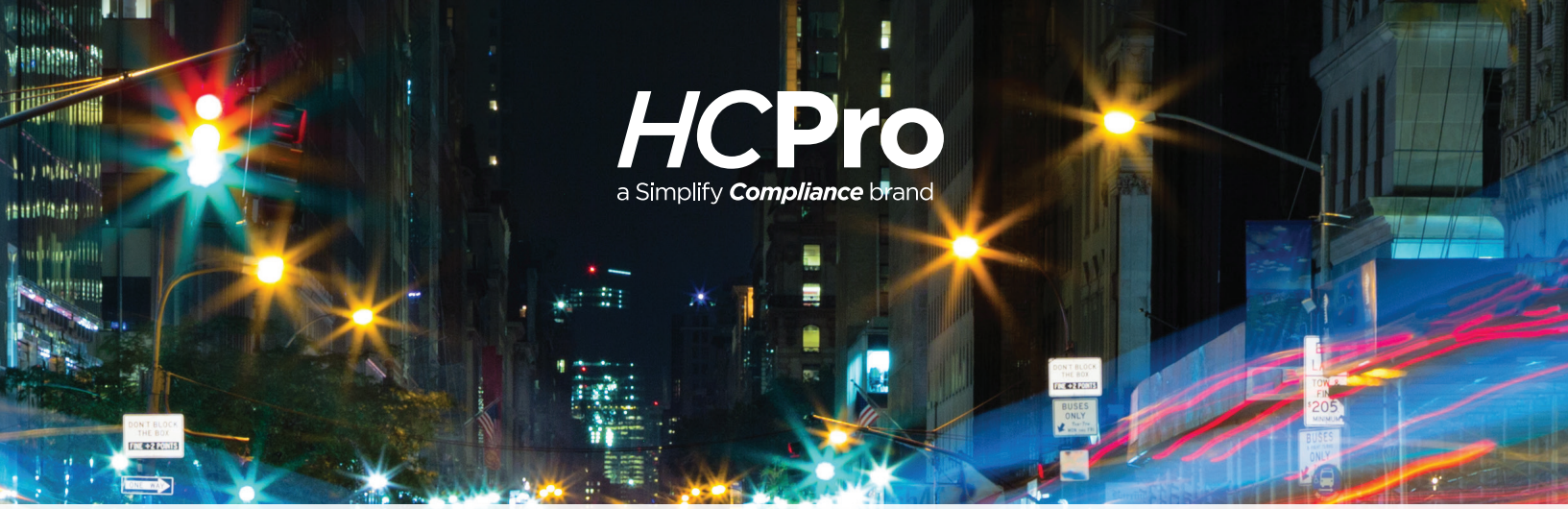

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The CMS Compliance Crosswalk

2020 Edition

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Introduction

In 2010, the Centers for Medicare & Medicaid Services (CMS) mandated that states ensure that all nonaccredited, non-deemed hospitals and critical access hospitals are surveyed at least every three years and that targeted surveys occur for not less than 5% of all hospitals and critical access hospitals in the state. Given the differences in survey process (state inspections versus accreditation survey/consultation), there is good reason for hospitals to consider accreditation by a deemed status accreditor.

Any hospital that receives Medicare or Medicaid reimbursement for services must meet the federal requirements outlined by CMS called *Conditions of Participation* (*CoP*). In addition, most hospitals and healthcare systems participate in a voluntary survey process through an accreditation agency, such as The Joint Commission. However, in recent years, other accrediting bodies have been formed and received deeming authority from CMS.

In addition, the U.S. healthcare industry continues in a state of uncertainty given the healthcare reform efforts at the federal level. The opioid crisis, pharmaceutical pricing, and customer experiences are being discussed frequently by governmental agencies, hospital executives, and care providers.

In the survey arena, as they work to protect the health, safety, and welfare of their citizens, state agencies have increased licensure fees. This has resulted in increased staffing for survey and enforcement activities. Many state agencies are also reporting increases in consumer complaints, adding more justification to increase survey activity.

Accrediting organizations are also feeling the pressure of CMS as they are audited to ensure they are amply upholding the CMS *CoP*s. In turn, these accrediting bodies respond by tightening their inspection procedures to ensure their "deemed status" is maintained. CMS also made the decision that they will not accept any accreditation decisions or recommendations from an accrediting organization while the provider or supplier is under the jurisdiction of a state agency. Regardless of the accreditor used, it is imperative to be compliant with the CMS *CoP*s and interpretive guidelines.

Organizations must maintain a constant state of readiness and ongoing compliance in order to have successful outcomes. Doing so can seem overwhelming when you have multiple surveys to prepare for, but healthcare facilities do not necessarily need to prepare different documents or different processes to meet the regulatory standards.

To help healthcare organizations maintain preparations for surveys, this book:

- Outlines and provides tools to assist in assessing compliance and survey readiness
- Helps hospitals understand the requirements and relationships of accrediting organizations' standards to the CMS *CoP*s
- Compares the similarities and differences between requirements
- Provides survey tips for compliance
- Identifies documents or processes that are already in place so survey preparation can be done without duplicating efforts

The main building blocks for survey readiness included throughout this publication are:

- The CMS *CoP*s, which were taken from the *State Operations Manual, Appendix A—Survey Protocol, Regulations, and Interpretive Guidelines for Hospitals* (revised February 21, 2020)
- The new CMS Emergency Preparedness *CoP* (§482.15), taken from the *State Operations Manual, Appendix Z—Emergency Preparedness for All Provider and Certified Supplier Types* (effective November 15, 2017, revised most recently February 1, 2019)
- Related standards from multiple accrediting agencies, including the Center for Improvement in Healthcare Quality (CIHQ), National Integrated Accreditation for Healthcare Organizations/DNVGL Healthcare USA (NIAHO/DNVGL), and The Joint Commission
- A summary and analysis section outlining the similarities and differences between CMS and these accrediting agencies' standards
- Other survey tips and recommendations for helpful documents to have available where applicable
- A variety of tools and resources to assist with survey preparation and readiness (located in the appendixes)

Following is a general table of contents comparison between CMS, The Joint Commission, NIAHO/DNVGL, and CIHQ to show some of the similarities.

CMS	The Joint Commission	NIAHO/DNVGL	CIHQ
Compliance with Federal, State and Local Law	Accreditation Participation Requirements and Leadership	Governing Body	Governance & Leadership
Governing Body	Leadership	Governing Body Chief Executive Officer	Governance & Leadership

CMS	The Joint Commission	NIAHO/DNVGL	CIHQ
Patient Rights	Patient Rights	Patient Rights	Patient Rights
Emergency Preparedness	Emergency Management	Physical Environment	Emergency Preparedness
Quality Assessment and Performance Improvement Program	Performance Improvement	Quality Management System	Quality Assessment & Performance Improvement, plus Targeted Patient Quality & Safety Practices
Medical Staff	Medical Staff	Medical Staff	Medical Staff
Nursing Services	Nursing and Medication Management	Nursing Services and Medication Management	Nursing Services
Medical Record Services	Information Management and Record of Care	Medical Record Services	Management of the Medical Record
Pharmaceutical Services	Medication Management	Medication Management	Medication Management
Radiological Services	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Medical Imaging	Radiology Services
Laboratory Services	Waived Testing	Laboratory Services	Laboratory Services
Food and Dietetic Services	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Dietary Services	Dietary (Nutrition) Services
Utilization Review		Utilization Review	Utilization Review
Physical Environment	Environment of Care and Life Safety	Physical Environment	Managing the Care Environment
Infection Control	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention & Control
Discharge Planning	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Discharge Planning	Discharge Planning Services

CMS	The Joint Commission	NIAHO/DNVGL	CIHQ
Organ, Tissue and Eye Procurement	Transplant Safety	Organ, Eye and Tissue Procurement	Organ, Tissue & Eye Procurement
Surgical Services	Provision of Care, Treatment and Services, Medical Staff, Performance Improvement, Medical Records and Human Resources	Surgical Services	Operative & Invasive Services
Anesthesia Services		Anesthesia Services	Anesthesia Services
Nuclear Medicine Services		Nuclear Medicine Services	Nuclear Medicine Services
Outpatient Services		Outpatient Services	Outpatient Services
Emergency Services		Emergency Department	Emergency Services
Rehabilitation Services		Rehabilitation Services	Rehabilitation Services
Respiratory Services		Respiratory Care Services	Respiratory Services
Note: CMS proposed significant new rules addressed throughout the *CoP*s	Human Resources	Staffing Management	Human Resources
	National Patient Safety Goals		Note: Includes separate section on Use of Restraint & Seclusion

In addition, there are similarities and differences in how the various agencies survey, as outlined below.

CMS

CMS is part of the Department of Health and Human Services and is responsible for issuing the *CoP*s as standards of care. Surveys are at no cost and occur annually, unless an organization has deemed status. CMS surveys are typically conducted by surveyors from the state health department agency and focus much more closely on patient care documentation and the corresponding policies and procedures that drive care implementation. Surveyors tend to be less interactive with staff and physicians; they look at patient records doucumentation for absence of compliance with relevant *CoP*s and will turn to staff to ask why something was not documented or why a process deviated from stated policy. They typically spend less time on the patient care units than Joint Commission surveyors do.

Visit this site to see CMS' *State Operations Manual, Appendix A — www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf*

The Joint Commission

Established in 1951, The Joint Commission is the oldest of the accrediting agencies. Standards were developed in the early 1900s when the American College of Surgeons created its hospital standardization program, the precursor to today's survey process. The Joint Commission is also the most well known of the accrediting bodies. In addition, it fulfills regulatory and payer requirements and provides education and guidance. Survey cost can be expensive. The Joint Commission has proprietary standards (e.g., National Patient Safety Goals) as well as prescriptive standards, along with complex scoring methods. Over the years, The Joint Commission has become more aligned with CMS *CoP*s, but there are still differences. Using hospital staff's responses to questions to guide further queries, Joint Commission surveyors are more interactive than CMS. Documentation is examined within the context of

elements of performance (EP) validation. The response of clinical staff and physicians can keep Joint Commission surveyors from delving too deeply into patient records. Policies/procedures, medical staff bylaws, and other documents are reviewed against actual practice. Additionally, surveyors use tracer methodology to identify areas of noncompliance.

NIAHO/DNVGL

NIAHO/DNVGL started in 1864 as a global maritime risk management and insurance entity in Norway. DNV Healthcare is an international accrediting body that incorporates ISO 9000 and 9001 into its standards. It was approved by CMS as a deeming authority in 2008. Surveys are conducted annually with the deemed status survey happening every third year. Like The Joint Commission, NIAHO/DNVGL fulfills regulatory and payer requirements and provides education and guidance. With a focus on standardizing processes and achieving quality outcomes, NIAHO/DNVGL standards are closely aligned with CMS *CoP*s. The company recently added some proprietary standards, and the cost of annual surveys can be somewhat expensive.

CIHQ

CIHQ is the newest accrediting body and was granted deeming authority in July 2013. A former consulting company for accreditation and regulatory compliance support, CIHQ can accredit acute and critical access hospitals. Almost 95% of CIHQ's standards align with CMS *CoP*s.

State Health Department Agency

State agencies survey according to CMS *CoP*s to determine certification to participate in Medicare and Medicaid programs. There is no requirement to be surveyed by one of the other agencies listed earlier outside of the hospital's respective state. The agencies use the *Medicare State Operations Manual* to determine compliance with minimal standards.

The bottom line is that all healthcare organizations will undergo some kind of survey at some point in time. The key is to understand and educate staff about the changes and at the same time remain flexible to manage the changes and processes. Many similarities between CMS and the various accrediting agencies exist. Hopefully, by understanding these similarities as well as the nuances, ongoing survey preparation can be efficient and can help your organization achieve excellent results. After all, the goal of all participants—the hospital, the regulatory agency, and the patient—is high-quality care and service that meets and exceeds standards and expectations. The choice is yours!

Happy reading and good luck in whichever accreditation program your organization pursues. Contact information for the accrediting bodies discussed in this publication is listed next.

Center for Improvement in Healthcare Quality (CIHQ)
P.O. Box 3620
McKinney, TX 75070
Phone: 866-324-5080
Fax: 805-934-8588
Website: *www.cihq.org*

Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
Phone: 410-786-3000
Website: *www.cms.gov*

National Integrated Accreditation for Healthcare Organizations/DNVGL Healthcare USA (NIAHO/DNVGL)
400 Techne Center Drive, Suite 100
Milford, OH 45150
Phone: 866-523-6842
Website: *www.dnvglhealthcare.com*

The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
Phone: 630-792-5000
Fax: 630-792-5005
Website: *www.jointcommission.org*

State Health Departments

See Appendix D

Omnibus Burden Reduction Final Rule 3346-F

CMS *CoP* regulations are updated periodically. Changes are first published in the *Federal Register,* followed 60 days later by the release of a Quality, Safety and Oversight Group (QSO) memo spelling out the details. One such memo released November 29, 2019, outlines rule changes that are intended to help "cut the red tape" in healthcare, improve efficiency, and relieve healthcare providers from burdensome regulations. While governmental agencies often oversell initiatives like this, there are some changes that will be of interest. The entire text of changes for all provider types as published in the Federal Register may be downloaded at: *www.federalregister.gov/documents/2019/09/30/2019-20736/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and*

On December 20, 2019, CMS published QSO 20-07 that further described changes to the regulations and some interpretive guidance that will help to implement the burden reduction. The remainder of the Interpretive Guidelines was promised in early 2020.

The first changed A-tag for hospitals is A-0148, which states that patients have a right to access their medical records and providers have a responsibility to provide them upon request. HIPAA law and the Federal Office of Civil Rights govern this process. When the organization has a certified electronic health record (EHR) and the patient requests an electronic copy of their medical record, it must be provided at no cost. If the patient

requests a paper copy of their record, the regulations permit an actual cost for the labor component and the actual cost for the paper and mailing (if needed). In addition, state laws may take precedence if the state requires the copy to be free. If state law permits some specific charge per page higher than the actual cost, then HIPAA takes precedence and the lower, actual cost is all that can be charged.

In A-0168, CMS has replaced the acronym LIP with LP to denote a "licensed independent practitioner." This basically becomes a "find and replace" exercise for providers, where previous references to licensed independent practitioners in your documents are changed to licensed practitioners. Given the vastly expanded roles of nurse practitioners, physician assistants, and others in healthcare today, CMS is making it clear that the regulations in this tag and others allow them to fulfill all the duties they are authorized to perform under state law. This may help reduce some confusion about roles and responsibilities.

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Tags A-0320, A-0321, A-0322, and A-0785 describe the newly allowed unified QAPI and infection control and prevention programs in system hospitals. This change benefits multihospital systems, allowing them to have an integrated QAPI and infection prevention program across their health system. Before, multihospital system hospitals had to operate these functions independently.

Tags A-0358 to A-0362 establish the acceptability of the "less than a full H&P or comprehensive H&P" for selected patients receiving outpatient surgery. Many hospitals already have a full H&P template and a so-called "short form" or focused H&P template, so this rule change may just be authorizing a practice that is already in place. The medical staff bylaws must include a requirement that an H&P be completed and documented for each patient no more than 30 days prior to or 24 hours after hospital admission or registration, but prior to surgery or a procedure requiring anesthesia services, except when the patient is receiving an outpatient surgical or procedural service and when the medical staff has developed and maintained a policy (in accordance with §482.22(c)(5)(v)) that identifies specific patients that do not require a comprehensive medical H&P, or any update to it, prior to the specific outpatient surgery or procedure.

Tag A-0399 describes the regulation established that allows some outpatient departments to not have an RN on duty. The hospital will have to develop policies authorizing specific departments who want to implement this. However, this is another change that was already in place for many hospitals with physician practices—they already had medical assistants working with the physicians rather than RNs.

There is a lengthy section of the *State Operations Manual* on medication preparation and administration that is reproduced in the memo, but the change is negligible. CMS deleted specific, unneeded references to requirements in USP Chapter <797>. CMS already requires hospitals to comply with national standards of practice, of which USP is one.

Tag A-0747 establishes new CMS requirements for antibiotic stewardship programs, which most organizations have already initiated.

Tags A-0799 to A-0817 describe CMS' new regulations for the discharge planning process. These were not part of the burden reduction notice but actually a separate set of regulations posted in the *Federal Register* first back in November 2015, that later had their own burden reduction edits and were revised in a final *Federal Register* notice in September 2019. The new requirements appear conceptually very similar to the existing requirements. One new tag is A-0804. This will still require hospitals to provide lists of after-care providers, but in addition, the hospital will now have to share objective quality measures with the patient for home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care acute hospitals. CMS will be assisting in development of this data on its website.

Joint Commission Updates

In late May 2020, The Joint Commission announced several standards changes for deemed-status hospitals and critical access hospitals (CAH).

Effective **July 1, 2020**, changes related to the hospital deeming renewal application with the Centers for Medicare & Medicaid Services (CMS) were made to the following chapters and standards:

- Human Resources—now requires that the qualifications and supervision requirements for staff performing special respiratory therapy procedures be defined in writing.
- Leadership—now suggests that performance improvement activities could include use of an information technology system to improve patient safety and quality.Leadership—all laboratory services must meet applicable requirements at 42 CFR 482.27.
- Medication Management—the glossary has been updated to include a definition of "family members" who are helping patients self-administer medication.
- Record of Care—set a medication record retention requirement of at least five years.
- Transplant Safety—specified that staff designated to discuss potential organ donation are educated and trained.

Effective **September 13, 2020**, changes pertaining to the recent CMS final rules on burden reduction and discharge planning go into effect for hospitals and CAHs. These additional changes for hospitals include the following:

- Leadership—the emergency management plan needs to be reviewed at least every two years rather than annually. (Also applicable to CAHs.)
- Provision of Care—if approved by the medical staff, a brief assessment may serve in lieu of a comprehensive history and physical for outpatient surgery or procedures. (Also applicable to CAHs that have rehabilitation or psychiatric distinct part units.)
- Provision of Care—elimination of several requirements for swing beds. (Also applicable to CAHs.)

- Provision of Care—the discharge plan in the medical record must include the complete list of available post-hospital discharge care agencies and options that was provided to the patient. (Also applicable to CAHs that have rehabilitation or psychiatric distinct part units.)
- Provision of Care—the identification of post-hospital discharge needs must also consider hospice care, post-hospital extended care, home health, and non-healthcare service needs, as well as the need for community-based care providers.
- Provision of Care—added a note that discharge planning is performed by, or under the supervision of, a registered nurse, social worker, or other qualified person.
- Provision of Care—added a note that the hospital must inform other service providers of the patient's treatment preferences.
- Record of Care—specified that patients have the right to access their medical record in whatever format they prefer.
- Patient Rights—eliminated a requirement for defining how the hospital obtains permission to perform an autopsy. (Also applicable to CAHs.)

Finally, The Joint Commission announced changes to the Medication Management (MM) and Record of Care (RC) chapters related to titratable medications. The MM chapter change, effective **January 1, 2021**, codifies in MM.04.01.01 the required elements of a medication titration order that had been previously outlined in an FAQ. The RC chapter change, effective **September 13, 2020**, is a note that permits hospitals to define in policy when it would be acceptable to use "block charting" when an urgent patient care circumstance requires rapid medication titration changes.

§482.11 *CoP*: Compliance with Federal, State, and Local Laws		
Tag #	CMS *CoP* (2020)	CMS Interpretive Guidelines and Survey Procedures
A-0020	The hospital must ensure that all applicable federal, state, and local law requirements are met.	
A-0021	a. The hospital must be in compliance with applicable federal laws related to the health and safety of patients.	*Link to Survey Procedures for §482.11(a)*
A-0022	b. The hospital must be (1) licensed or (2) approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals.	*Link to Interpretative Guidelines §482.11(b)* *Link to Survey Procedures for §482.11(b)*
A-0023	c. The hospital must ensure that personnel are licensed or meet other applicable standards that are required by state or local laws.	*Link to Interpretive Guidelines for §482.11(c)* *Link to Survey Procedures for §482.11(c)*
Related Center for Improvement in Healthcare Quality (CIHQ) standards • Governance and Leadership: GL-2 • Human Resources: HR-1		
Related Joint Commission standards • Accreditation Participation Requirements: APR.01.03.01, EP2 • Leadership: LD.04.01.01, EP1–3 • Management of Human Resources: HR.01.02.05, EP1, 3 • Medical Staff: MS.06.01.03, EP6; MS.06.01.05, EP2, 8		
Related National Integrated Accreditation for Healthcare Organizations/Det Norske Veritas Healthcare, Inc., (NIAHO/DNVGL) standards • Governing Body: GB.1-SR.1a and b and SR.1d • Staffing Management: SM.1 • Medical Staff: MS.8, SR.1a–e, SR.2a–e		

§482.11 (a–c) *CoP* Analysis/Guidelines

All accreditors are similar when it comes to compliance with federal, state, and local laws. All are looking to see that the hospital and all departments that require a license or certification have a current license or certification and meets the licensure standards for the state in which the hospital resides. Both are looking to see that hospital personnel

required to be licensed have a current license to practice; these licensure laws vary state to state. Positions needing a license could include but are not limited to medical doctors (MD), doctors of osteopathy (DO), RN, physician assistants (PA), occupational therapists (OT), physical therapists (PT), speech language pathologists (SLP), respiratory therapists (RT), registered dietitians (RD), and various procedural staff. This includes nonemployees.

Not all states license all types of care providers; there are several national registrations (i.e., RDs and registered cardiovascular invasive specialists) that may not be licensed in their states, so it is important to understand and distinguish when differences exist. If states do not license these workers, it will be important to investigate whether there is state regulation regarding medical delegation and an assessment performed to validate that there is compliance with that regulation. All regulators require primary source verification of licensure. Criminal background checks may also be required as part of the onboarding process, dependent on state law. NIAHO/DNVGL requires that a process is in place to verify licensure and expirations and that the data are shared with the quality assessment and performance improvement (QAPI) structure or human resources (HR) team when such activity is completed at the departmental level. Verification of qualifications, training/education, and permits should be checked.

Survey Tips:

- If there is not an electronic mechanism for monitoring renewal of licenses, create a listing of all hospital and departmental licenses (required and voluntary) and ensure responsibility for timely renewal.
- Have HR and managers maintain proof of primary source verification of current licensure (including managers, employees, nonemployees, and licensed practitioners [LP])
- Ensure nonemployee contracts for workers who enter patient care areas have requirements for occupational health screening and background checks that are similar to those for employees and that primary source verification of licensure is performed for all direct care providers.
- Review medical staff files to verify that credential information is current.
- Verify that workers who are not licensed in your state are operating under state regulatory requirements
- CMS requires deemed status accreditors to immediately notify them when deemed status has been removed for Condition Level noncompliance

Suggested Documents:

- Hospital's state license and federal certification certificate and accreditation certificate; Hospital Drug Enforcement Administration (DEA) license, Clinical Laboratory Improvement Amendments (CLIA) license, and radio therapeutic and nuclear medicine licensure/certifications in related departments; other voluntary licensure (i.e., trauma designation, psych designation, neonatal intensive care unit [NICU] designation)
- Personnel files/credentials information (paper or electronic) with proof of primary source verification
- Bylaws regarding credentialing and privileging
- Policies and procedures regarding volunteer LPs and non-LPs during disaster

§482.13 *CoP*: Patient Rights (continued)		
Tag #	CMS *CoP* (2020)	CMS Interpretive Guidelines and Survey Procedures
A-0154	(e) Standard: Restraint or seclusion—All patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.	*Link to Interpretive Guidelines for §482.13(e)* *Link to Survey Procedures for §482.13(e)*
A-0159	(1) Definitions:	
	(i) A restraint is:	
	(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely	*Link to Interpretive Guidelines for §482.13(e)(1)(i)(A)* *Link to Survey Procedures for §482.13(e)(1)(i)(A)*
A-0160	(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition	*Link to Interpretive Guidelines for §482.13(e)(1)(i)(B)* *Link to Survey Procedures for §482.13(e)(1)(i)(B)*
A-0161	(C) A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort)	*Link to Interpretive Guidelines for §482.13(e)(1)(i)(C)* *Link to Survey Procedures for §482.13(e)(1)(i)(C)*
A-0162	(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.	*Link to Interpretive Guidelines for §482.13(e)(1)(ii)* *Link to Survey Procedures for §482.13(e)(1)(ii)*

A-0164	(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.	*Link to Interpretive Guidelines for §482.13(e)(2)* *Link to Survey Procedures for §482.13(e)(2)*
A-0165	(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.	*Link to Interpretive Guidelines for §482.13(e)(3)* *Link to Survey Procedures for §482.13(e)(3)*
A-0166	(4) The use of restraint or seclusion must be:	
	(i) In accordance with a written modification to the patient's plan of care.	*Link to Interpretive Guidelines for §482.13(e)(4)(i)* *Link to Survey Procedures for §482.13(e)(4)(i)*
A-0167	(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with state law.	*Link to Interpretive Guidelines for §482.13(e)(4)(ii)* *Link to Survey Procedures for §482.13(e)(4)(ii)*
A-0168	(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner (LP) who is responsible for the care of the patient as specified under §481.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with state law.	*Link to Interpretive Guidelines for §482.13(e)(5)* *Link to Survey Procedures for §482.13(e)(5)*
A-0169	(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as-needed basis (PRN).	*Link to Interpretive Guidelines for §482.13(e)(6)* *Link to Survey Procedures for §482.13(e)(6)*
A-0170	(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.	*Link to Interpretive Guidelines for §482.13(e)(7)* *Link to Survey Procedures for §482.13(e)(7)*
A-0171	(8) Unless superseded by state law that is more restrictive:	
	(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9–17 years of age; or (C) 1 hour for children under 9 years of age	*Link to Interpretive Guidelines for §482.13(e)(8)(i)* *Link to Survey Procedures for §482.13(e)(8)(i)*

Appendix B

Types of Surveys

CMS

Annual certification surveys: For non–deemed status facilities, these are conducted each year (usually within 12–15 months of last certification survey). A review of all the *Conditions of Participation* (*CoP*) is conducted, with deficiencies cited by tag number. A plan of correction is required for each tag noted to be out of compliance.

Hospitals accredited by The Joint Commission, National Integrated Accreditation for Healthcare Organizations (NIAHO), and American Osteopathic Association have been authorized by CMS' approval program and are deemed to meet *CMS Conditions of Participation in the Medicare Program*. These providers are referred to as "deemed status" and, as such, are not required to undergo annual certification surveys.

Complaint/incident survey: Applies to all CMS-certified organizations. If a patient, family member, resident, or an organization's employee submits a concern/complaint to CMS or the state's Department of Health, a complaint survey may be conducted. An occurrence reported to a state agency or public incident may also result in an investigation. For hospitals that are deemed status providers, state-level complaints/incidents are entered and forwarded to the CMS regional office for review. Surveys can be focused on the area outlined in the complaint/incident and surveyed based on state regulation or can be expanded by CMS to include some or all of the *CoP*.

The statutory authority for the CMS complaint/incident process is found in Sections 1864(c) and 1865 of the Social Security Act. Regulations authorizing such surveys are found in *CFR* 488.7(a)(2). Complaint/incidents that allege immediate jeopardy are investigated immediately. Complaints/incidents triaged and determined to be non-immediate jeopardy are typically investigated within 45 days.

Extension surveys: Conducted as needed based on findings of annual certification surveys or complaint/incident surveys; may also be conducted when expansions or significant organizational changes occur.

Appendix C

How to Respond to an Action Plan or Plan of Correction

When an organization is cited by surveyors for noncompliance with standards or *Conditions of Participation (CoP*), corrections must be completed within a specified time period. For The Joint Commission, action is required to be completed and submitted as an Evidence of Standards Compliance (ESC) within 60 days following the receipt of final written report, which will occur within 10 business days of the close of the survey. For Centers for Medicare & Medicaid Services (CMS) or state agency surveys, plans of correction (POC) are required for all deficiencies noted in the Form 2567 report and are due within 10 calendar days. CMS usually requires that the length of time for a correction to roll out cannot exceed 60 days, unless an extension is requested separately. If an immediate jeopardy situation has been identified, the length of time for correction cannot exceed 23 days and the immediate aspects of the situation should be resolved by the time of survey team exit.

For CMS *CoP*–level deficiencies identified by any accrediting agency, a return visit by that organization will occur within 45 days to ensure that the POC was implemented as written and to verify that the POC has resulted in sustained improvement. On these 45 day surveys, surveyors are free to also complete a review of all the *CoP*s, but typically they focus only on the issues that rolled up to cause the *CoP*-level finding(s). It is important to demonstrate that all planned corrections have been completed and as such it is important to have proof of the corrections being implemented. For this reason, it is recommended that organizations compile notebooks that show some sort of root cause analysis (RCA) to identify why the failure occurred, proof of actions taken, educational tools used and overall staff compliance with receiving education, and roll-up quality monitoring results. Details of education (i.e., individual department rosters showing each employee received information or emails to medical staff or board) or individual audit tools should also be available; however, it is suggested that these details be made available only up request and kept separate from the notebooks presented upon surveyor arrival.

The key to writing an acceptable ESC/POC that will be approved is specificity, brevity, and being realistic. Also, avoid relying simply on "we reeducated staff" as your sole action. For most areas of noncompliance, staff lacking knowledge about a process is usually not the root cause. Rather, some process flaw is the likely culprit, or failure of management to oversee that staff perform that which they know how to do is the

Appendix D

Websites to State Departments of Health

State	Website Address
Alabama	*www.alabamapublichealth.gov*
Alaska	*www.dhss.alaska.gov*
Arizona	*www.azdhs.gov*
Arkansas	*www.healthy.arkansas.gov*
California	*www.cdph.ca.gov*
Colorado	*www.colorado.gov/cdphe*
Connecticut	*www.ct.gov/dph*
Delaware	*www.dhss.delaware.gov*
Florida	*www.floridahealth.gov*
Georgia	*www.dph.georgia.gov*
Hawaii	*www.health.hawaii.gov*
Idaho	*www.healthandwelfare.idaho.gov*
Illinois	*www.idph.state.il.us*
Indiana	*www.in.gov/idsh*
Iowa	*www.idph.iowa.gov*
Kansas	*www.kdheks.gov*
Kentucky	*www.chfs.ky.gov/dph*
Louisiana	*www.ldh.la.gov*
Maine	*www.maine.gov/dhhs/*
Maryland	*www.health.maryland.gov*
Massachusetts	*www.mass.gov/orgs/department-of-public-health*
Michigan	*www.michigan.gov/mdhhs*
Minnesota	*www.health.state.mn.us*
Mississippi	*www.msdh.state.ms.us*
Missouri	*www.health.mo.gov*
Montana	*www.dphhs.mt.gov*
Nebraska	*www.dhhs.ne.gov*
Nevada	*www.dpbh.nv.gov*
New Hampshire	*www.dhhs.nh.gov*

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