

CRITICAL ACCESS HOSPITAL SURVEY TOOL

FACILITY _____ LICENSE# _____ PHONE _____ DATE _____
 ADMINISTRATOR _____ ADDRESS _____
 SURVEYOR _____ SURVEY INITIAL _____ RESURVEY _____

RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
C-0150	§485.608 Condition of Participation: Compliance With Federal, State, and Local Laws and Regulations The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.	Failure of the CAH to meet a Federal, State or local law may only be cited when the Federal, State or local authority having jurisdiction has made both a determination of noncompliance and has taken a final adverse action as a result. Refer or report suspected violations to the appropriate Federal, State, or local agency.	
C-0151	§485.608(a) Standard: Compliance with Federal Laws and Regulations The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients.	Each CAH must be in compliance with applicable Federal laws and regulations related to the health and safety of patients. This includes other Medicare regulations and Federal laws and regulations not specifically addressed in the CoPs. State Survey Agencies are expected to assess the CAH's compliance with the following Medicare provider agreement regulation provisions when surveying for compliance with §485.608(a):	
C-0152	§485.608(b) Standard: Compliance With State and Local Laws and Regulations All patient care services are furnished in accordance with applicable State and local laws and regulations.	Prior to going on the survey, determine what professional specialists provide patient care services at the CAH and review State practice act requirements.	
C-0153	Standard: Licensure of CAH	Prior to the survey, determine whether the	

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	<p>The CAH is licensed in accordance with applicable Federal, State and local laws and regulations.</p>	<p>CAH is subject to licensure requirements and verify that the licensing agency has approved the CAH as meeting the standards for licensure as set forth by the agency of the State or locality responsible for licensing CAHs.</p>	
<p>C-0154</p>	<p>§485.608(d) Standard: Licensure, Certification or Registration of Personnel Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.</p>	<ul style="list-style-type: none"> • Verify for those personnel required to be licensed by the State, that the CAH has established, and follows, procedures for determining that personnel providing patient care services are properly licensed. • Check a sample of personnel files to verify that licensure information is up to date. Verify that appropriate categories of staff and personnel are licensed in accordance with State requirements. Verify state licensure compliance of the direct care personnel, as well as administrators and supervisory personnel, and any contracted personnel. • Verify that there are procedures in place to guarantee licensure of employees working at the CAH under contract or agreement. • Review CAH policies regarding certification, licensure, and registration of 	

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		personnel. Are the CAH policies compliant with State and local laws? Are the personnel in compliance with CAH policy?	
C-0160	§485.610 Condition of Participation: Status and Location	The CAH must meet the location requirements of §485.610(b) and §485.610(c) at the time of the initial survey. Compliance with these location requirements must be reconfirmed at the time of every subsequent full survey. If the CAH moves, its eligibility for continued CAH status must be reassessed in accordance with §485.610(d).	
C-0161	§485.610(a) Standard: Status The facility is:	Confirm that a CAH meets the basic status requirement prior to scheduling the survey. The appropriate RO will reverify the status requirement prior to approving a CAH for Medicare certification.	
	(1) A currently participating hospital that meets all conditions of participation set forth in this subpart;		
	(2) A recently closed facility, provided that the facility-- (i) Was a hospital that ceased operations on or after the date that is 10 years before November 29, 1999; and		

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	(ii) Meets the criteria for designation under this subpart as of the effective date of its designation; or		
	(3) A health clinic or a health center (as defined by the State) that-- (i) Is licensed by the State as a health clinic or a health center; (ii) Was a hospital that was downsized to a health clinic or a health center; and (iii) As of the effective date of its designation, meets the criteria for designation set forth in this subpart.		
C-0162	§485.610(b) Standard: Location in a Rural Area or Treatment as Rural The CAH meets the requirements of either paragraph (b)(1) or (b)(2) of this section or the requirements of either (b)(3) or (b)(4) of this section.		Confirm with the RO that a CAH applicant or an existing CAH meets the rural location requirement prior to scheduling the survey.
	(1) The CAH meets the following requirements: (i) The CAH is located outside any area that is a Metropolitan Statistical Area, as defined by the Office of Management and Budget, or that has been recognized as urban under		

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	<p>§412.64(b), excluding paragraph (b)(3) of this chapter; (ii) The CAH has not been classified as an urban hospital for purposes of the standardized payment amount by CMS or the Medicare Geographic Classification Review Board under §412.230(e) of this chapter and is not among a group of hospitals have been redesignated to an adjacent urban area under §412.232 of this chapter.</p>		
	<p>(2) The CAH is located within a Metropolitan Statistical Area, as defined by the Office of Management and Budget, but is being treated as being located in a rural area in accordance with §412.103 of this chapter.</p>	<p>Under 42 CFR 485.610(b)(1)(i), a rural area is any area that is outside a Metropolitan Statistical Area (MSA), as defined by the Federal Office of Management and Budget (OMB). The CMS RO will consult the latest OMB Bulletin updating statistical area definitions and providing guidance on their usage. Specifically, List #1 in the Bulletin identifies all of the MSAs in alphabetical order. This list may be used to identify MSAs in the State. List #2 in the Bulletin provides a list of each MSA, along with the counties contained within that MSA. OMB Bulletins may be found at: http://www.whitehouse.gov/omb/bulletins_default/</p>	

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	<p>(3) Effective for October 1, 2004 through September 30, 2006, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2004, was not part of a Metropolitan Statistical Area as defined by the Office of Management and Budget, but as of FY 2005 was included as part of such Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on June 3, 2003.</p>		
	<p>(4) Effective for October 1, 2009 through September 30, 2011, the CAH does not meet the location requirements in either paragraph (b)(1) or (b)(2) of this section and is located in a county that, in FY 2009, was not part of a Metropolitan Statistical Area as defined by the</p>		

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	Office of Management and Budget, but as of FY 2010, was included as part of such Metropolitan Statistical Area as a result of the most recent census data and implementation of the new Metropolitan Statistical Area definitions announced by the Office of Management and Budget on November 20, 2008.		
C-0165	<p>§485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification The CAH is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital or another CAH, or before January 1, 2006, the CAH is certified by the State as being a necessary provider of health care services to residents in the area. A CAH that is designated as a necessary provider on or before December 31, 2005, will maintain its necessary provider designation after January 1, 2006.</p>		

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C-0166	<p>§485.610(d) Standard: Relocation of CAHs With a Necessary Provider Designation A CAH that has a necessary provider designation from the State that was in effect prior to January 1, 2006, and relocates its facility after January 1, 2006, can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider designation only if the relocated facility meets the requirements as specified in paragraph (d)(1) of this section.</p>	<p>Renovation or expansion of a CAH's existing building or addition of building(s) on the existing main campus of the CAH is not considered a relocation. However, as discussed in the adoption of this regulation (70 FR 47472), all newly-constructed, necessary provider CAH facilities, including entirely new replacement facilities constructed on the same site as the existing CAH main campus, are considered relocated facilities. The determination of whether or not CAHs with a necessary provider designation have met the requirements at §485.610(d) will be made by the RO, generally prior to an SA or accreditation survey. The RO will utilize the evaluation criteria set forth in the SOM, Chapter 2, §2256F to make this determination. At the conclusion of its review, the RO will notify the SA of its results.</p>	
	<p>(1) If a necessary provider CAH relocates its facility and begins providing services in a new location, the CAH can continue to meet the location requirement of paragraph (c) of this section based on the necessary provider</p>		

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	<p>designation only if the CAH in its new location--</p> <p>(i) Serves at least 75 percent of the same service area that it served prior to its relocation;</p> <p>(ii) Provides at least 75 percent of the same services that it provided prior to the relocation; and</p> <p>(iii) Is staffed by 75 percent of the same staff (including medical staff, contracted staff, and employees) that were on staff at the original location.</p>		
	<p>(2) If a CAH that has been designated as a necessary provider by the State begins providing services at another location after January 1, 2006, and does not meet the requirements in paragraph (d)(1) of this section, the action will be considered a cessation of business as described in §489.52(b)(3).</p>		
C-0167	§485.610(e) Standard: Off-campus and Co-Location	A CAH may not be co-located with another hospital or CAH, because this would violate	

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	<p>Requirements for CAHs. A CAH may continue to meet the location requirement of paragraph(c) of this section based only if the CAH meets the following:</p>	<p>the minimum distance requirement found at §485.610(c). However, some CAHs that were designated as necessary providers prior to January 1, 2006, and therefore exempted from this distance requirement, also chose to co-locate with another hospital. Co-location occurs when a necessary provider CAH shares the same campus and/or building in which the CAH is currently located with another hospital or necessary provider CAH. For example, a necessary provider CAH shares the same campus with an unrelated psychiatric or rehabilitation hospital.</p>	
	<p>(1) If a CAH with a necessary provider designation is co-located (that is, it shares a campus, as defined in §413.65(a)(2) of this chapter, with another hospital or CAH), the necessary provider CAH can continue to meet the location requirement of paragraph (c) of this section only if the co-location arrangement was in effect before January 1, 2008, and the type and scope of services offered by the facility co-located with the</p>		

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	<p>necessary provider CAH do not change. A change of ownership of any of the facilities with a co-location arrangement that was in effect before January 1, 2008, will not be considered to be a new co-location arrangement.</p>		
	<p>(3) If either a CAH or a CAH that has been designated as a necessary provider by the State does not meet the requirements in paragraph (e)(1) of this section, by co-locating with another hospital or CAH on or after January 1, 2008, [or creates or acquires an off-campus provider-based location or off-campus distinct part unit on or after January 1, 2008, that does not meet the requirements in paragraph (e)(2) of this section,] the CAH's provider agreement will be subject to termination in accordance with the provisions of §489.53(a)(3) of this subchapter, unless the CAH terminates the off-campus arrangement or the co-location</p>		

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	arrangement, or both.		
C-0168	Standard: Off-campus and co-location requirements for CAHs. A CAH may continue to meet the location requirement of paragraph(c) of this section based only if the CAH meets the following:		
	(2) If a CAH or a necessary provider CAH operates an off-campus provider-based location, excluding an RHC as defined in §405.2401(b) of this chapter, but including a department or remote location, as defined in §413.65(a)(2) of this chapter, or an off-campus distinct part psychiatric or rehabilitation unit, as defined in §485.647, that was created or acquired by the CAH on or after January 1, 2008, the CAH can continue to meet the location requirement of paragraph (c) of this section only if the off-campus provider-based location or off-campus distinct part unit is located more than a 35 mile drive (or, in		

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	the case of mountainous terrain or in areas with only secondary roads available, a 15 mile drive) from a hospital or another CAH.		
C-0170	<p>§485.612 Condition of Participation: Compliance With CAH Requirements at the Time of Application Except for recently closed facilities as described in §485.610(a)(2), or health clinics or health centers as described in §485.610(a)(3), the facility is a hospital that has a provider agreement to participate in the Medicare program as a hospital at the time the hospital applies for designation as a CAH.</p>		
C-0190	<p>§485.616 Condition of Participation: Agreements</p>		
C-0191	<p>§485.616(a) Standard: Agreements With Network Hospitals In the case of a CAH that is a member of a rural health network</p>		<ul style="list-style-type: none"> • If the CAH is a member of a rural health network having a communications system, ask to see the agreement. • How does the CAH participate with other

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	<p>as defined in §485.603 of this chapter, the CAH has in effect an agreement with at least one hospital that is a member of the network for:</p>	<p>hospitals and facilities in the network communications system?</p> <ul style="list-style-type: none"> o Is a communications log kept at the facility? o Ask staff if there have been difficulties in contacting network members. If so, ask how the CAH deals with communication delays. <ul style="list-style-type: none"> • How does the network’s communications system compare with any available communications equipment in the CAH? • When the network communications system is not in operation, how does the CAH communicate and share patient data with other network members? • Review any policies and procedures related to the operation of any communications system. • How is the CAH staff educated on the use of any communication system utilized in the facility? • Review any written agreements with the local EMS service. 		

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C-0192	§485.616(a)(1) Patient referral and transfer;		
C-0193	§485.616(a)(2) The development and use of communications systems of the network, including the network's system for the electronic sharing of patient data, and telemetry and medical records, if the network has in operation such a system; and		
C-0194	§485.616(a)(3) The provision of emergency and non-emergency transportation between the facility and the hospital.		
C-0195	§485.616(b) Standard: Agreements for Credentialing and Quality Assurance Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least--		
	(1) One hospital that is a member of the network;		
	(2) One QIO or equivalent entity;		

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	or		
	(3) One other appropriate and qualified entity identified in the State rural health care plan.		
C-0196	Standard: Agreements for credentialing and privileging of telemedicine physicians and practitioners.		
	<p>(1) The governing body of the CAH must ensure that, when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the following requirements with regard to its physicians or practitioners providing telemedicine services:</p> <p>(i) Determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.</p> <p>(ii) Appoint members of the</p>	<ul style="list-style-type: none"> • Ask the CAH's leadership whether it uses telemedicine services. If yes, • Ask to see a copy of the written agreement(s) with the distant-site hospital(s). Does each agreement include the required elements concerning credentialing and privileging of the telemedicine physicians and practitioners by the distant-site hospital? • Does the CAH have documentation indicating that it granted privileges to each telemedicine physician and practitioner? • Does the documentation indicate that the CAH's governing body or responsible individual made the privileging decision based on the privileging decisions of the distant-site hospital? If yes: 	

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	<p>medical staff after considering the recommendations of the existing members of the medical staff. (iii) Assure that the medical staff has bylaws. (iv) Approve medical staff bylaws and other medical staff rules and regulations. (v) Ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. (vi) Ensure the criteria for selection are individual character, competence, training, experience, and judgment. (vii) Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society.</p>	<ul style="list-style-type: none"> • Does the agreement address the required elements concerning the distant-site hospital's Medicare participation, appropriate licensure of telemedicine physicians and practitioners, current list of telemedicine physicians and practitioners with privileges, and review by the CAH of the telemedicine physicians' and practitioners' services? 	
	<p>(2) When telemedicine services are furnished to the CAH's patients through an agreement</p>	<ul style="list-style-type: none"> • Ask to see the list provided by the distant-site hospital of the telemedicine physicians and practitioners, including their privileges 	

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	<p>with a distant-site hospital, the CAH's governing body or responsible individual may choose to rely upon the credentialing and privileging decisions made by the governing body of the distant-site hospital regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site hospital, that the following provisions are met:</p> <p>(i) The distant-site hospital providing telemedicine services is a Medicare-participating hospital.</p> <p>(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician's or practitioner's privileges;</p> <p>(iii) The individual distant-site physician or practitioner holds a</p>	<p>and pertinent licensure information.</p> <ul style="list-style-type: none"> • Ask for evidence that the CAH conducts the required review of the telemedicine services provided by the telemedicine physicians and practitioners, including any associated adverse events and complaints, and that it provides the required feedback to the distant-site hospital. 		

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	<p>license issued or recognized by the State in which the CAH is located; and (iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital such information for use in the periodic appraisal of the individual distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints the CAH has received about the distant-site physician or practitioner.</p>		
C-0197	<p>§485.616(c)(3) The governing body of the CAH must ensure that</p>	<ul style="list-style-type: none"> • Ask the CAH's leadership whether it uses telemedicine services. If yes, 	

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	<p>when telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the agreement is written and specifies that the distant-site telemedicine entity is a contractor of services to the CAH and as such, in accordance with §485.635(c)(4)(ii), furnishes the contracted services in a manner that enables the CAH to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in this section with regard to its physicians and practitioners providing telemedicine services.</p>	<ul style="list-style-type: none"> • Ask to see a copy of the written agreement(s) with the distant-site telemedicine entity(ies). Does each agreement explicitly state that the distant-site telemedicine entity will provide telemedicine services in a manner that enables the CAH to comply with all applicable CoPs? • Does the CAH have documentation indicating that it granted privileges to each telemedicine physician and practitioner? • Does the documentation indicate that the CAH's governing body or responsible individual made the privileging decision based on the privileging decisions of the distant-site telemedicine entity? If yes: 		
	<p>§485.616(c)(4) When telemedicine services are furnished to the CAH's patients through an agreement with a distant-site telemedicine entity, the CAH's governing body or responsible individual may choose to rely upon the credentialing and</p>	<ul style="list-style-type: none"> • Does the written agreement with the distant-site telemedicine entity address the required elements concerning the distant-site telemedicine entity's utilization of a medical staff credentialing and privileging process that meets the requirements of the hospital CoPs, licensure of telemedicine physicians and practitioners, current list of telemedicine 		

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	<p>privileging decisions made by the governing body of the distant-site telemedicine entity regarding individual distant-site physicians or practitioners. The CAH's governing body or responsible individual must ensure, through its written agreement with the distant-site telemedicine entity, that the following provisions are met:</p> <p>(i) The distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at (c)(1)(i) through (c)(1)(vii).</p> <p>(ii) The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides a current list to the CAH of the distant-site physician's or practitioner's privileges at the distant-site telemedicine entity.</p>	<p>physicians and practitioners with privileges at the distant-site telemedicine entity, and written review by the CAH of the telemedicine physicians' and practitioners' services?</p> <ul style="list-style-type: none"> • Is there a list provided by the distant-site telemedicine entity of the telemedicine physicians and practitioners covered by the agreement, including their privileges and pertinent licensure information? • Is there evidence that the CAH reviews the services provided by the telemedicine physicians and practitioners, including any adverse events and complaints, and provides written feedback to the distant-site telemedicine entity? • Ask the CAH how it verifies that the telemedicine entity fulfills the terms of the agreement with respect to its credentialing and privileging process and otherwise assures that services are provided in a manner that enables the CAH to meet all applicable CAH requirements? (Surveyors do not attempt to independently verify 		

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	<p>(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the CAH whose patients are receiving the telemedicine services is located.</p> <p>(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the CAH whose patients are receiving the telemedicine services, the CAH has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site telemedicine entity such information for use in periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the CAH's patients and all complaints</p>	<p>whether or not the distant-site telemedicine entity's credentialing and privileging process fulfills the regulatory requirements. Surveyors focus only on what actions the CAH takes to ensure that the distant-site telemedicine entity complies with the terms of the agreement.)</p>	

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	the CAH has received about the distant-site physician or practitioner.		
C-0200	<p>§485.618 Condition of Participation: Emergency Services The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.</p>		<ul style="list-style-type: none"> • Verify that emergency services are organized under the direction of a qualified member of the medical staff. • Verify that procedures and policies for emergency medical services (including triage of patients and any respiratory services provided) are established, evaluated, and updated on an ongoing basis. • Verify that there are sufficient medical and nursing personnel qualified in the needs anticipated by the facility and that there are specific assigned duties for emergency care • Review any policies and procedures for emergency services in the CAH. What evidence indicates that the CAH is capable of providing necessary emergency care for its inpatients and outpatients?

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		<ul style="list-style-type: none"> • Review a sample of patient records for patients treated in the emergency services department to see if the CAH followed its own policies and procedures. • Verify that emergency services are provided in accordance with acceptable standards of practice. • Interview staff to determine that they are knowledgeable, within their own level of participation in emergency care including: <ul style="list-style-type: none"> o Parenteral administration of electrolytes, fluids, blood and blood components; o Care and management of injuries to extremities and central nervous system; o Prevention of contamination and cross infection; and o Provision of emergency respiratory services. • Determine if the CAH provides any degree of respiratory care services and that the type 		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
		<p>and amount of respiratory care provided meets the needs of the patients and is delivered in accordance with acceptable standards of practice.</p> <ul style="list-style-type: none"> • Review the CAH policies and procedures to verify that the scope of the diagnostic and/or therapeutic respiratory care services provided is defined in writing and approved by the medical staff. • Review staffing schedules to determine that the number and type of staff available is appropriate to the volume and types of treatments furnished. • If blood gases or other laboratory tests are performed as part of the delivery of respiratory services, verify that there is a current CLIA certificate. 	
C-0201	<p>§485.618(a) Standard: Availability Emergency services are available on a 24-hours a day basis.</p>	<p>Ascertain by record review of patients admitted through the emergency department, interviews with staff, patients, and families, and/or observations that ED services were made available to patients presenting on a 24-hour a day basis. How does the CAH ensure that emergency services are made</p>	

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
C-0202	<p>§485.618(b) Standard: Equipment, Supplies, and Medication Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases.</p>		
C-0203	<p>§485.618(b)(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrhythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions.</p>		
C-0204	<p>§485.618(b)(2) Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes,</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.</p>		
<p>C-0205</p>	<p>§485.618(c) Standard: Blood and Blood Products The facility provides, either directly or under arrangements, the following--</p>		
	<p>(1) Services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis.</p>		
	<p>(2) Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the persons directly responsible for the</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	operation of the facility.		
C-0206	<p>§485.618(c)(2) Blood storage facilities that meet the requirements of 42 CFR part 493, subpart K, and are under the control and supervision of a pathologist or other qualified doctor of medicine or osteopathy. If blood banking services are provided under an arrangement, the arrangement is approved by the facility's medical staff and by the persons directly responsible for the operation of the facility.</p>		
C-0207	<p>§485.618(d) Standard: Personnel (1) Except as specified in paragraph (d)(2) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, or a nurse practitioner with training or experience in emergency care on call and immediately available by telephone or radio contact, and available on site within the following timeframes:</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS	
	<p>(i) Within 30 minutes, on a 24-hour a day basis, if the CAH is located in an area other than an area described in paragraph (d)(1)(ii) of this section; or</p> <p>(ii) Within 60 minutes, on a 24-hour a day basis, if all of the following requirements are met:</p> <p>(A) The CAH is located in an area designated as a frontier area (that is, an area with fewer than six residents per square mile based on the latest population data published by the Bureau of the Census) or in an area that meets criteria for a remote location adopted by the State in its rural health care plan, and approved by CMS, under section 1820(b) of the Act.</p> <p>(B) The State has determined under criteria in its rural health care plan, that allowing an emergency response time longer than 30 minutes is the only feasible method of providing emergency care to residents of the</p>	<p>member is on call 24 hours a day and available on site at the CAH within 30 minutes, or 60 minutes in certain frontier areas.</p> <ul style="list-style-type: none"> • Interview staff to determine how the CAH staff knows who is on call. • What documentation demonstrates that a MD/DO, nurse practitioner, physician assistant, or registered nurse (as allowed under (d)(2)) with emergency training or experience has been on call and available on site at the CAH within 30 or 60 minutes, as appropriate? 		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>area served by the CAH. (C) The State maintains documentation showing that the response time of up to 60 minutes at a particular CAH it designates is justified because other available alternatives would increase the time needed to stabilize a patient in an emergency. (2) A registered nurse satisfies the personnel requirement specified in paragraph (d)(1) of this section for a temporary period if-- (i) The CAH has no greater than 10 beds; (ii) The CAH is located in an area designated as a frontier area or remote location as described in paragraph (d)(1)(ii)(A) of this section; (iii) The State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation on the issue of using RNs on a temporary basis as part of their State rural health care plan with the State Boards of Medicine</p>		

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	<p>and Nursing, and in accordance with State law, requesting that a registered nurse with training and experience in emergency care be included in the list of personnel specified in paragraph (d)(1) of this section. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of emergency services in the States. The letter from the Governor must also describe the circumstances and duration of the temporary request to include the registered nurses on the list of personnel specified in paragraph (d)(1) of this section;</p> <p>(iv) Once a Governor submits a letter, as specified in paragraph (d)(2)(ii) of this section, a CAH must submit documentation to the State survey agency demonstrating that it has been unable, due to the shortage of such personnel in the area, to provide adequate coverage</p>		

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	<p>as specified in this paragraph (d). (3) The request, as specified in paragraph (d)(2)(ii) of this section, and the withdrawal of the request, may be submitted to us at any time, and are effective upon submission.</p>		
<p>C-0209</p>	<p>§485.618(e) Standard: Coordination With Emergency Response Systems The CAH must, in coordination with emergency response systems in the area, establish procedures under which a doctor of medicine or osteopathy is immediately available by telephone or radio contact on a 24-hours a day basis to receive emergency calls, provide information on treatment of emergency patients, and refer patients to the CAH or other appropriate locations for treatment.</p>	<p>The CAH, not the local ambulance service, is responsible for ensuring that an effective procedure is in place to meet this requirement.</p> <ul style="list-style-type: none"> • Verify that the CAH has policies and procedures in place to ensure an MD/DO is available by telephone or radio, on a 24-hour a day basis to receive emergency calls and provide medical direction in emergency situations? • What evidence demonstrates that the procedures are followed and evaluated for effectiveness? • Interview staff to see how an MD/DO is contacted when emergency instructions are needed. 	
<p>C-0210</p>	<p>§485.620 Condition of Participation: Number of Beds</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	and Length of Stay		
C-0211	<p>§485.620(a) Standard: Number of Beds Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds. <i>Inpatient beds may be used for either inpatient or swing-bed services.</i></p>		
C-0212	<p>§485.620(b) Standard: Length of Stay The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient.</p>		
C-0220	§485.623 Condition of		This COP applies to all locations of the

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>Participation: Physical Plant and Environment</p>		
<p>C-0221</p>	<p>§485.623(a) Standard: Construction The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services.</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
C-0222	<p>§485.623(b) Standard: Maintenance The CAH has housekeeping and preventive maintenance programs to ensure that-- (1) All essential mechanical, electrical, and patient-care equipment is maintained in safe operating condition;</p>		
C-0223	<p>§485.623(b)(2) There is proper routine storage and prompt disposal of trash;</p>		
C-0224	<p>§485.623(b)(3) Drugs and biologicals are appropriately stored;</p>		
C-0225	<p>§485.623(b)(4) The premises are clean and orderly;</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
		<p>supplies are stored in proper spaces, not in corridors. Spills are not left unattended. There are no floor obstructions. The area is neat and well kept. There is no evidence of peeling paint, visible water leaks, or plumbing problems.</p>	
C-0226	<p>§485.623(b)(5) There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.</p>	<ul style="list-style-type: none"> • Verify that all food and medication preparation areas are well lighted. • Verify that the CAH is in compliance with ventilation requirements for patients with contagious airborne diseases, such as tuberculosis, patients receiving treatments with hazardous chemical, surgical areas, and other areas where hazardous materials are stored. • Verify that food products are stored under appropriate conditions (e.g., time, temperature, packaging, location) based on nationally-accepted sources such as the United States Department of Agriculture, the Food and Drug Administration, or other nationally-recognized standard. • Verify that pharmaceuticals are stored at temperatures recommended by the product 	

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>manufacturer.</p> <ul style="list-style-type: none"> • Verify that each anesthetizing location has temperature control mechanisms. • Review the records for anesthetizing locations temperature and humidity to ensure levels are maintained. • Review temperature and humidity maintenance records for anesthetizing locations to ensure, if monitoring determined temperature or humidity levels were not within acceptable parameters, the corrective actions were performed in a timely manner to achieve acceptable levels. 		
<p>C-0227</p>	<p>§485.623(c) Standard: Emergency Procedures The CAH assures the safety of patients in non-medical emergencies by--</p>	<p>Use the Life Safety Code Survey Report Form (CMS-2786) to evaluate compliance with this item.</p>	
	<p>(1) Training staff in handling emergencies, including prompt reporting of fires, extinguishing of fires, protection and, where necessary, evacuation of patients,</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	personnel, and guests, and cooperation with firefighting and disaster authorities;		
C-0228	§485.623(c)(2) Providing for emergency power and lighting in the emergency room and for battery lamps and flashlights in other areas;	The CAH must comply with the applicable provisions of the Life Safety Code, National Fire Protection Amendments (NFPA) 101, 2000 Edition and applicable references such as NFPA-99: Health Care Facilities, for emergency lighting and emergency power.	
C-0229	§485.623(c)(3) Providing for an emergency fuel and water supply;		
C-0230	§485.623(c)(4) Taking other appropriate measures that are consistent with the particular conditions of the area in which the CAH is located.	Verify that the CAH has developed and implemented a comprehensive plan to ensure the safety and well-being of patients during local emergency situations.	
C-0231	§485.623(d) Standard: Life Safety From Fire (1) Except as otherwise provided in this section, the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the	<ul style="list-style-type: none"> • There is a separate survey form, (CMS-2786) used by the Fire Authority surveyor to evaluate compliance with the Life Safety Code and a separate 1985 Life Safety Code Addendum to be used when surveying for compliance with the 1985 Life Safety Code. (Life Safety Code Guidelines and a copy of the 1985 Life Safety Code Addendum are contained in SOM Appendix I.) 	

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capital Street NW, Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH.</p>	<ul style="list-style-type: none"> • Survey the entire building occupied by the CAH unless there is a 2-hour firewall separating the space designated as the CAH from the remainder of the building. A 2-hour floor slab does not count; it must be a vertical firewall to constitute a separate building or part of a building. 	
C-0232	<p>§485.623(d)(2) If CMS finds that the State has a fire and safety code imposed by State law that</p>	<p>This revision deletes “grandfathering” of older editions of the LSC and allows the use of a State code if approved by CMS.</p>	

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	adequately protects patients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.		
C-0233	§485.623(d)(3) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients.		
C-0234	§485.623(d)(4) The CAH maintains written evidence of regular inspection and approval by State or local fire control agencies.		
C-0235	§485.623(d)(5) A critical access CAH must be in compliance with the following provisions beginning on March 13, 2006: (i) Chapter 19.3.6.3.2 exception number 2. (ii) Chapter 19.2.9, Emergency		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	Lighting.		
C-0240	§485.627 Condition of Participation: Organizational Structure		
C-0241	§485.627(a) Standard: Governing Body or Responsible Individual The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.		<p>The CAH must have only one governing body (or responsible individual) and this governing body (or responsible individual) is responsible for the conduct of the CAH as an institution. In the absence of an organized governing body, there must be written documentation that identifies the individual or individuals that are responsible for the conduct of the CAH operations.</p>
C-0242	§485.627(b) Standard: Disclosure The CAH discloses the names and addresses of-- (1) Its owners, or those with a controlling interest in the CAH or in any subcontractor in which the CAH directly or indirectly has a 5 percent or more ownership interest, in accordance with		<ul style="list-style-type: none"> • Review CAH policy for reporting changes of ownership. • How does the CAH implement its policy or procedure for reporting changes in ownership to the State agency?

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	subpart C of part 420 of this chapter;		
C-0243	§485.627(b)(2) The person principally responsible for the operation of the CAH;		
C-0244	§485.627(b)(3) The person responsible for medical direction		
C-0250	§485.631 Condition of Participation: Staffing and Staff Responsibilities		
C-0251	§485.631(a) Standard: Staffing (1) The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.		
C-0252	§485.631(a)(2) Any ancillary personnel are supervised by the professional staff.		
C-0253	§485.631(a)(3) The staff is sufficient to provide the services essential to the operation of the CAH.		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
C-0254	<p>services)?</p> <ul style="list-style-type: none"> • Review staffing schedules and daily census records. <p>§485.631(a)(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.</p>		<ul style="list-style-type: none"> • If the CAH does not have regular announced hours of operation, ask the individual who is principally responsible for the operation of the CAH, when is the CAH is open to the public to provide outpatient services.
C-0255	<p>§485.631(a)(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.</p>		<p>Review nursing staff schedules to ensure that a registered nurse, clinical nurse specialist or licensed practical nurse is on duty whenever the CAH has one or more inpatients.</p>
C-0256	<p>§485.631(b) Standard: Responsibilities of the Doctor of Medicine or Osteopathy</p>		
C-0257	<p>485.631(b)(1) The doctor of medicine or osteopathy-- (i) Provides medical direction for the CAH'S health care activities and consultation for, and medical supervision of, the health care staff;</p>		<p>What evidence demonstrates that an MD/DO provides medical direction for the CAH'S health care activities and is available for consultation and supervision of the CAH health care staff?</p>

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
C-0258	<p>§485.631(b)(1)(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH’S written policies governing the services it furnishes.</p>	<ul style="list-style-type: none"> • What evidence demonstrates that an MD/DO has participated in the development of policies governing CAH services? • How does the CAH ensure that an MD/DO periodically reviews these policies? 	
C-0259	<p>§485.631(b)(1)(iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH’S patient records, provides medical orders, and provides medical care services to the patients of the CAH; and</p>	<ul style="list-style-type: none"> • How does the CAH ensure that an MD/DO periodically reviews CAH patient records in conjunction with staff mid-level practitioners and provides medical care to CAH patients? 	
C-0260	<p>§485.631(b)(1) [The doctor of medicine or osteopathy-] (iv) Periodically reviews and signs the records of <i>all inpatients</i> cared for by nurse practitioners, clinical nurse specialists, or physician assistants. (v) Periodically reviews and signs</p>	<p>Select a sample of inpatient and outpatient records, including both open and closed records.</p> <ul style="list-style-type: none"> • An MD/DO has reviewed and signed all records that were open at the time of the review, and all inpatient records that were closed since the MD/DO’s last review; and 	

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS	
	<p>a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.</p>	<ul style="list-style-type: none"> • That reviews take place within the timeframe specified by the CAH's policy. • If State law requires a physician to review or co-sign (or both) any outpatient records of patients whose care is/was managed by non-physician practitioner, determine whether an MD or DO has reviewed and/or co-signed a representative sample of these records within the timeframe specified in the CAH's policies. • Review selected records from the CAH's outpatient sample to verify that there is evidence of an MD or DO review and/or signature. 		
<p>C-0261</p>	<p>§485.631(b)(2) A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with</p>	<ul style="list-style-type: none"> • Does the CAH have policies and procedures that address the minimum amount of time and frequency of MD or DO presence on-site at the CAH? Can the CAH demonstrate how its policy reflects the volume and type of services the CAH provides such that there is sufficient MD/DO presence on-site to support the services provided? • Is there documentation showing that an MD 		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>medical emergencies, or patient referral.</p>		
<p>C-0262</p>	<p>§485.631(c) Standard: Physician Assistant, Nurse Practitioner, and Clinical Nurse Specialist Responsibilities</p>		
<p>C-0263</p>	<p>485.631(c)(1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH'S staff-- (i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes;</p>		
<p>C-0264</p>	<p>485.631(c)(1)(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.</p>		
<p>C-0265</p>	<p>§485.631(c)(2) The physician assistant, nurse practitioner, or</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy: (i) Provides services in accordance with the CAH'S policies.</p>		
C-0267	<p>§485.631(c)(2)(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.</p>		
C-0268	<p>§485.631(c)(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
		<ul style="list-style-type: none"> • Verify that an MD/DO is responsible for and is monitoring the care of each Medicare or Medicaid patient for all medical problems during the hospitalization. • If mid-level practitioners admit patients, verify that every Medicare/Medicaid patient is being monitored by an MD/DO who is responsible for any medical problem outside the scope of practice of the admitting practitioners. 	
C-0270	§485.635 Condition of Participation: Provision of Services		
C-0271	§485.635(a) Standard: Patient Care Policies (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.	<ul style="list-style-type: none"> • Verify that the CAH has written policies covering the health care services that are furnished in the CAH. • Observe staff delivering health care services to patients. Is the actual provision of services consistent with the CAH's written policies? 	
C-0272	§485.635(a)(2) The policies are developed with the advice of <i>members of the CAH's professional healthcare staff, including one or more doctors of</i>	<ul style="list-style-type: none"> • Review any meeting minutes for the group of healthcare professionals that advises the CAH's governing body or responsible individual on patient care policies to determine if the group's composition meets 	

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	<p>medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH.</p>	<p>the regulatory requirements.</p> <ul style="list-style-type: none"> • Interview all staff listed as part of the policy development advisory group to determine if they had the opportunity to express opinions and make recommendations to the group, for the group’s consideration as a group recommendation. • Can the CAH provide documentation that the advisory group developed written recommendations on the CAH’s patient care policies for consideration by the CAH’s governing body/responsible individual? • Is there evidence that the group reviewed the CAH’s existing policies at least annually and indicated whether or not it recommended any changes? 		
C-0273	<p>§485.635(a)(3) The policies include the following: (i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement.</p>	<p>Verify that the CAH’s healthcare policies identify and describe all healthcare services offered by the CAH, including services provided under arrangement or by agreement.</p>		
C-0274	<p>§485.635(a)(3) [The policies include the following:]</p>	<p>Verify that written policies and procedures detail how the CAH plans to comply with the</p>		

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	<p>(ii) Policies and procedures for emergency medical services.</p>		
<p>C-0275</p>	<p>§485.635(a)(3) [The policies include the following:] (iii) Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the</p>		

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	<p>periodic review and evaluation of the services furnished by the CAH.</p>		
<p>C-0276</p>	<p>§485.635(a)(3) (iv) Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.</p>		
<p>C-0277</p>	<p>§485.635(a)(3) (v) Procedures for reporting adverse drug reactions and errors in the administration of drugs.</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
C-0278	<p>§485.635(a)(3) (vi) A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.</p>		

- *Verify that the CAH has designated a qualified individual to be responsible for the infection control program.*
- *Can the responsible individual demonstrate that the CAH's program adheres to nationally recognized practices or guidelines?*
- *Is the environment sanitary throughout the CAH?*
- *Do CAH staff employ standard precautions appropriately?*
- *Do CAH staff employ safe infection control practices for preparing and administering medications?*
- *Can the responsible individual demonstrate that infection control incidents, problems, and trends are analyzed and that corrective actions are taken and further assessed?*
- *Is there evidence of training of staff in infection control practices pertinent to their roles?*

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C-0279	<p>§485.635(a)(3) (vii) Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving post hospital SNF care.</p>		
C-0280	<p>§485.635(b) Standard: Patient Services (1) General</p> <p><i>(i)</i> The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician’s office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or</p>		

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RULE	SURVEYOR GUIDELINES	Y/N	COMMENTS
	<p>emergency department. These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.</p>	<p>needs of the patient care provided.</p>	
<p>C-0281</p>	<p>§485.635(b) [Standard: Patient Services (1) General] (ii) The CAH furnishes acute care inpatient services.</p>	<ul style="list-style-type: none"> • Verify that the CAH is furnishing acute care inpatient services by reviewing data on the number of patients admitted over the prior year. 	
<p>C-0282</p>	<p>§485.635(b)(2) Laboratory Services The CAH provides basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include the following: (i) Chemical examination of urine by stick or tablet method</p>	<ul style="list-style-type: none"> • Ask the CAH to identify which laboratory services it offers. Are the required lab services provided at the CAH’s main campus? • Does the CAH have a CLIA certificate or waiver, as applicable, for all laboratory tests performed in CAH facilities? • Verify that the CAH has a procedure in place for obtaining tests that are needed but unavailable at the CAH laboratory. • If the CAH refers specimens to another laboratory for testing, does the CAH have documentation that the referral laboratory is 	

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	<p>or both (including urine ketones). (ii) Hemoglobin or hematocrit. (iii) Blood glucose. (iv) Examination of stool specimens for occult blood. (v) Pregnancy tests. (vi) Primary culturing for transmittal to a certified laboratory.</p>	<p>CLIA certified for the appropriate tests?</p>	
<p>C-0283</p>	<p>§485.635(b)(3) Radiology services. Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards.</p>	<ul style="list-style-type: none"> • Interview the person responsible for radiologic services. • Ask what radiologic services the CAH offers at its main campus. At off-site locations ask how the CAH ensures patient needs for radiologic services are met, if applicable. • Determine if the radiologic services staff is familiar with the policies and procedures related to safety. • Verify that patient shielding (aprons, etc.) are properly maintained and routinely inspected by the CAH. 	

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		<ul style="list-style-type: none"> • Observe areas where radiologic testing is done and check for safety problems. • Verify that hazardous materials are clearly labeled. Review records to verify that they are tracked, handled and stored properly in a safe manner with the requisite containers. • Review records to verify that periodic tests of radiology personnel by exposure meters or test badges are performed. • Equipment maintenance: • Review the inspection records to verify that periodic inspections and maintenance are conducted in accordance with the manufacturer's recommendations. 	
C-0284	§485.635(b)(4) Emergency procedures. In accordance with the requirements of §485.618, the CAH provides medical services as a first response to common life-threatening injuries and acute illness.	The survey procedures for §485.618 apply.	
C-0285	§485.635(c) Standard: Services Provided Through Agreements	<ul style="list-style-type: none"> • Determine whether the CAH verifies that 	

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	<p>or Arrangements (1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including (5) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.</p>	<p>every entity providing health care services to the CAH's patients under an agreement participates in Medicare, with the exception of a distant-site telemedicine entity providing telemedicine services under an agreement or arrangement.</p>	
C-0287	<p>§485.635(c)(1) [The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—] (i) Services of doctors of medicine or osteopathy; §485.635(c)(2) If the agreements or arrangements are not in</p>	<ul style="list-style-type: none"> • Verify that the CAH has arrangements with one or more MDs or DOs for referral of discharged CAH patients who need medical services not available at the CAH. • Are the referral arrangements in writing? If not, can the CAH document that patients referred to an outside MD or DO have been offered appointments and treatment? • Does the CAH have policies and 	

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	<p>writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated. Interpretive Guidelines §485.635(c)(1)(i) & §485.635(c)(2)</p>	<p>procedures addressing referral of discharged patients? Are the CAH's practitioners and staff who handle the discharge of patients familiar with these policies and procedures?</p>	
<p>C-0288</p>	<p>§485.635(c)(1) [The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—] <i>(ii)</i> Additional or specialized diagnostic and clinical laboratory services that are not available at the CAH; and §485.635(c)(2) If the agreements or arrangements are not in writing, the CAH is able to present evidence that patients referred by the CAH are being accepted and treated.</p>	<ul style="list-style-type: none"> • Verify that the CAH has an agreement or arrangement with an outside laboratory and an outside diagnostic imaging facility for services not provided in the CAH. • If the agreement or arrangement is not in writing, can the CAH document that it is sending specimens to an outside laboratory and patients to an outside diagnostic imaging facility when needed, and that it is receiving test results? • Do policies and procedures address which imaging and lab services are provided under arrangement, as well as, for lab services, collection, preservation, transportation, receipt, and reporting of tissue specimen results? 	
<p>C-0289</p>	<p>§485.635(c)(1) [The CAH has agreements or arrangements (as</p>	<ul style="list-style-type: none"> • Verify that the CAH has an agreement or arrangement with a vendor to provide dietary 	

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	<p>appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—] (iii) Food and other services to meet inpatients' nutritional needs to the extent these services are not provided directly by the CAH.</p>	<p>services to inpatients if the CAH does not use its own staff to provide these services.</p>	
<p>C-0291</p>	<p>§485.635(c)(3) The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.</p>	<ul style="list-style-type: none"> • Review the list of contracted services and verify that it contains all required information. 	
<p>C-0292</p>	<p>§485.635(c)(4) The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following: (i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements. (ii) Ensuring that a contractor of services (including one for shared services and joint ventures)</p>	<ul style="list-style-type: none"> • Ask the CAH's CEO to demonstrate how he or she provides oversight of all contracted services related to patient care. 	

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	furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.		
C-0294	<p>§485.635(d) Standard: Nursing Services Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient’s needs and the specialized qualifications and competence of the staff available.</p>		<ul style="list-style-type: none"> • <i>Determine whether an RN has been designated responsible for nursing services at the CAH.</i> • Observe the nursing care in progress to determine the adequacy of staffing and to assess the delivery of care. Sources of information to use in the evaluation of the nursing services are: staffing schedules, nursing care plans <i>for inpatients</i> credentialing and training files (including contracted staff), and QA activities and reports.
C-0296	<p>485.635(d)(2) A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.</p>		<ul style="list-style-type: none"> • Determine that a registered nurse (or <i>physician assistant</i> where permitted by State law and <i>CAH policy</i>) supervises and evaluates the nursing care for each patient.

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C-0297	485.635(d)(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.		
C-0298	485.635(d)(4) A nursing care plan must be developed and kept current for each inpatient.		
C-0299	§485.635(e) Standard: Rehabilitation Therapy Services Physical therapy, occupational therapy, and speech-language therapy pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and		

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	<p>consistent with the requirements for therapy services in §409.17 of this subpart.</p>		
<p>C-1000</p>	<p>§485.635(f) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation....</p>		
<p>C-1001</p>	<p>§485.635(f) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients,</p> <ul style="list-style-type: none"> • Determine whether the CAH’s visitation policies and procedures require providing notice of the patient’s visitation 		

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<p>rights to each patient or, if appropriate, to a patient's support person and/or, as applicable, the patient's representative .</p> <ul style="list-style-type: none"> • Review the CAH's standard notice of visitation rights. Does it clearly explain the: • CAH's visitation policy, including any limitations or restrictions, such as visiting hours, numbers of visitors, or unit-specific restrictions, etc., and the clinical rationale for such limitations or restrictions? • right of the patient to have designated visitors, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny consent to visitation? 	<ul style="list-style-type: none"> • CAH's visitation policy, including any limitations or restrictions, such as visiting hours, numbers of visitors, or unit-specific restrictions, etc., and the clinical rationale for such limitations or restrictions? • right of the patient to have designated visitors, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny consent to visitation? • Ask a sample of current CAH patients or patients' support persons • Ask a sample of current CAH patients or patients' support persons (where appropriate) whether the CAH did not limit some or all visitors, contrary to the patient's wishes. 		

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	<p>• Review a sample of medical records to determine if there is documentation that the required notice was provided and if it was provided in advance of care, unless circumstances made this not feasible. including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. A CAH must meet the following requirements:</p> <p>(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, in advance of furnishing patient care whenever possible.</p> <p>(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent,</p>		

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	to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.		
C-1002	<p>§485.635(f) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. A CAH must meet the following requirements:</p> <p>(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual</p>	<ul style="list-style-type: none"> • Review the CAH’s visitation policies and procedures to determine whether they restrict, limit, or otherwise deny visitation to individuals on a prohibited basis. • Ask CAH patients (or patients’ support persons, where appropriate) whether the CAH has limited visitors against their wishes? If yes, verify whether the restriction/limitation on visitors was addressed in the CAH’s visitation policies and in the patient notice, and whether it was appropriately based on a clinical rationale rather than impermissible discrimination. 	

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	<p>orientation, or disability. (4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.</p>		
C-0300	<p>§485.638 Condition of Participation: Clinical Records</p>		
C-0301	<p>§485.638(a) Standard: Records System (1) The CAH maintains a clinical records system in accordance with written policies and procedures.</p>		<ul style="list-style-type: none"> • Verify that a medical record is maintained for each person receiving care. • Verify that written procedures ensure the integrity of authentication and protect the security of patient records. • Verify that medical records are stored and maintained in locations where the records are secure, with protection from damage, flood, fire, theft, etc., and limits access to only authorized individuals.
C-0302	<p>§485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.</p>		<p>For CAH surveys that are conducted after the initial certification survey, examine a sample of records using an adequate sample size to evaluate the scope of services provided. In a very small CAH, look at all inpatient and outpatients records, if appropriate.</p>
C-0303	<p>§485.638(a)(3) A designated member of the professional staff</p>		<ul style="list-style-type: none"> • Verify that the CAH employs adequate medical record personnel.

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	<p>is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized.</p>	<ul style="list-style-type: none"> • Review the organizational structure and policy statements and interview the person responsible for the service to ascertain that the medical records service is structured appropriately to meet the needs of the CAH and the patients. 	
<p>C-0304</p>	<p>§485.638(a)(4) For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- (i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;</p>	<ul style="list-style-type: none"> • Verify that the medical staff have specified which procedures or treatments require a written informed consent. • Verify that medical records contain consent forms for all procedures or treatment that are required by CAH policy. • Verify that consent forms are properly executed. • Review of sample of active and closed medical records for completeness and accuracy in accordance with Federal and State laws and regulations and CAH policy. The sample should be at least 10 percent of the average daily census, as appropriate. 	
<p>C-0305</p>	<p>§485.638(a)(4)(ii) Reports of physical examinations, diagnostic and laboratory test</p>	<ul style="list-style-type: none"> • Determine that the bylaws require a physical examination and medical history be done for each patient. 	

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	results, including clinical laboratory services, and consultative findings;		
C-0306	§485.638(a)(4)(iii) All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics, progress notes describing the patient's response to treatment;		
C-0307	§485.638(a)(4)(iv) Dated signatures of the doctor of medicine or osteopathy or other health care professional.		

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		is maintained under adequate safeguards by the CAH administration. • Verify that the CAH’S policies and procedures provide for appropriate sanctions for unauthorized or improper use of the computer codes.	
C-0308	§485.638(b) Standard: Protection of Record Information (1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.	• Verify that only authorized persons are permitted access to records maintained by the medical records department. • Verify that the CAH has a policy to grant patients direct access to his/her medical record if the responsible official (e.g., practitioner responsible for patient's care) determines that direct access is not likely to have an adverse effect on the patient. • Verify that adequate precautions are taken to prevent physical or electronic altering, damaging or deletion/destruction of patient records or information in patient records.	
C-0309	§485.638(b)(2) Written policies and procedures govern the use and removal of records from the CAH and the conditions for the release of information.	• Observe the CAH’S security practices for patient records. Are patient records left unsecured or unattended? Are patient records unsecured or unattended in hallways, patient rooms, nurses stations, or on counters where an unauthorized person could gain access to	

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C-0310	<p>§485.638(b)(3) The patient’s written consent is required for release of information not required by law.</p>		
C-0311	<p>§485.638(c) Standard: Retention of Records The records are retained for at least 6 years from date of last entry, and longer if required by State statute, or if the records may be needed in any pending proceeding.</p>		
C-0320	<p>§485.639 Condition of Participation: Surgical Services. If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section.</p>		
C-0321	<p>§485.639(a) Standard: Designation of Qualified</p>		<ul style="list-style-type: none"> • Review the CAH’S method for reviewing the surgical privileges of practitioners. This

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	<p>Practitioners The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by-- (1) A doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (2) A doctor of dental surgery or dental medicine; or (3) A doctor of podiatric medicine.</p>	<p>method should require a written assessment of the practitioner's training, experience, health status, and performance.</p> <ul style="list-style-type: none"> • Determine that a current roster listing each practitioner's specific surgical privileges is available in the surgical suite and the area where the scheduling of surgical procedures is done. • Determine that a current list of surgeons suspended from surgical privileges or who have restricted surgical privileges is retained in these areas/locations. 		
C-0322	<p>§485.639(b) Standard: Anesthetic Risk and Evaluation (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this</p>	<ul style="list-style-type: none"> • Review records to determine that each patient has a pre-anesthesia evaluation by an individual qualified to administer anesthesia. The evaluation must be performed prior to surgery. • Review medical records to determine that a post-anesthesia follow-up report is written for each patient receiving anesthesia services, by the individual who administered 		

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	<p>section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.</p>	<p>the anesthesia prior to discharge from anesthesia services. Documentation should include those items specified in interpretive guidelines.</p>	
<p>C-0323</p>	<p>§485.639(c) Standard: Administration of Anesthesia The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope-of-practice laws. (1) Anesthesia must be administered by only-- (i) A qualified anesthesiologist; (ii) A doctor of medicine or osteopathy other than an anesthesiologist; including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (iii) A doctor of dental surgery or</p>	<ul style="list-style-type: none"> • Review the qualifications of individuals authorized to deliver anesthesia. • Determine that there is documentation of current licensure or current certification status for all persons administering anesthesia. 	

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	dental medicine; (iv) A doctor of podiatric medicine; (v) A certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter; (vi) An anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or (vii) A supervised trainee in an approved educational program, as described in §§ 413.85 or 413.86 of this chapter.		
C-0324	§485.639(c)(2) In those cases in which a CRNA administers the anesthesia, the anesthetist must be under the supervision of the operating practitioner except as provided in paragraph (e) of this section. An anesthesiologist's assistant who administers anesthesia must be under the supervision of an anesthesiologist.		
C-0325	§485.639(d) Standard: Discharge All patients are discharged in the company of a responsible	Verify that the CAH has policies and procedures in place to govern discharge procedures and instructions.	

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	<p>adult, except those exempted by the practitioner who performed the surgical procedure.</p>		
<p>C-0326</p>	<p>§485.639(e) Standard: State Exemption (1) A CAH may be exempted from the requirement for MD/DO supervision of CRNAs as described in paragraph (c)(2) of this section, if the State in which the CAH is located submits a letter to CMS signed by the Governor, following consultation with the State’s Boards of Medicine and Nursing, requesting exemption from MD/DO supervision for CRNAs. The letter from the Governor must attest that he or she has consulted with the State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State’s citizens to opt-out of the current</p>		

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	<p>MD/DO supervision requirement, and that the opt-out is consistent with State law. (2) The request for exemption and recognition of State laws and the withdrawal of the request may be submitted at any time, and are effective upon submission.</p>		
<p>C-0330</p>	<p>§485.641 Condition of Participation: Periodic Evaluation and Quality Assurance Review</p>	<p>If the CAH produces a law, regulation, or standard of practice from a nationally recognized organization, evaluate whether the CAH'S policies and procedures reflect the law, regulation, or standard of practice. Then, evaluate whether the CAH'S actual practice reflects their policies and procedures, as well as the law, regulation or standard of practice.</p>	
<p>C-0331</p>	<p>§485.641(a) Standard: Periodic Evaluation (1) The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of--</p>	<ul style="list-style-type: none"> • How is information obtained to be included in the periodic evaluation? • How does the CAH conduct the periodic evaluation? • Who is responsible for conducting the periodic evaluation? 	
<p>C-0332</p>	<p>§485.641(a)(1)(i) The utilization</p>	<p>How does the CAH ensure that the yearly</p>	

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	of CAH services, including at least the number of patients served and the volume of services;	program evaluation includes a review of all CAH services, the number of patients served and the volume of services provided?	
C-0333	§485.641(a)(1)(ii) A representative sample of both active and closed clinical records;	<ul style="list-style-type: none"> • Who is responsible for the review of both active and closed clinical records? • How are records selected and reviewed in the periodic evaluation? • How does the evaluation process ensure that the sample of records is representative of services furnished? 	
C-0334	§485.641(a)(1)(iii) The CAH'S health care policies.	What evidence demonstrates that the health care policies of the CAH are evaluated, reviewed and/or revised as part of the annual program evaluation?	
C-0335	§485.641(a)(2) The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed.	<ul style="list-style-type: none"> • How does the CAH use the results of the yearly program evaluation? • Were policies, procedures and /or facility practices added, deleted or revised as a result of the yearly program evaluation if needed? 	
C-0336	§485.641(b) Standard: Quality Assurance	Review a copy of the CAH QA plan and other documentation regarding QA activities,	

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	<p>The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--</p>		
<p>C-0337</p>	<p>§485.641(b)(1) All patient care services and other services affecting patient health and safety, are evaluated;</p>		
<p>C-0338</p>	<p>§485.641(b)(2) Nosocomial infections and medication therapy are evaluated;</p>		
<p>C-0339</p>	<p>§485.641(b)(3) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical</p>		

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	<p>nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH;</p>	<ul style="list-style-type: none"> • How is clinical performance of mid-level practitioners evaluated? • What evidence demonstrates that there is an ongoing evaluation of care provided by mid-level practitioners (e.g., reports, periodic written evaluation, QA meeting notes)? • How does the reviewing MD/DO inform the CAH if he/she determines that there are problems relative to the diagnosis and treatment provided by mid-level practitioners? 	
<p>C-0340</p>	<p>§485.641(b)(4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by-- (i) One hospital that is a member of the network, when applicable; (ii) One QIO or equivalent entity; (iii) One other appropriate and</p>	<ul style="list-style-type: none"> • Is there evidence that the CAH has an agreement for outside review of the quality of care provided on-site (i.e., not including telemedicine services) by the CAH’s MDs and DOs with at least one of the following: a hospital that is a member of the same rural health network as the CAH; a Medicare Quality Improvement Organization, or its equivalent; or another appropriate and qualified entity identified in the State’s Rural 	

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	<p>qualified entity identified in the State rural health care plan; (iv) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site hospital, the distant-site hospital; or (v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (b)(4)(i) through (iii) of this section;</p>	<p>Health Plan?</p> <ul style="list-style-type: none"> • If the CAH has one or more agreements for the provision of telemedicine services to CAH patients by a distant-site hospital(s), does each such agreement include a provision for the distant-site hospital to conduct the required outside review of the quality of telemedicine services provided by the MDs and DOs covered by the agreement? • If the CAH has one or more agreements for the provision of telemedicine services to CAH patients by a distant-site telemedicine entity, does the CAH have an agreement for outside review of the quality of telemedicine services provided by the MDs and DOs covered under the agreement? Is the outside review agreement with at least one of the following: a hospital that is a member of the same rural health network as the CAH; a Medicare Quality Improvement Organization, or its equivalent; another appropriate and qualified entity identified in the State's Rural Health Plan; or a distant-site hospital with which the CAH has an 		

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		agreement for telemedicine services? • Can the CAH provide examples of any reviews of the quality and appropriateness of diagnosis and treatment of the CAHs MDs and DOs conducted by an eligible outside entity in the prior 12 – 24 months?	
C-0341	§485.641(b)(5)(i) The CAH staff considers the findings of the evaluations, including any findings or recommendations of the QIO, and takes corrective action if necessary.		
C-0342	§485.641(b)(5)(ii) The CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.	• How does the CAH ensure that proper remedial actions are taken to correct deficiencies identified in the quality assurance program? • Who is responsible for implementing remedial actions to correct deficiencies identified by the quality assurance program?	
C-0343	§485.641(b)(5)(iii) The CAH documents the outcome of all remedial action.	How does the CAH document the outcome of any remedial action?	
C-0344	§485.643 Condition of Participation: Organ, Tissue, and Eye Procurement	The CAH must have written policies and procedures to address its organ procurement responsibilities.	

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	<p>The CAH must have and implement written protocols that:</p>		
<p>C-0345</p>	<p>§485.643(a) Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;</p>		<ul style="list-style-type: none"> • Review the CAH’S written agreement with the OPO to verify that it addresses all required information. • Verify that the CAH’S governing body has approved the CAH’S organ procurement policies. • Review a sample of death records to verify that the CAH has implemented its organ procurement policies. • Verify that the organ, tissue and eye donation program is integrated into the CAH’S QA program.
<p>C-0346</p>	<p>§485.643(b) Incorporate an agreement with at least one</p>		<p>Verify that the CAH has an agreement with at least one tissue bank and one eye bank that</p>

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	<p>tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;</p>	<p>specifies criteria for referral of all individuals who have died in the CAH. The agreement must also acknowledge that it is the OPO's responsibility to determine medical suitability for tissue and eye donation, unless the CAH has an alternative agreement with a different tissue and/or eye bank.</p>	
<p>C-0347</p>	<p>§485.643(c) Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the</p>	<ul style="list-style-type: none"> • Verify that the CAH ensures that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, including the option to decline to donate. • Review training schedules and personnel files to verify that all designated requestors have completed the required training. • How does the CAH ensure that only designated requestors are approaching families to ask them to donate? 	

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	methodology for approaching potential donor families and requesting organ or tissue donation;		
C-0348	§485.643(d) Encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the family of potential donors;	<ul style="list-style-type: none"> • Interview a CAH-designated requestor regarding approaches to donation requests. • Review the designated requestor training program to verify that it addresses the use of discretion. • Review the facility complaint file for any relevant complaints. 	
C-0349	§485.643(e) Ensure that the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. §485.643(f) For purpose of these	<ul style="list-style-type: none"> • Review inservice training schedules and attendance sheets. • How does the CAH ensure that all appropriate staff have attended an educational program regarding donation issues and how to work with the OPO, tissue bank, and eye bank? • Verify by review of policies and records that the CAH works with the OPO, tissue bank, and eye bank in reviewing death records. 	

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	<p>standards, the term “organ” means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).</p>		
<p>C-0350</p>	<p>§485.645 Special Requirements for CAH Providers of Long-Term Care Services (“Swing-Beds”) A CAH must meet the following</p>		

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	<p>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.</p>		
<p>C-0351</p>	<p>§485.645(a) Eligibility A CAH must meet the following eligibility requirements: (1) The facility has been certified as a CAH by CMS under §485.606(b) of this subpart; and (2) The facility provides not more than 25 inpatient beds, and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. Any bed of a unit of the facility that is licensed as a distinct-part SNF at the time the facility applies to the State for designation as a CAH is not counted under paragraph (a) of this section.</p>		
<p>C-0352</p>	<p>§485.645(b) Facilities Participating as Rural Primary Care Hospitals (RPCHs) on</p>		

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	<p>September 30, 1997 These facilities must meet the following requirements: (1) Notwithstanding paragraph (a) of this section, a hospital that participated in Medicare as a RPCH on September 30, 1997, and on that date had in effect an approval from CMS to use its inpatient facilities to provide post-hospital SNF care may continue in that status under the same terms, conditions, and limitations that were applicable at the time these approvals were granted.. (2) A CAH that was granted swing-bed approval under paragraph (b)(1) of this section may request that its application to be a CAH and swing-bed provider be reevaluated under paragraph (a) of this section. If this request is approved, the approval is effective not earlier than October 1, 1997. As of the date of approval, the CAH no longer has any status under paragraph (b)(1) of this</p>			

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	section and may not request reinstatement under paragraph (b)(1) of this section.		
C-0355	<p>§485.645(c) Payment Payment for inpatient RPCH services to a CAH that has qualified as a CAH under the provisions in paragraph (a) of this section is made in accordance with §413.70 of this chapter. Payment for post-hospital SNF-level of care services is made in accordance with the payment provisions in §413.114 of this chapter.</p>		
C-0360	<p>§485.645(d) SNF Services The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: (1) Resident rights (§483.10(b)(3) through (b)(6), (d), (e), (h), (i), (j)(1)(vii) and (viii), (1), and (m) of this chapter). (2) Admission, transfer, and discharge rights (§483.12(a) of this</p>		

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	<p>chapter). (3) Resident behavior and facility practices (§483.13 of this chapter). (4) Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §483.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy. (5) Social services (§483.15(g) of this chapter). (6) Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l) of this chapter, except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to</p>		

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	<p>comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter. (7) Specialized rehabilitative services (§483.45 of this chapter). (8) Dental services (§483.55 of this chapter). (9) Nutrition (§483.25(i) of this chapter).</p>		
C-0361	<p>§483.10(a) Exercise of Rights (1) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. (3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law</p>	<ul style="list-style-type: none"> • Look for on-going efforts on the part of facility staff to keep residents informed. • Look for evidence that information is communicated in a manner that is understandable to residents. • Is information available when it is most useful to the residents such as when they are expressing concerns, raising questions, and on an on-going basis? • Is there evidence in the medical record that the patient was informed of his rights, including the right to accept or refuse medical or surgical treatment? 	

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	<p>to act on the resident’s behalf. (4) In the case of a resident who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the resident’s rights to the extent provided by State law. §483.10(b) Notice of Rights and Services (1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under section 1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident’s stay. Receipt of such information, and any amendments to it, must be acknowledged in</p>		

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	<p>writing; (2) The resident or his or her legal representative has the right-- (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and (ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. (3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition;</p>		
C-0362	<p>§483.10(b)(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive</p>	<p>If the facility participates in any experimental research involving residents, does it have an Institutional Review Board or other committee that reviews and approves research protocols? The requirement at</p>	

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	<p>as specified in paragraph 8 of this section; and</p>		
<p>C-0363</p>	<p>§483.10(b)(5) The facility must-- (i) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of-- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each resident when</p>		

§483.75(c) Relationship to Other HHC Regulations may apply, see 45 CFR Part 46, Protection of Human Subjects of Research). “Although these regulations at §483.75(c) are not in themselves considered requirements under this part, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with Federal funds.”

- Examples:
- Telephone;
 - Television/radio for personal use;
 - Personal comfort items including smoking materials, notions, novelties, and confection;
 - Cosmetic and grooming items and services in excess of those for which payment is made;
 - Personal clothing;
 - Personal reading matter;
 - Gifts purchased on behalf of a resident;

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	<p>changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. (6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>	<ul style="list-style-type: none"> • Flowers and plants; • Social events and entertainment offered outside the scope of the activities program; • Non-covered special care services such as privately hired nurses or aides; • Private room, except when therapeutically required, for example, isolation for infection control; • Specially prepared or alternative food requested; 	
	<p>§483.10(b)(8) The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment</p>	<p>Review the records of sampled residents admitted on or after December 1, 1991, for facility compliance with advance directive notice requirements.</p> <ul style="list-style-type: none"> • Determine to what extent the facility educates its staff regarding advance directives. • Determine to what extent the facility provides education for the community regarding individual rights under State law to formulate advance directives. 	

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	<p>and, at the individual’s option, formulate an advance directive. This includes a written description of the facility’s policies to implement advance directives and applicable State law. Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. If an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, facility may give advance directive information to the individual’s family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or</p>		

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	<p>other concerned persons in accordance with State law. The facility is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>“Advance directive” means a written instruction, such as a living will or durable power of attorney for health care recognized under State law, relating to the provision of health care when the individual is incapacitated.</p>		
C-0364	<p>§483.10(d) Free Choice The resident has the right to-- (1) Choose a personal attending MD/DO;</p>		
C-0365	<p>§483.10(d)(2) Be fully informed in advance about care and treatment and of any changes in</p>		

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	<p>that care or treatment that may affect the resident's well-being; and</p>		
<p>C-0366</p>	<p>§483.10(d)(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.</p>		<ul style="list-style-type: none"> • Look for evidence that the resident was afforded the right to participate in care planning or was consulted about care and treatment changes.
<p>C-0367</p>	<p>C-0367 §483.10(e) Privacy and Confidentiality The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in</p>		<p>Document any instances where you observe a resident's privacy being violated. Completely document how the resident's privacy was violated. Documentation Example: Resident #12 left without gown or bed covers and unattended on 2B Corridor at 3:30 p.m. February 25, 2001. Identify the responsible party, if possible.</p>

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	<p>paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident’s right to refuse release of personal and clinical records does not apply when-- (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.</p>		
<p>C-0368</p>	<p>§483.10(h) Work The resident has the right to-- (1) Refuse to perform services for the facility; (2) Perform services for the facility, if he or she chooses, when-- (i) The facility has documented the need or desire for work in the plan of care; (ii) The plan specifies the nature of the services performed and whether the services are voluntary or paid; (iii) Compensation for paid</p>	<ul style="list-style-type: none"> • Are residents engaged in work (e.g., doing housekeeping, doing laundry, preparing meals)? • Pay special attention to the possible work activities of residents with intellectual disabilities or mental illness. • If a resident is performing work, determine whether it is voluntary, and whether it is described in the plan of care. Is the work mutually agreed upon between the resident and the treatment team? 	

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	services is at or above prevailing rates; and (iv) The resident agrees to the work arrangement described in the plan of care.		
C-0369	§483.10(i) Mail The resident has the right to privacy in written communications, including the right to-- (1) Send and promptly receive mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense.		
C-0370	§483.10(j) Access and Visitation Rights (1) The resident has the right and the facility must provide immediate access to any resident by the following: (vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and (viii) Subject to reasonable restrictions and the resident's right		

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	to deny or withdraw consent at any time, others who are visiting with the consent of the resident.		
C-0371	The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.		
C-0372	§483.10(m) Married Couples The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.		
C-0373	§483.12 Admission, Transfer and Discharge Rights §483.12(a) Transfer and Discharge (1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or		

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	not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.		
C-0374	<p>§483.12(a)(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-</p> <ul style="list-style-type: none"> (i) The transfer or discharge is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility; (ii) The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility; (iii) The safety of individuals in the facility is endangered; (iv) The health of individuals in the facility would otherwise be endangered; (v) The resident has failed, after reasonable and appropriate notice, 	<p>During closed record review, determine the reasons for transfer/discharge.</p> <ul style="list-style-type: none"> • Do records document accurate assessments and attempts through care planning to address the resident’s needs through multidisciplinary interventions, accommodation of individual needs, and attention to the resident’s customary routine? • Did the resident’s MD/DO document the record if the resident was transferred/discharged for the sake of the resident’s welfare and the resident’s needs could not be met in the facility (e.g., a resident develops an acute condition requiring hospitalization) or the resident’s health improved to the extent that the transferred/discharged resident no longer needed the services of the facility? • Did a MD/DO document the record if residents were transferred because the health of individuals in the facility is endangered? 	

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	<p>to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (vi) The facility ceases to operate.</p>	<ul style="list-style-type: none"> • Do the records of residents who are transferred/discharged due to safety reasons reflect the process by which the facility concluded that in each instance transfer or discharge was necessary? • If the entity to which the resident was discharged is another long term care facility, evaluate the extent to which the discharge summary and the resident’s MD/DO justify why the facility could not meet the needs of this resident. 		
C-0376	<p>§483.12(a)(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (a)(2)(i) through (v) of this section, the resident’s clinical record must be documented. The documentation must be made by-- (i) The resident’s MD/DO when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and</p>			

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	(ii) A MD/DO when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.		
C-0377	<p>§483.12(a)(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must--</p> <p>(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</p> <p>(ii) Record the reasons in the resident’s clinical record; and</p> <p>(iii) Include in the notice the items described in paragraph (a)(6) of this section.</p>		
C-0378	<p>§483.12(a)(5) Timing of the notice.</p> <p>(i) Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the</p>		

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	facility at least 30 days before the resident is transferred or discharged. (ii) Notice may be made as soon as practicable before transfer or discharge when-- (A) The safety of individuals in the facility would be endangered under paragraph (a)(2)(iii) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (a)(2)(iv) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(ii) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(i) of this section; or (E) A resident has not resided in the facility for 30 days.		
C-0379	§483.12(a)(6) Contents of the		

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	<p>notice. The written notice specified in paragraph (a)(4) of this section must include the following:</p> <ul style="list-style-type: none"> (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement that the resident has the right to appeal the action to the State; (v) The name, address and telephone number of the State long term care ombudsman; (vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and 		

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	(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.		
C-0380	§483.12(a)(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.		
C-0381	§483.13 Resident Behavior and Facility Practices §483.13(a) Restraints The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.	<ul style="list-style-type: none"> • Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. • Determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated. • Did the team institute measures in the care plan to address reversal of any decline in 	

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C-0382	<p>health status?</p> <ul style="list-style-type: none"> • Determine the intended use of any restraints. Was the use for convenience or discipline? <p>§483.13(b) Abuse The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p>		<ul style="list-style-type: none"> • Offsite, pre-survey review of complaints can focus the survey team’s on-site review of actual incidents and predisposing factors to abuse or neglect and misappropriation of property. • Report and record any instances where the survey team observes an abusive incident. Completely document who committed the abusive act, the nature of the abuse, and where and when it occurred. Ensure that the facility addresses that incident immediately. • If the survey team’s observations and resident’s responses signal the presence of abuse, determine how the facility prevents and reports abusive behavior. <p>?</p>
C-0383	<p>§483.13(c) Staff Treatment of Residents</p>		

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	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (1) The facility must--</p> <p>(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;</p>		
C-0384	<p>§483.13(c)(1)(ii) Not employ individuals who have been-- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (iii) Report any knowledge it has of actions by a court of law against an employee, which would</p>	<p>During Sample Selection--</p> <ul style="list-style-type: none"> • If the team has identified a problem in mistreatment, neglect or abuse of residents or misappropriation of their property, then request-- • Spot check employment applications for questions about convictions or mistreatment, neglect or abuse of residents, or misappropriation of their property. Determine if applicants have answered these questions and if affirmative answers had resulted in rejections of employment candidates. 	

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	<p>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State</p>	<ul style="list-style-type: none"> • Contact the State Nurse Aide Registry or Board of Nursing, as appropriate. Determine if applicants with a finding concerning mistreatment, neglect, and abuse of residents or misappropriation of their property have been rejected. • Ask for the results of any in-house investigations of mistreatment, neglect, or abuse of residents, misappropriation of their property, or injuries of unknown sources. 		

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	law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.		
C-0385	<p>C-0385 §483.15(f) Activities (1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who-- (i) Is a qualified therapeutic recreation specialist or an activities professional who-- (A) Is licensed or registered, if applicable, by the State in which practicing; and (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a</p>	<ul style="list-style-type: none"> • Observe individual, group and bedside activities. 	

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	recognized accrediting body on or after October 1, 1990; or (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State.		
C-0386	§483.15(g) Social Services (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (2) A facility with more than 120 beds must employ a qualified social worker on a full-time basis. (3) Qualifications of social worker. A qualified social worker is an individual with-- (i) A bachelor's degree in social work or a bachelor's degree in a	For residents selected for review: <ul style="list-style-type: none"> • How do facility staff implement social services interventions to assist the resident in meeting treatment goals? • How do staff that are responsible for social work monitor the resident's progress in improving physical, mental and psychosocial functioning? Has goal attainment been evaluated and the care plan changed accordingly? • How does the care plan link goals to psychosocial functioning/well being? 	

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	<p>human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and (ii) One year of supervised social work experience in a health care setting working directly with individuals.</p>	<ul style="list-style-type: none"> • Has the staff responsible for social work established and maintained relationships with the resident’s family or legal representative? • What attempts does the facility make to access services for Medicaid recipients when a Medicaid State Plan does not cover those services? • Look for evidence that social services interventions successfully address residents’ needs and link social supports, physical care, and physical environment with residents’ needs and individuality. 	
<p>C-0388</p>	<p>§483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity. (b) Comprehensive assessment. (1) Resident assessment instrument. A facility must make a comprehensive assessment of a</p>		

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	<p>resident's needs. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge potential. (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols. 		

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	<p>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p>		
<p>C-0389</p>	<p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident’s physical or mental condition. (For purposes of this section, “readmission” means a return to the facility following a temporary absence for</p>		

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	hospitalization or for therapeutic leave.)		
C-0390	<p>§483.20(b)(2)(ii) Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident’s physical or mental condition. (For purposes of this section, a “significant change” means a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires inter-disciplinary review or revision of the care plan, or both.)</p> <p>(iii) Not less often than once every 12 months.</p>		
C-0395	<p>§483.20(k) Comprehensive Care Plans</p> <p>(1) The facility must develop a</p>		

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	<p>comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following--</p> <p>(i) The services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25; and</p> <p>(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>		
<p>C-0396</p>	<p>§483.20(k)(2) A comprehensive care plan must be--</p> <p>(i) Developed within 7 days after the completion of the comprehensive assessment;</p> <p>(ii) Prepared by an</p>	<ul style="list-style-type: none"> • Was interdisciplinary expertise utilized to develop a plan to improve the resident’s functional abilities? • In what ways does staff involve residents and families, surrogate, and/or 	

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	<p>interdisciplinary team, that includes the attending MD/DO, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.</p>	<p>representatives in care planning?</p> <ul style="list-style-type: none"> • Does staff make an effort to schedule care plan meetings at the best time of the day for residents and their families? • Do facility staff attempt to make the process understandable to the resident/family? • Is the care plan evaluated and revised as the resident's status changes? • Ask in your resident interviews, "Have you had concerns or questions about your care and brought them to the attention of facility staff?" If yes, "What happened as a result?" 	
C-0397	<p>§483.20(k)(3) The services provided or arranged by the facility must-- (i) Meet professional standards of quality;</p>	<p>Question those practices that have a negative outcome or have a potential negative outcome.</p>	
C-0398	<p>§483.20(k)(3)(ii) Be provided by qualified persons in accordance with each resident's written plan of care.</p>		

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C-0399	<p>§483.20(l) Discharge Summary When the facility anticipates discharge a resident must have a discharge summary that includes-- (1) A recapitulation of the resident's stay; (2) A final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and (3) A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.</p>		
C-0400	<p>§483.25(i) Nutrition Based on a resident's comprehensive assessment, the facility must ensure that a resident: (1) Maintains acceptable</p>		

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	parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible;		
C-0401	§483.25(i)(2) Receives a therapeutic diet when there is a nutritional problem.		
C-0402	§483.45 Specialized Rehabilitative Services §483.45(a) Provision of Services If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and intellectual disabilities, are required in the resident's comprehensive plan of care, the facility must-- (1) Provide the required services;		

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	or (2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.		
C-0403	§483.45(b) Qualifications Specialized rehabilitative services must be provided under the written order of a MD/DO by qualified personnel.		
C-0404	§483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.		
C-0405	§483.55(a) Skilled Nursing Facilities A facility-- (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; (2) May charge a Medicare resident an additional amount for routine and emergency dental		

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<p>C-0406</p>	<p>services; §483.55(a)(3) Must if necessary, assist the resident-- (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (4) Promptly refer residents with lost or damaged dentures to a dentist.</p>	<ul style="list-style-type: none"> • Do residents selected for comprehensive or focused reviews, as appropriate, with dentures, use them? • Are residents missing teeth and may be in need of dentures? • Do sampled residents have problems eating and maintaining nutritional status because of poor oral health or oral hygiene? • Are resident's dentures intact? Properly fitted? 	
<p>C-0407</p>	<p>§483.55(b) Nursing Facilities The facility (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident: (i) Routine dental service (to the extent covered under the State plan); and (ii) Emergency dental services;</p>		

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C-0408	§483.55(b)(2) Must, if necessary, assist the resident-- (i) In making appointments; and (ii) By arranging for transportation to and from the dentist's office; and (3) Must promptly refer residents with lost or damaged dentures to a dentist.		