CAH continues to meet the CoP for the provider type, it continues to operate but loses swing-bed approval.

Swing-beds need not be located in a special section of the CAH. The patient need not change locations in the facility merely because his/her status changes unless the facility requires it.

The change in status from acute care to swing-bed status can occur within one facility or the patient can be transferred from another facility for swing-bed admission.

There must be discharge orders from acute inpatient care services and subsequent admission orders for swing-bed services, the same as if the patient had been transferred to a separately certified skilled nursing facility. The same clinical record may be used for a swing-bed patient, but it must include discharge orders from acute care and admission orders to swing-bed services, and the swing-bed services (which may be SNF or NF level services) must be clearly delineated within the clinical record.

There is no length of stay restriction for any CAH swing-bed patient. There is no Medicare requirement to place a swing-bed patient in a nursing home and there are no requirements for transfer agreements between CAHs and nursing homes. *While there is no length of stay limit for patients in swing-bed status, the intended use for swing beds is for a transitional time period to allow the patient to fully recover to return home or while awaiting placement into a nursing facility. The CAH should document in the patient’s medical record efforts made for nursing facility placement.*

Medicare coverage rules require that, in order to be eligible for coverage of post-hospital swing-

bed care, a beneficiary must have a qualifying 3-day inpatient stay in a participating or qualified hospital or participating CAH prior to admission to a swing-bed.

There is no requirement for a CAH to use the MDS form for recording the patient assessment or for nursing care planning.

Swing-bed patients receive a SNF level of care, and the CAH is reimbursed for providing a SNF level of care, however swing-bed patients are not SNF patients. Swing-bed patients in CAHs are considered to be patients of the CAH.

***NOTE:** Swing-beds must not be confused with beds in a skilled nursing facility (SNF) or nursing facility (NF), including a distinct part SNF/NF, that shares the same building/campus as the CAH but is a separately certified provider with its own Medicare provider agreement.*

C-0351

(Rev.)

§485.645(a) Eligibility

A CAH must meet the following eligibility requirements:

- (1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and**
- (2) The facility provides not more than 25 inpatient beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.**

Interpretive Guidelines §485.645(a) Eligibility

CAHs seeking swing-bed approval are screened prior to survey for their eligibility for swing-beds. However, the CMS RO makes the determination whether the CAH has satisfied the eligibility criteria, regardless of whether the SA or AO, as applicable, recommends approval of swing-bed status (this responsibility may not be delegated to the SA).

The eligibility criteria at 42 CFR 485.645(a) requires:

- The CAH has a Medicare provider agreement;*
- An initial CAH applicant may seek swing-bed approval. If the CAH applicant meets all Federal Requirements for participation, including those for swing-bed approval, the CAH applicant's approval for swing-bed services will be effective with the CAH's effective date of Medicare participation;*

C-0361

(Rev.)

§485.645(d) SNF Services

The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:

§485.645(d)(1) Resident Rights (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2), (e)(4), (f)(4)(ii), (f)(4)(iii), (f)(9), (g)(8), (g)(17), (g)(18) introductory text, (h) of this chapter).

- *§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.*
- *§483.10(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including:*
 - (1) *The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.*
- *§483.10(c)(2)(iii) The right to be informed, in advance, of changes to the plan of care.*
- *§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.*
- *§483.10(d) Choice of attending physician. The resident has the right to choose his or her attending physician.*
 - (1) *The physician must be licensed to practice, and*
 - (2) *If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment.*
 - (3) *The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.*
 - (4) *The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the*

alternative physician participation with the resident and honor the resident's preferences, if any, among options.

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

- *§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.*
- *§483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.*
- *§483.10(f)(4)(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;*
- *§483.10(f)(4)(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;*
- *§483.10(f)(9) The resident has a right to choose to or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when—*
 - (i) The facility has documented the resident's 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.*
- *§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:*
 - (i) Privacy of such communications consistent with this section; and*
 - (ii) Access to stationery, postage, and writing implements at the resident's own expense.*
- *§483.10(g)(17) The facility must—*

- (i) *Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—*

 - (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 Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.*
- *§483.10(g)(18)[introductory text only] The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.*
- *§483.10(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical 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) *The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.*
 - (3) *The resident has a right to secure and confidential personal and medical records.*

 - (i) *The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.*
 - (ii) *The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.*

Interpretive Guidelines §485.645(d)(1)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(1)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

C-0373

(Rev.)

§485.645(d)(2) Admission, Transfer and Discharge Rights (§483.5 definition of transfer & discharge, §483.15(c)(1), (c)(2), (c)(3), (c)(4), (c)(5), (c)(7), (c)(8), and (c)(9) of this chapter).

- *§483.5 definition of transfer & discharge: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility*
- *§483.15(c)(1) Transfer and discharge—(1) Facility requirements—*
 - (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—*
 - (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;*
 - (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;*
 - (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;*
 - (D) The health of individuals in the facility would otherwise be endangered;*
 - (E) 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. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or*
 - (F) The facility ceases to operate.*
 - (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.*

The facility must document the danger that failure to transfer or discharge would pose.

- *§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.*

(i) Documentation in the resident's medical record must include:

(A) The basis for the transfer per paragraph (c)(1)(i) of this section.

(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by—

(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and

(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.

(iii) Information provided to the receiving provider must include a minimum of the following:

(A) Contact information of the practitioner responsible for the care of the resident

(B) Resident representative information including contact information.

(C) Advance Directive information.

(D) All special instructions or precautions for ongoing care, as appropriate.

(E) Comprehensive care plan goals,

(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2), as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

- *§483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must—*
 - (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.*
 - (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and*
 - (iii) Include in the notice the items described in paragraph (c)(5) of this section.*
- *§483.15(c)(4) Timing of the notice.*
 - (i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.*
 - (ii) Notice must be made as soon as practicable before transfer or discharge when—*
 - (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;*
 - (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;*
 - (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;*
 - (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or*
 - (E) A resident has not resided in the facility for 30 days.*
- *§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:*
 - (i) The reason for transfer or discharge;*
 - (ii) The effective date of transfer or discharge;*
 - (iii) The location to which the resident is transferred or discharged;*
 - (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such*

requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

- (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;*
 - (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and*
 - (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.*
- §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.*
 - §483.15(c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.70(l).*
 - §483.15(c)(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in §483.5) are subject to the requirements of §483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.*

Interpretive Guidelines §485.645(d)(2)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(2)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

§485.645(d)(3) Freedom from abuse, neglect and exploitation (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) of this chapter).

- *§483.12(a)(1) Freedom from abuse, neglect, and exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility must—(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;*
- *§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.*
- *§483.12(a)(3) Not employ or otherwise engage individuals who—*
 - (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;*
 - (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.*
- *§483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.*
- *§483.12(b) The facility must develop and implement written policies and procedures that:*
 - (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,*
 - (2) Establish policies and procedures to investigate any such allegations,*
- *§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:*
 - (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result*

in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

- (2) Have evidence that all alleged violations are thoroughly investigated.*
- (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.*
- (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.*

Interpretive Guidelines §485.645(d)(3)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(3)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

C-0385

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§485.645(d)(4) Patient Activities (§483.24(c) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §483.24(c)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.

- *§483.24(c) Activities.*

- (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.*
- (2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who—*

(i) Is licensed or registered, if applicable, by the State in which practicing; and

(ii) Is:

(A) 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

(B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or

(C) Is a qualified occupational therapist or occupational therapy assistant; or

(D) Has completed a training course approved by the State.

Interpretive Guidelines §485.645(d)(4)

Group, individual, and independent activities provided to swing-bed patients in the CAH must be directed by qualified staff. CAHs with swing-beds are required to comply with §483.24(c) with the exception that the services may be directed either by a qualified professional meeting the requirements of §483.24(c)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.

Refer to Appendix PP of the State Operations Manual (SOM) for additional interpretive guidelines.

Survey Procedures §485.645(d)(4)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

In addition, if the activities director does not meet the requirement at 483.24(c)(2), review CAH policy that identifies requisite qualifications of the activities director and the consultation requirements with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.

C-0386

(Rev.)

§485.645(d)(5) Social Services (§483.40(d) and §483.70(p) of this chapter).

- *§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.*
- *§483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:*
 - (1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and*
 - (2) One year of supervised social work experience in a health care setting working directly with individuals.*

Interpretive Guidelines §485.645(d)(5)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(5)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

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(Rev.)

§485.645(d)(6) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), and §483.21(b) and (c)(2) of this chapter), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter).

- *§483.20(b) Comprehensive assessments—*
 - (1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:*
 - (i) Identification and demographic information.*
 - (ii) Customary routine.*
 - (iii) Cognitive patterns.*
 - (iv) Communication.*

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychosocial well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnoses and health conditions.

(xi) Dental and nutritional status.

(xii) Skin condition.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge planning.

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2) (i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

(iii) Not less often than once every 12 months.

- *§483.21(b) Comprehensive care plans.*

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25, or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25, or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv) In consultation with the resident and the resident's representative(s)—

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

- (2) A comprehensive care plan must be—*
- (i) Developed within 7 days after completion of the comprehensive assessment.*
 - (ii) Prepared by an interdisciplinary team, that includes but is not limited to—*
 - (A) The attending physician.*
 - (B) A registered nurse with responsibility for the resident.*
 - (C) A nurse aide with responsibility for the resident.*
 - (D) A member of food and nutrition services staff.*
 - (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.*
 - (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.*
 - (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.*
- (3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must—*
- (i) Meet professional standards of quality.*
 - (ii) Be provided by qualified persons in accordance with each resident's written plan of care.*
 - (iii) Be culturally-competent and trauma-informed.*
- *§483.21(c)(2) Discharge summary. When the facility anticipates discharge a resident must have a discharge summary that includes, but is not limited to, the following:*
 - (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.*
 - (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to*

authorized persons and agencies, with the consent of the resident or resident's representative.

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

Interpretive Guidelines §485.645(d)(6)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(6)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

****NOTE:*** *The CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). Also, note that CAHs are not required to complete the PASARR. However, if a patient had a PASARR completed by a facility that was required to do so prior to admission into a CAH swing bed, the recommendations from the PASARR should be included in the CAHs comprehensive treatment plan for the patient.*

C-0402

(Rev.)

§485.645(d)(7) Specialized Rehabilitative Services (§483.65 of this chapter)

- ***§483.65 (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must—***

(1) Provide the required services; or

(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.

(b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

Interpretive Guidelines §485.645(d)(7)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(7)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

C-0404

(Rev.)

§485.645(d)(8) Dental Services (§483.55 of this chapter)

- *§483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.*

(a) Skilled nursing facilities. A facility

(1) Must provide or obtain from an outside resource, in accordance with §483.70(g), 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;

(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;

(4) Must if necessary or if requested, assist the resident—

(i) In making appointments; and

(ii) By arranging for transportation to and from the dental services location; and

(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

(b) Nursing facilities. The facility

- (1) Must provide or obtain from an outside resource, in accordance with §483.70(g), 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;**
- (3) Must, if necessary or if requested, assist the resident—
 - (i) In making appointments; and*
 - (ii) By arranging for transportation to and from the dental services locations;**
- (3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;*
- (4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and*
- (5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.*

Interpretive Guidelines §485.645(d)(8)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines.

Survey Procedures §485.645(d)(8)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.

C-0410

§485.645(d)(9) Nutrition (§483.25(g)(1) and (g)(2) of this chapter).

- §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the*

facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

(2) Is offered sufficient fluid intake to maintain proper hydration and health

Interpretive Guidelines §485.645(d)(9)

Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines

Survey Procedures §485.645(d)(9)

Refer to Appendix PP of the State Operations Manual (SOM) for survey procedures.