CRITICAL ACCESS HOSPITAL

RISK ASSESSMENT

JANUARY 2023

CRITIAL ACCESSS HOSPITAL RISK MANAGEMENT ASSESSMENT

This document should not be construed as medical or legal advice. The facts applicable to your situation may vary, or the law applicable in your jurisdiction may differ. Contact your attorney or other professional advisors if you have questions related to your legal or medical obligations or rights; state or federal laws; contract interpretation; or other legal questions.

Of Note: If the subject matter is associated with a specific regulation from the Centers for Medicare and Medicaid or Kansas Hospital Regulation it is noted as such. If the notation is in red this is an indication that the issue is cited frequently in the survey process. It is important to check the CMS Conditions of Participation regularly as they do change often. Links to the references used in this document are listed in the back under References.

CRITIAL ACCESSS HOSPITAL RISK MANAGEMENT ASSESSMENT

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CERTICIATION OF CAH STATUS	YES	NO	N/A	FINDINGS/COMMENTS
1. Agreement with supporting hospital signed and available. **(C-0802)**				
2. CAH Policies and Procedures are up to date and signed.				
3. Communication system policy up to date and signed.				
4. Transfer agreements are current and a copy in CAH Certification manual.				
5. EMS agreements are current and a copy in CAH manual.				
6. Annual CAH Review direct care diagnostic & therapeutic services & supplies policies completed and in CAH manual.				
7. Policy development committee: physician (MD/DO), one or more of: PA, NP, CNS. (Removed requirement for one non-CAH staff)				
8. Must provide diagnostic and therapeutic services as those provided in doctor's office or at entry of healthcare organization like an outpatient department or ED- provide directly or under contract.				
9. Must have supplies as that typically found in an ambulatory healthcare setting and a physician/s office.				
10. Must provide adequate services, equipment, staff, and facilities adequate to provide the outpatient services.				
11. CAHs have flexibility to arrange for contracted services; CMS removed the language requiring directly provided services in the areas of general diagnostic, therapeutic services, radiology services, laboratory services, and emergency procedures.				

CERTICIATION OF CAH STATUS	YES	NO	N/A	FINDINGS/COMMENTS
12. CMS expects CAHs to provide timely diagnosis and treatment of patients and expects general diagnostic and therapeutic, laboratory, radiology, and emergency services to be offered on- site.				
13. CAH furnishes acute care inpatient services.				
14. Average LOS is 96 hours. Must certify that Medicare patients may be expected to be discharged or admitted to a hospital within 96 hours.				
15. CAH is not required to maintain a minimum average daily census of patients receiving inpatient acute care services or maintain a minimum number of beds that are to be used for inpatient services.				
16. CAH maintains no more than 25 acute care beds at any one time. (not including observation beds)				
17. Any of the 25 beds can be used to provide acute or swing bed, dependent on patient need.				
18. Does not count if CAH has up to 10 bed rehab unit or behavioral health unit.				
19. Do not count in 25 bed count exam or procedure tables, stretchers, Operating Room tables, ED carts, 10 bed distinct rehab or behavioral health unit, newborn bassinets and isolette for well-baby boarders and PACU bed and inpatient beds in Medicare-certified distinct part rehabilitation or psychiatric units.				
20. Do not count OB beds if active labor but do count birthing rooms Staff where patient stays after giving birth.				

AGREEMENTS	YES	NO	N/A	FINDINGS/COMMENTS
1. Agreement (at least one) with a rural health network hospital & one acute care hospital related to patient referral and transfer, communication, emergency, and non-emergency patient transportation. **(C-0862)**				
2. Agreement/Policy and procedure related to communication system.				
3. CAH communication with other hospitals – do you keep a communication log?				
4. Does the agreement define how the network shares patient data, electronic data, telemetry, medical records with other hospitals.				
5. CAH has a way for to communicate and share patient data with other network members when the system is not in operation.				
6. Staff training provided to operate the communication system.				
7. If no communications system in place; how does the CAH communicate and share patient data with the tertiary facility? **(C-0866)**				
8. Does the CAH have a written agreement with the local EMS service to provide transportation between the CAH and the tertiary facility? **(C-0868)**				
9. How emergency & non-emergency transport is provided between them.				
10. Agreement for patient referrals and transfers. Who will provide for transport.				
11. Agreement between CAH, one of its network hospitals if applicable, a QIO or equivalent entity, or one other state approved entity for credentialing and quality assurance activities. **(C-0870)**				
12. Agreement must include medical record reviews for the determination of quality and medical necessity of care.				

AGREEMENTS	YES	NO	N/A	FINDINGS/COMMENTS
13. Have policy and procedure to determine how information is obtained, used and how confidentiality is maintained.				
14. Telemedicine agreement: List of providers must be approved by governing board and medical staff. **(C-0872)**				
15. Written agreement for telemedicine includes Distant site hospital participates in Medicare; hospital provides current list of practitioners, including their privileges, each practitioner holds a license in the State where the CAH is located and CAH reviews the services provided by telemedicine and provides feedback to the distant site hospital.				

GOVERNING BODY/BOARD OF TRUSTEES	YES	NO	N/A	FINDINGS/COMMENTS
1. 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. (C-0962)				
2. Operations policy – Governing board must implement and monitor total operations of CAH.				
3. Governing board authority/responsibilities documented in bylaws.				
4. CEO, delegation of authority for daily operations, as applicable.				
5. Reporting changes in operating officials to the state.				
6. Reporting changes in Medical Director to state.				
7. Governing board approves Medical Staff bylaws, rules and policies.				
8. Governing board is responsible for conduct of CAH and for quality of care to patients.				
9. Governing board approves the Risk Management plan annually.				
10. Governing board approves Quality Assurance/Performance Improvement plan annually.				
11. Governing board approves Infection Control plan annually.				

GOVERNING BODY/BOARD OF TRUSTEES	YES	NO	N/A	FINDINGS/COMMENTS
12. Governing board must determine what categories of practitioners are eligible for appointment and reappoint to Medical Staff (NP, PA, Dentist, CRNA) and there is written criteria for staff appointments.				
13. Criteria for Medical Staff is based on individual character, competence, training, experience, and judgment.				
14. Confirm that Board appoints all members to the Medical Staff including Telemedicine Staff.				
15. Board must ensure written agreement with the distant site hospital (DSH) or distant site telemedicine entity (DSTE) is present. **(C-0872)**				
16. The agreement should include credentialing and privileging of the telemedicine physicians and practitioners by the distant site hospital.				
17. Ensure documentation indicating the granted privileges to each telemedicine physician and practitioner.				
18. Documentation indicates the governing body or responsible individual made the privileging decision based on the privileging decisions of the distant site hospital.				
19. Governing Board determines what category of practitioners are eligible for appointment to the medical staff.				
20. Board appoints with recommendation of the medical staff.				

GOVERNING BODY/BOARD OF TRUSTEES	YES	NO	N/A	FINDINGS/COMMENTS
21. Board approves the Medical Staff bylaws and other medical staff rules and regulations.				
22. Make sure medical staff is accountable to the board for quality of care provided to the patients.				
23. Criteria is established and followed for selection of medical staff that is based on individual character, competence, training, experience, and judgment.				
24. Privileges are never based solely on certification, fellowship, or membership in a special body or society.				
25. Written agreement is present stating the distant-site hospital participates in Medicare and has an independent obligation to comply with all Conditions of Participation.				
26. Provide written agreement stating DSTE will provide services to ensure compliance with CoPs. **(C-0874)**				
27. List physicians/practitioners covered by agreement, includes privileges and licensure information.				
28. 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.				

GOVERNING BODY/BOARD OF TRUSTEES	YES	NO	N/A	FINDINGS/COMMENTS
29. Does the CAH verify 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.				
30. Provide verification that the DSTE fulfills terms to Medical Staff process to enable CAH to meet applicable CAH requirements.				
31. CAH has documentation indicating that it granted privileges to each telemedicine physician and practitioner. (through medical staff granting of privileges and approval by governing board)				
32. There is documentation that indicates the CAHs governing body or responsible individual made the privileging decision based on the privileging decisions of the distant site telemedicine entity?				

MEDICAL STAFF CREDITIALING & PRIVILEGING	YES	NO	N/A	FINDINGS/COMMENTS
1. Governing Board determines what category of Practitioners are eligible for appointment to the Medical Staff. **(C-0962)**				
2. Board appoints with recommendation of the Medical Staff.				
3. Board approves the Medical Staff bylaws and other Medical Staff rules and regulations.				
4. Make sure Medical Staff is accountable to the board for quality of care provided to the patients.				
5. Criteria is established and followed for selection of Medical Staff that is based on individual character, competence, training, experience, and judgment.				
6. Privileges are never based solely on certification, fellowship, or membership in a special body or society.				
7. When telemedicine is required, the Board must ensure written agreement with the distant site hospital (DSH) or distant site telemedicine entity (DSTE) is present. **(C-0872)**				
8. The agreement should include credentialing and privileging of the telemedicine physicians and practitioners by the distant site hospital.				
9. Written agreement is present stating the distant-site hospital participates in Medicare and has an independent obligation to comply with all Conditions of Participation.				

MEDICAL STAFF CREDITIALING & PRIVILEGING	YES	NO	N/A	FINDINGS/COMMENTS
10. Governing board will follow general medical staff credentialing and privileging when granting telemedicine privileges.				
11. CAH has professional staff that includes one or more physicians, and may include PA, NP, or CNS.				
12. The medical staff shall be limited to practitioners who have made application in accordance with the bylaws of the medical and the governing body. (KS Hosp Reg 28-34-6)				
13. The medical staff shall adopt bylaws that define the requirements for admission to staff membership and for the delegation and retention of clinical and admitting privileges.				
14. Each CAH facility shall have an active medical staff to deliver the preponderance of medical services within the hospital.				
15. The active medical staff shall have primary responsibility for the organization and administration of the medical staff.				
16. Each member of the active medical staff shall be eligible to vote at staff meetings, hold office and serve on staff committees.				
17. The CAH may in addition to active medical staff provide for additional kinds of medical staff privileges. The additional staff categories shall in no way modify the privileges, duties, and responsibilities of the active medical staff.				

MEDICAL STAFF CREDITIALING & PRIVILEGING	YES	NO	N/A	FINDINGS/COMMENTS
18. The medical staff shall develop and adopt, subject to the approval of the governing board, a set of bylaws that shall be followed by each provider for at least the following: a) The organizational structure of the medical staff, b) Qualifications for staff membership and procedures for admission, retention, assignment and either reduction or withdrawal of privileges, c) Procedures and standards for the review of staff credentials, d) A mechanism for an appeal by practitioner who receives an unfavorable medical staff recommendation, e) Delineation of clinical privileges and duties of professional personnel who function in a clinical capacity and who are not members of the medical staff, f) Methods for the selecting of officers and department or service chairpersons and a description of their duties and responsibilities, g) The composition and function of standing committees. h) Mechanism by which the medical staff consults with and reports to the governing body.				

MEDICAL STAFF CREDITIALING & PRIVILEGING	YES	NO	N/A	FINDINGS/COMMENTS
19. The medical staff shall develop and adopt, subject to the approval of the governing board, a set of rules that shall be followed by each provider for at least the following: a) Requirements for completing medical records, b) Medical staff meetings for the purpose of review the performance of the medical staff and each department of service and reports and recommendations of medical staff and multidisciplinary committees, c) A mechanism for review of the medical staff performance that shall include consideration of relevant ethics and statutory codes of conduct, d) The medical staff shall develop and implement a system to review medical services rendered, evaluate their quality, and provide an educational program for medical staff members, e) This system shall include written criteria for the evaluation of medical care that shall cover admission, length of stay, and professional services furnished and shall be conducted on at least a sample basis, f) Medical orders, g) Medication or treatment shall be administered only upon written and signed orders of a practitioner who is acting within the scope of that practitioner's license and who is qualified according to medical staff bylaws, h) Authentication requirements of verbal orders.				
20. Each member of the medical staff assigned to the emergency department will know and follow EMTALA regulations and requirements. (C-2400)				
21. The medical staff will determine the appropriate professional and licensed staff to perform medical screening exams under the EMTALA regulations (C-2406)				

PHYSICIAN RESPONSIBILITIES	YES	NO	N/A	FINDINGS/COMMENTS
1. MD/DO must provide medical directions and supervision of staff must be present for sufficient period of time. (must be present at least once every two weeks) **(C- 0981 & C-0982)**				
2. PA/NP to participate in developing and reviewing written policy and procedure.				
3. MD/DO participates in developing, executing & periodically reviewing policies. **(C-0982)**				
4. Policy that specifies a time frame for the maximum interval between inpatient reviews.				
5. MD/DO with advanced practitioners periodically reviews patient records, provides orders and provides medical services to CAH patients (define "periodically") **(C-0984)**				
6. For inpatient records of patients whose care is/was managed by a non-physician practitioner: a) 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 b) that reviews take place within the timeframe specified by the CAH's policy. (Consider if CAH has EHRs that can be reviewed and signed off remotely) **(C-0986)**				
7. Physicians will complete medical records per facility policy and/or state requirements. (48 hours of admission/30 days discharge)				
8. Physicians will participate in Risk Management activities. (adverse findings, also noted in reappointment process)				

PHYSICIAN RESPONSIBILITIES	YES	NO	N/A	FINDINGS/COMMENTS
9. Standard of care required reporting to licensing agency post peer review determination.				
10. MD/DO must provide medical directions and supervision of staff.				
11. Surveyor will want evidence that the physician provided oversight and is available for consultation or patient referral.				
12. CAH has professional staff that includes one or more physicians, and may include PA, NP, or CNS **(C-0970)**				
13. Need to have organizational chart which shows names of all MD/DO and PA, NP, or CNS (C-0971)				
14. Surveyor will review work schedules.				
15. Professional staff supervises all ancillary personnel. **(C-0972)**				
16. Staffing policies (have sufficient staff to take care of patients and provide essential services to CAH operation) **(C-0974)**				
17. Have staffing schedules and daily census records available for reviewing.				
18. MD, DO, NP, PA, or CNS must be available at all times to furnish care. **(C-0976)**				
19. Must show practitioner is available and shows up when patient presents to the hospital.				
20. MD, DO, NP, PA or CNS will follow EMTALA requirements as noted in CoP appendix V.				
21. Student/resident assignments will be monitored at all times. (not to be used as free labor)				
22. Medical staff will participate in department or other committees and reporting findings to the medical staff. (i.e., infection control, P&T, UR, etc..)				
23. Medical staff will participate, when necessary, in disruptive provider procedures/review.				

PHYSICIAN RESPONSIBILITIES	YES	NO	N/A	FINDINGS/COMMENTS

ADVANCED DIRECTIVES & PATIENT RIGHTS	YES	NO	N/A	FINDINGS/COMMENTS
1. Does facility have policy and procedure regarding advanced directives? **(C-0812)**				
2. Does the hospital provide written information to patients at the time of admission concerning their rights under state law to make decisions concerning medical care?				
3. Provision of care is not conditioned, or other discrimination against a patient, on whether or not the individual has an advance directive.				
4. CAH & staff compliance with federal, state, and local laws & regulations.				
5. Staff must comply with their advance directives and are educated to policy and procedures.				
6. Provide advance directive information to the competent patient when admitted, including how to file a complaint.				
7. Inpatients and Outpatients have the right to make advance directives, including psychiatric advance directives.				
8. Advance directive applies to ED, observation, and same day surgery patient.				
9. Information on advance directives is provided to all inpatients.				

ADVANCED DIRECTIVES & PATIENT RIGHTS	YES	NO	N/A	FINDINGS/COMMENTS
10. Have advance directives to designate a support person for person of exercising the visitation rights.				
11. If patient is incapacitated, a durable power of attorney (DPOA) must be used to inform decisions and consent for the patient.				
12. CAH must also seek the consent of the patient's representative when informed consent is required for a care decision.				
13. Prominent documentation in MEDICAL RECORD of completing advance directive.				
14. Provide community education regarding issues concerning advance directives and the hospital must document its efforts. (video and audible tapes acceptable)				
15. Patient has the right to refuse treatment.				
16. Must disclose if *hospital is a* physician-owned hospital.				
17. Physician's must also discloses to patients who they refer.				
18. Disclose in writing if physician is not on premise 24 hours a day for emergencies. Sign acknowledgement if patient admitted.				

ADVANCED DIRECTIVES & PATIENT RIGHTS	YES	NO	N/A	FINDINGS/COMMENTS
19. A sign is posted conspicuously stating the hospital does not have a physician present in the hospital 24-hours per day, 7 days a week and indicates how the hospital will meet the medical needs of any patient with an emergency medical condition.				
20. Patient signed acknowledgement that they understand a physician may not be present during all hour's services are furnished to the patient.				
21. Patient care services furnished in accordance with state and local laws, regulations. **(C-0814)**				
22. Ensure delegating as allowed by law.				
23. Ensure practicing according to scope of practice, such as NP, CNS, PA.				
24. Staff are licensed, certified, or registered per federal, state & local laws. **(C-0818)**				
25. Review personnel files to be sure credentials and licensure is up to date.				
26. All patients have the right to be free from physical or mental abuse and corporal punishment.				
27. 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.				
28. 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.				

ADVANCED DIRECTIVES & PATIENT RIGHTS	YES	NO	N/A	FINDINGS/COMMENTS
29. To ensure compliance with restraint and seclusion requirements see CMS CoP's Appendix A.				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Provision of emergency services as a direct service of the CAH- includes provision of services to both inpatients and outpatients. (C-0880)				
2. The ED cannot be a provider-based offsite location.				
3. Under direction of qualified medical director. (performs/practices emergency medicine)				
4. Qualified Registered Nurse in charge of emergency room staff. (must have RN on duty at all times with CPR certification)				
5. Staff will be appropriately certified for services provided.				
6. Policies and procedures are developed and approved by the medical staff including mid-level practitioners regarding the care provided in the emergency room.				
7. Policies and procedures are reviewed and revised when quality assurance activities indicate the need.				
8. Policies and procedures for department operation during disasters.				
9. Procedures for patient Triage.				
10. Procedures for Trauma care.				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
11. Appropriate emergency equipment/supplies: • Suction, • oxygen equipment, • Cardiopulmonary resuscitation units (crash carts) shall be available and ready for use. This equipment shall include equipment used for: ○ tracheal intubation, ○ tracheotomy, ○ ventilating, ○ bronchoscopy, ○ intra-pleural decompression, and ○ intravenous fluid administration. • standard drugs, • parental fluids, • plasma substitutes, and • surgical supplies shall be on hand for immediate use in treating life-threatening conditions.				
12. Must determine the categories and numbers of staff needed in the ED. (MD/DO, RN, ward clerks, PA, NP, EMTs)				
13. The scope of diagnostic and /or therapeutic respiratory services offered by the CAH should be defined in writing, and approved by the Medical Staff such as (intubation, breathing treatments, CT scans, venous Doppler's, ultrasound etc.				
14. Qualifications, education, training, of personnel authorized to perform respiratory care services and if supervision is needed.				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
15. Written policies to address the following respiratory services: • Equipment assembly and operation • Safety practices, including infection control measures Handling storage, and dispensing of therapeutic gases • Cardiopulmonary resuscitation • Procedures to follow in the advent of adverse reactions to treatments or interventions: • Pulmonary function testing • Therapeutic percussion and vibration • Bronchopulmonary drainage • Mechanical ventilator and oxygenation support • Aerosol humidification, and therapeutic gas administration • Administration of medications; and • Procedures for obtaining and analyzing blood samples. (arterial blood gases)				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
16. ED staff education to include: • Parenteral administration of electrolytes, fluids, blood and blood components • Care and management of injuries to extremities and central nervous system • Prevention of contamination and cross infection • Provision of emergency respiratory services • Make sure staff knows where the equipment • is located • Know how supplies are replaced and who is • responsible for doing this and watch for • expired suture • Patient care equipment maintenance: how • performed, schedule (defibrillator) • What to do when equipment fails • Who will examine sterilized equipment for • expiration dates • Who will examine oxygen supply system to • determine functional capabilities • Check the force of the vacuum (suction) • equipment to see that it is in operating condition.				
17. Emergency services available on a 24-hr/d basis. CAH must maintain the types, quality and numbers of supplies, drugs and biologicals, blood and blood products, and equipment. **(C-0882)**				
18. PA's or NP's cannot admit patients to themselves. KS regulations state patients must be admitted to a physician attending. Do they provide notification of admits?				
19. On-call roster will be posted in the ED.				
20. Qualified provider available to see patient within 30 min (rural) or 60 min (frontier) and how CAH ensures patients are seen within the required time.				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
21. Maintain a list of medical providers and their delineation of criteria for ED privileges.				
22. CAH must maintain the types, quality and numbers of supplies, drugs and biologicals, blood and blood products, and equipment.				
23. Ensure that the required equipment, supplies, and medications are always readily available. (C-0884)				
24. How does the CAH ensure that staff knows where drugs and biological are kept, inventory maintained, Drugs and biological replaced. (C-0886)				
25. Who is responsible for monitoring drugs and biologicals? Medications locked if opened dated. Refrigerator with meds, temperature, log for temps, crash cart meds checked and verify narcotic count.				
26. Be prepared to share knowledge during interview on: (C-0888) 1. Parental administration of electrolytes, fluids, blood and blood components 2. Care and management of injuries to extremities and central nervous system 3. Prevention of contamination and cross infection 4. Provision of emergency respiratory services.				
27. How CAH provides needed equipment and supplies.				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
28. Equipment and supplies commonly used in life-saving procedures, includes Airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.				
29. Make sure staff knows where the equipment is located.				
30. Know how supplies are replaced and who is responsible for doing this and watch for expired suture.				
31. Patient care equipment maintenance: how performed, schedule. (defibrillator and other equipment)				
32. What to do when equipment fails.				
33. Who will examine sterilized equipment for expiration dates.				
34. Who will examine oxygen supply system to determine functional capabilities.				
35. Check the force of the vacuum (suction) equipment to see that it is in operating condition.				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
36. RN with training and experience in emergency care can conduct specific medical screening exam. RN must be on site and immediately available when a patient requests care and the nature of the request must be within scope of practice for a RN and consistent with state law, medical staff bylaws.				
37. Coordination with emergency response systems/ambulance ensure that procedures are in place for coordination with EMEDICAL STAFF to make available by telephone or radio contact, on a 24-hours a day basis, a MD or DO to receive emergency calls and provide medical direction in emergency situations.				
38. Ensure there is a plan in place to demonstrate that procedures are followed and evaluated for effectiveness.				
39. Ensure EMTALA signage is appropriate and visible to all entering the ED. (C-2406)				
40. EMTALA compliance for transfers. (C-2400)				
41. Transfers are appropriate and timely.				
42. RN with training and experience in emergency care can conduct specific medical screening exam. RN must be on site and immediately available when a patient requests care and the nature of the request must be within scope of practice for a RN and consistent with state law, medical staff bylaws. If you have facilities that are considered "frontier/remote location" will need to add more as to RNs**.(C-0894)**				
43. QA in place for EMTALA compliance.				
44. Procedure for early transfer severely ill or injured.				

EMERGENCY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
45. Policy/procedure for emotionally ill or under influence of drugs, alcohol, DOA.				
46. Standardized Hand-off procedures.				
47. AMA or refusal of treatment procedures.				
48. QA in place for AMA discharges.				
49. Policy for law enforcement officer requested blood ETOH/Drug specimens and chain of custody.				
50. Geriatric Fall Evaluations/Prevention.				
51. Department security measures reviewed regularly.				
52. Current policies/procedures for every service/procedure given. (medical staff approved) **(C1012)**				
53. Level IV Trauma – maintain compliance.				
54. Trauma Registry participation.				
55. Integration with the CAH-wide QA program.				
56. Trending of ER Incidents and movement into QA when trends are noted.				

INFORMED CONSENT	YES	NO	N/A	FINDINGS/COMMENTS
1. Medical Record-required elements – Identification and social data, informed consent forms for any procedures or surgical procedures. **(C-1110)**				
2. What precautions are taken to ensure confidentiality and prevent unauthorized persons from gaining access.				
3. Medical Record retention period is 10 years and longer – Need system that is able to pull any old Medical Record within this time frame.				
4. Informed Consent Form should contain at least the following. • Name of patient, and when appropriate, patient's legal guardian; • Name of CAH; • Name of procedure(s); • name of practitioner(s) performing the procedures(s); • Signature of patient or legal guardian.				
5. Consent form must include: • Date and time consent is obtained; • Statement that procedure was explained to patient or guardian; • Signature of professional person witnessing the consent; • Name/signature of person who explained the procedure to the patient or guardian.				
6. Are all staff aware that informed consent is not merely a signed form, but rather a process that involves discussing with patients the benefits and risks of procedures and treatments?				

INFORMED CONSENT	YES	NO	N/A	FINDINGS/COMMENTS
7. Do all providers understand informed consent is a nondelegable duty that the treating health care provider must perform?				
8. Are staff members who participate in certain aspects of the informed consent process, such as general patient education, properly trained and credentialed?				
9. Are staff members knowledgeable about the statutes and regulations related to informed consent in Kansas?				
10. Are staff members aware of the laws governing informed consent for minors in Kansas when treating pediatric patients?				
11. Do informed consent forms adhere to applicable federal and state statutes and regulations concerning informed consent?				
12. Does the facility have a policy for managing situations that might complicate the informed consent process, such as treating a patient who has cognitive disabilities?				
13. Do the types of procedures or treatments and their relative complexity help inform the thoroughness and level of detail presented during the informed consent process?				
14. As part of the informed consent process, does the provider consider each patient's: • Current understanding of their condition? • Overall capacity to understand the information provided, including any language or health literacy barriers? • Cultural, religious, socioeconomic, or ideological circumstances that might affect their decision-making process?				
15. Based on each patient's specific condition and circumstances, are modifications to the informed consent process used, rather than a one-size-fits-all approach?				

INFORMED CONSENT	YES	NO	N/A	FINDINGS/COMMENTS
16. Does the informed consent process and form (if applicable) include basic elements, such as the patient's name, the procedure name, a description of the procedure, the benefits and risks of the procedure, alternative treatment options, the patient's signature acknowledging understanding, and a witness signature?				
17. Do providers follow a process like informed consent when a patient refuses treatment i.e., do they discuss the benefits and risks of not pursuing treatment and alternative options?				
18. Are thorough and valid informed consent processes and forms are used for patients who participate in research or investigational procedures or treatments?				
19. Do providers use lay language and clear descriptions of treatments and procedures when conducting the informed consent process?				
20. Do providers avoid medical jargon and try to explain complex medical concepts in ways that aid patient comprehension when conducting the informed consent process? (e.g., using visual aids)				
21. Do written materials, including forms and patient educational pieces, adhere to the principles of plain language?				
22. Are interpreters and auxiliary aids used as part of the informed consent process for patients who have limited English proficiency or disabilities such as hearing impairment?				
23. Is patient comprehension of the informed consent process assessed through such methods as the teach-back technique?				
24. Does the facility have a protocol for consistently documenting informed consent (or informed refusal) and patient education in patient records?				

INFORMED CONSENT	YES	NO	N/A	FINDINGS/COMMENTS
25. Do providers document the informed consent or informed refusal process in each patient's record, regardless of the complexity of the procedure?				
26. At a minimum, does informed consent or informed refusal documentation include: • Information about the patient's diagnosis? • The procedure or treatment being recommended to the patient and its purpose? • The benefits and risks of the procedure or treatment as discussed with the patient? • The patient's acceptance or refusal of the treatment plan, including reason for refusal, if applicable? • Information about any patient education (written or verbal) provided?				
27. Are signed informed consent forms included in patient records?				

SURGERY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Under the direction of Surgical Medical Director. (Physician must practice in/perform surgical procedures) **(C-1140)**				
2. Designation of qualified practitioners: surgery performed only by MD, DO, dentists, oral surgeons, or Podiatrist when privileged to do so by governing body. **(C-1142)**				
3. Surgical privileges are specified in writing must designate who are allowed to perform surgery, need policy/procedures. Update privileges every 2 years.				
4. Medical Staff appraisal procedure must evaluate each practitioner's training, education, experience and demonstrated competence.				
5. Scope of surgical services must be in writing and approved by Medical Staff.				
6. When Supervision required – MD/DO surgeon is in the same room working on same patient.				
7. As established by the QI program, credentialing, adherence to hospital policy/procedures, and laws.				
8. There is a current list of surgeons with specific surgical privileges and list of surgeons suspended /limited privileges.				
9. OR organizational chart shows lines of authority and delegation within the department.				
10. Clinical procedures documented and appropriate policies and procedures are correlated.				

SURGERY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
11. Qualified RN on duty during services.				
12. Qualified RN in Recovery Room.				
13. OR supervised by experienced staff member, address qualifications of supervisor of OR rooms in policy and procedures and authorized by state law.				
14. If LPN or scrub nurses used, must be under RN supervision who is immediately available to physically step in as needed.				
15. Scrub and circulating nurse duties.				
16. Acceptable OR attire (if using skull caps, all hair must be covered, and caps must be laundered per sterilization guides in the facility.				
17. Personnel policies unique to OR.				
18. Aseptic surveillance & technique; scrub techniques.				
19. Required equipment and supplies are readily available. Required items but not limited to: • Cardiac Monitor • Resuscitator, • Defibrillator, • Tracheostomy set, • Blood transfusion capabilities, • Suction, • Oxygen equipment, • Intravenous fluid administration. • Standard drugs, • Parental fluids, • Plasma substitutes, and • Surgical supplies shall be on hand for immediate use sterile and non-sterile.				
20. Surgical suite traffic is controlled.				

SURGERY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
21. Policy and procedure for observers/and equipment representatives in the surgical area and suite.				
22. Sterilization and disinfection procedures.				
23. Equipment available for rapid and routine sterilization of OR materials, equipment monitored, inspected, tested and maintained by the CAHs biomedical equipment program.				
24. Sterilized materials are packaged, handled, labeled and stored in a manner that ensures sterility i.e., in a moisture and dust-controlled environment, Policy and procedure on expiration dates.				
25. Handling infections and biomed waste.				
26. Identification of infected and non-infected cases.				
27. Housekeeping in OR –requirements/procedures.				
28. Quality of outpatient surgical services must be consistent with inpatient.				
29. Scheduling of patients for surgery.				
30. Policy on DNR status in the OR suite.				
31. Appropriate equipment and types and numbers of personnel are present.				
32. History and Physical in Medical record prior to start of procedure.				

SURGERY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
33. All or part of H&P may be delegated to other practitioners (PA, NP) if allowed by state law and CAH. Surgeon must sign and assume full responsibility.				
34. Informed consent documented by Surgeon in the medical record.				
35. Properly executed informed consent form is in the Medical record.				
36. Informed consent form should include: • Name of patient/legal guardian • Name of CAH • Name of Procedure • Name of practitioner performing procedure/important aspects • Signature of patient/legal guardian • Date and time consent obtained • Statement procedure explained to patient/guardian • Signature of professional person witnessing consent • Name/signature of person who explain procedure.				
37. Surgical counts in accordance with accepted standards of practice.				
38. Transfer requirements to and from recovery room.				
39. OR Register complete with required information.				
40. OP report in Medical Record within 24 hours.				
41. On-Call or Call-In schedule or system in place.				

SURGERY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
42. All tissue removed is examined and result documented. (All tissue exams must be performed by MD. SRE – Lost specimen that cannot be or used diagnostics and cannot be replaced.				
43. Implant/explant policy and procedure.				
44. Pre & Post Op diagnosis correlation and documentation.				
45. All documentation is completed in timely manner.				
46. Post OP follow up telephone calls are documented in the medical record.				
47. Safety practices.				
48. Malignant Hypothermia Procedures.				
49. OR specific Fire Safety policy and procedure.				
50. Patient Positioning policy and procedures.				
51. Blanket and Solution Warmers are within safe range and are monitored daily with documentation on log.				
52. Processes to prevent wrong site, wrong patient or wrong procedure are in place and performed by all staff/medical staff in the or suite or procedure room. SRE - document procedure for prevention and those in room at time.				
53. Policy and procedure Unintended Foreign Body. SRE – What processes are in place to prevent, monitor and/or report an unintended FB in patient after surgery.				
54. Policy and procedure Death of ASA Class 1 patient. SRE - What processes are in place to prevent monitor and/or report the intraoperative or immediately post-operative /post procedure death.				

SURGERY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
55. CAHs biomedical equipment program to include equipment monitoring, inspected, tested, and maintained.				
56. Integration with the CAH-wide QA program.				
57. Trending of ER Incidents and movement into QA when trends are noted.				

ANESTHESIA SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Medical Staff bylaws include criteria for determining anesthesia and other surgical care practitioners' privileges. **(C-1145)**				
2. If no Anesthesiology service, the medical director of Surgical services will assume responsibility of anesthesia direction. **(KS Hosp. Reg)**				
3. CRNA may administer under order of operating practitioner or anesthesiologist. In an interdependent relationship the surgeon/anesthesiologist must be immediately available to provide hands-on intervention when needed.				
4. Anesthesia service shall establish policies, procedures, rules, and regulations for the control, storage, and safe use of combustible anesthetics, oxygen, and other medicinal gases in accordance with national fire protection association standards; types of anesthesia to be administered and procedures for each; personnel permitted to administer anesthesia; infection control; safety regulations to be followed; and responsibility for regular inspection, maintenance, and repair of anesthesia equipment and supplies. **(C-1145)**				
5. Surgical risk assessment immediately before surgery by qualified practitioner. **(C-1144)**				
6. Pre-anesthesia risk assessment immediately before surgery by qualified practitioner.				
7. Anesthesia recovery evaluation before discharge by qualified practitioner.				
8. Post anesthesia follow-up report must be written on all inpatients and outpatients prior to discharge.				
9. Written by the individual who is qualified to administer the anesthesia.				
10. Must include at a minimum: cardiopulmonary status, LOC, follow-up care and/or observations and any complications occurring during PACU.				

ANESTHESIA SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
11. Waste Anesthetic Gas Procedure.				
12. Policy in place to govern discharge procedures and instructions. **(C-1149)**				
13. Patients discharged in company of a responsible adult unless exempted by doctor.				

CENTRAL SUPPLY/STERILIZATION SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Appropriate Storage/labeling (Sterile supplies separate from nonsterile storage in dust-proof, moisture free bags/units – must occur facility wide with dates on each package/unit.				
2. Expiration date must be visible on all sterilized packages/units.				
3. Sterilizer accuracy is monitored.				
4. Surveillance of Sterilization processes/procedures.				
5. Policy & Procedure for Flash Sterilization.				
6. Policy & Procedure for Standard Sterilization.				
7. Policy and Procedure for High Definition-Scope Sterilization.				
8. Policy and Procedures as necessary for other specialized equipment.				
9. Infection control monitors in place.				
10. QA integration into CAH wide program.				

LABORATORY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Laboratory Policies: basic services provided directly through a contractual agreement with a certified laboratory: all procedures for tests performed whether available as routine and stat basis. cultures taken. **(C-1028)**	or			
2. Must provide emergency laboratory services 24 hours/ 7 days a week.				
3. Basic lab services to include, urine dipstick, hemoglobin or hematocrit, blood glucose, stool for occult blood, pregnancy tests, primary culturing for transmittal to certified laboratory. Need to make sure basic lab services are available to ensure an immediate diagnosis and treatment.				
4. Scope & complexity; lab services must be provided directly at the CAH campus by CAH staff in order to facilitate immediate diagnosis and treatment of patient. The CAH must have a current/valid CLIA certificate or Certificate of Waiver for all tests performed and appropriate to the level of services performed: 24/7.				
5. Written description of tests available for emergency testing; list approved by Medical Staff.				
6. Reference labs: Contracted lab must have CLIA certification.				
7. Policy and procedure for collection, preservation, transport, receipt & reporting of tissue specimens.				

LABORATORY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
8. Need policies and procedures for additional/specialized lab services covering collection preservation, transportation, receipt, and reporting of tissue specimen results.				
9. Quality control policies, measures, logs, instrument maintenance logs.				
10. Policy to make sure all lab tests are recorded in the medical record.				
11. Staff supervision, qualifications, orientation, training competencies.				
12. Infection control standards can be verbalized and are met.				
13. How emergency care available/provided to patients experiencing adverse reactions.				
14. Lab or diagnostic services that are not available at the CAH- have an agreement with 1 or more providers, be sure referred patients are accepted and treated.				
15. All tissues removed shall be macroscopically examined. If deemed necessary, by written hospital policies and procedures, tissues shall then be microscopically examined. A list of all tissues which routinely do not require microscopic examination shall be developed in writing by a pathologist and approved by the medical staff of each hospital.				
16. Blood storage under the control and supervision of pathologist or another qualified physician. **(C-0892)**				

LABORATORY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
17. If blood banking done under arrangement, the arrangement must be approved by medical staff and administration- have agreement available.				
18. Policy/procedure or contract/agreement/ arrangement for services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergency patients 24 hours a day. (IF No requirement to store blood on site) **(C-0890)**				
19. Call schedule will be reviewed.				
20. Documentation of blood refrigerator temperatures and corrective action as needed.				
21. Compatibility testing, if performed. (CLIA Certified)				
22. If collecting blood must register with FDA.				
23. Need agreement in writing re: provision of blood between CAH and testing lab.				
24. Ensure blood is properly stored to prevent deterioration.				
25. If types and cross matches must have necessary equipment such as Sero-Fuge and heat block.				
26. Can keep 4 units O Negative blood on hand at all times.				
27. Physician order to give uncrossed match blood must be signed.				

LABORATORY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
28. Policy and procedure for critical result reporting. SRE - Prevention, identification and/or reporting of patient death or serious injury due to failure to communicate laboratory or pathology test results				
29. Policy and procedure for each test performed.				
30. QA to be integrated into CAH wide QA program.				

RADIOLOGY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Supervision of the department by a credentialed member of the Medical Staff. **(C-1030)**				
2. Designation of staff qualified to operate equipment, approved by medical staff.				
3. Written policy, consistent with state law on personnel to operate radiology equipment and do procedures.				
4. Radiology Administration Policies: provided as a direct service; available 24/7; scope & complexity of services- approved by Medical Staff and governing body /CEO; if interpretation of imaging internally or contracted; acceptable standards of practice; meeting patient & staff safety standards.				
5. Can offer minimal set or more complex according to needs of the patients; interpretation however can be contracted out.				
6. Diagnostic, therapeutic and nuclear medicine must be provided in accordance with acceptable standards of practice and must meet professionally approved standards for safety.				
7. Scope or what you do has to be in writing and approved by MEDICAL STAFF and board and by standards recommended by nationally recognized professions such as the AMA and ACR.				
8. Periodic inspection of equipment & process for timely corrective action when needed, KS Hosp Reg At least every 2 years by an appropriate state agency, annual calibration of all x-ray gamma beam equipment.				

RADIOLOGY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
9. Identification of which tests a radiologist must interpret, approved by medical staff.				
10. Only privileged providers order tests.				
11. Radiologist or physician must sign (or electronically sign) all reports.				
12. Emergency radiation hazards, incidents, response & reporting and procedures.				
13. X-ray machine and /or portable x-ray machine has a technique chart posted and radiation protection shielding.				
14. Policy and procedures on adequate radiation shielding for patients, personnel and facilities which includes: shielding built into physical plant, types of personal protective shielding to use and under what circumstances, types of containers to be used for radioactive materials and clear signage identifying hazardous radiation area. **(KS 48-1607)**				
15. Policy: labeling all radioactive materials, including waste; transportation between locations within CAH, control access to radioactive materials and provide testing of equipment for hazards.				
16. Periodic checking of staff regularly exposed to radiation for the level of radiation exposure, via exposure meters or badge tests.				
17. Need copies of all reports and printouts, written policy and ensure integrity of authentication.				

RADIOLOGY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
18. File storage, security, retrieval, HIPAA.				
19. Staff are trained on all policies and procedures, including radiation safety, and are checked routinely for radiation exposure per exposure meters or badge tests.				
20. Policy/procedure for each exam performed. (Competency testing for each exam and certification in specialty modalities)				
21. Policy and Procedure for safety/protection of patient.				
22. Policy and Procedure for Critical result reporting. SRE-Prevention, identification and/or reporting of patient death or serious injury due to failure communication radiological exam results.				
23. Medical Record Safety. SRE-Prevention, identification and/or reporting patient death or serious injury associated with metallic objects introduced into the medical record area.				
24. Fall precautions implemented in all areas of Radiology exams.				
25. Contrast Safety Evaluation. Contradictions of giving oral or IV contrast and informed consent from the patient.				
26. No one under the age of 18 years of age may operate radiation producing equipment.				
27. Fluoroscopy conducted by or under direct supervision of a physician. **(KSA 65-431)**				

NURSING SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Services under the direction of an RN. **(C-1046)**				
2. Must designate an individual who is responsible for nursing services, including development of policies and procedures for nursing services and ongoing review analysis of quality of nursing care.				
3. All nurses must be licensed in Kansas. **(KS Hosp Regs)**				
4. Nursing services must meet the needs of all patients.				
5. How unit(s) adequately staffed & supervised.				
6. All agency nurses must be oriented and supervised.				
7. Will review nursing care plans, medical records, accident and investigate reports, staff schedules and policies/procedures.				
8. Orientation includes unit, emergency preparation, nursing policy/procedure, safety policy/procedure, including agency nurses. **(C-0978)**				
9. Must have RN on duty whenever the CAH has one or more patients.				
10. Must ensure appropriate staffing for outpatient nursing services.				
11. Must have sufficient numbers of supervisory and non-supervisory personnel to meet patient needs.				

NURSING SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
12. RN must provide nursing care to each patient or make assignments.				
13. How RN provides or assigns qualified care giver for each patient, including swing bed and SNF patients.				
14. Ensure all nursing personnel assigned to provide nursing care have the appropriate education, experience, licensure, competence and specialized qualifications.				
15. RN with training and experience in emergency care can conduct specific medical screening exam. RN must be on site and immediately available when a patient requests care and the nature of the request must be within scope of practice for a RN and consistent with state law, medical staff bylaws. If you have facilities that are considered "frontier/remote location" will need to add more as to RNs. **(C-0894)**				
16. Staffing policies. (have sufficient staff to take care of patients and provide essential services to CAH operation) **(C-0974)**				
17. How does the CAH ensure that staffing schedules correlate to the number of acuity of patients, including swing-bed patients. **(C-1048)**				
18. Minutes shall be kept of nursing staff meetings. **(Authorized by K.S.A. 65-431)**				

PATIENT CARE POLICIES	YES	NO	N/A	FINDINGS/COMMENTS
1. Services provided as stated in written policy & consistent with state law. **(C-1006)**				
2. Policy development committee: physician (MD/DO), one or more of: PA, NP, CNS Removed requirement for one non-CAH staff. **(C-0272)**				
3. Maintain documentation of the policy and procedures committee activity (at least yearly). Must reflect any changes made. (C-1008)				
4. P&P committee must review existing and new P&Ps at least biennially.				
5. Final decision on P&Ps is made by the board.				
6. If the P&P recommendations by the advisory group are rejected, then the board must include in the record and the rational for the change.				
7. Policy/procedure on scope of services provided by CAH directly or through agreement/contract. **(C-1010)**				
8. Include statements like “taking complete medical histories, providing complete physical examinations, laboratory tests including”. (with a list of tests provided)				
9. Include arrangements made with Hospital X for providing the following services with list of specialized diagnostic and lab testing.				

PATIENT CARE POLICIES	YES	NO	N/A	FINDINGS/COMMENTS
10. Policies for emergency care services; show how CAH would meet all of its emergency services requirements. **(C-1012)**				
11. How the CAH provides 24-hour emergency care to its patients?				
12. What equipment, supplies, medications, blood and blood products are maintained onsite, and which are readily available for treating emergency cases by agreement at other facilities?				
13. What types of personnel are available to provide emergency services and what are their required onsite response times?				
14. How the CAH coordinates with local emergency response systems?				
15. Medicare certified hospitals have a regulatory obligation to care for patients in a safe setting under the Medicare Hospital Conditions of Participation (CoPs) at §482.13(c)(2). **(QSO-23-04)**				
16. Hospital staff should follow current standards of practice for patient environmental safety, infection control, and security. The hospital must protect vulnerable patients, including newborns and children. Additionally, this standard is intended to provide protection for the patient's emotional health and safety as well as his/her physical safety. Respect, dignity and comfort would also be components of an emotionally safe environment.				
17. Hospitals should identify patients at risk for intentional harm to self or others, identify environmental safety risks for such patients, and provide education and training for staff and volunteers.				

PATIENT CARE POLICIES	YES	NO	N/A	FINDINGS/COMMENTS
18. Patients at risk of suicide (or other forms of self-harm) or who exhibit violent behaviors toward others receive healthcare services in both inpatient and outpatient locations of hospitals.				
19. Although all risks cannot be eliminated, hospitals are expected to demonstrate how they identify patients at risk of self-harm or harm to others and steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines. The potential risks include, but are not limited to, those from ligatures, sharps, harmful substances, access to medications, breakable windows, accessible light fixtures, plastic bags (for suffocation), oxygen tubing, bell cords, etc.				
20. All hospitals are expected to implement a patient risk assessment strategy, but it is up to the hospital to implement the appropriate strategies. For example, a patient risk assessment strategy in a post-partum unit would most likely not be the same risk assessment strategy utilized in the emergency department.				
21. Hospitals should also provide the appropriate level of education and training to staff regarding the identification of patients at risk of harm to self or others, the identification of environmental patient safety risk factors, and mitigation strategies. Staff would include direct employees, volunteers, contractors, per diem staff and any other individuals providing clinical care under arrangement. **(QSO-23-04)**				

OBSERVATION SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Observation is not appropriate for: Substitute for inpatient admission, for continuous monitoring, or medically stable patients who need diagnostic testing or outpatient procedure (blood, chemo, dialysis), patients awaiting nursing home placement, for convenience to the patient or family, for routine prep or recovery prior to or after diagnostic or surgical services, as a routine stop between the ED and inpatient admission, no prescheduled observations services or observation services begin and end with the order of the physician. **(C-0902)**				
2. There is an order for observation services prior to start of the service; order is not backdated.				
3. Standing orders for observation services are not permitted or utilized.				
4. Must provide documentation to show that observation bed is not an inpatient bed.				
5. Need specific criteria for observation services and it must be different than inpatient criteria.				
6. Policy on observation beds to meet-they do not count observation beds in 25 bed count now or in calculating average length of stay.				
7. Two Midnight Rule- Need an order and need to document medical necessity.				

INPATIENT ADMISSIONS/MED-SURG SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Admitting privileges must be consistent with what state law allows. **(C-0998)**				
2. MD/DO notified when PA, NP, CNS admits a patient to their service.				
3. MD/DO is responsible for and monitoring the care of each Medicare/Medicaid patient for all medical problems during hospitalization.				
4. There is periodic review of clinical privileges and performance by NP, CNS, PA. **(C-0999)**				
5. Review completed by MD/DO, can be via contract, by network member hospital, QIO, entity in State rural health plan.				
6. Telemedicine – can be reviewed by distant site hospital or entity.				
7. Patient care policies/services provided as stated in written policy & consistent with state law reflecting all patient care functions performed.				
8. Conditions, signs or developments requiring consultation and/or patient referral (to MD, others). **(C-1014)**				
9. Guideline on maintaining medical record -health care record policies.				

INPATIENT ADMISSIONS/MED-SURG SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
10. Need to policy to include the scope of medical acts which may be done by PA, NP, CNS. (Indicate what medical procedures the PA or NP can do)				
11. Guidelines need to describe the medical conditions, signs or development that require consultation.				
12. Nursing care plan started on admission and includes discharge planning, kept current on all patients. **(C-1050)**				
13. Plan must describe goals, discharge planning, physiological and psychosocial factors.				
14. Goals must be identified, measurable, and known to all appropriate personnel.				
15. Must be kept as part of the medical record.				
16. All or part of H&P may be delegated to other practitioners MD/DO assumes responsibility and sign. **(C-1114)**				
17. Bylaws reflect when H&P must be completed.				
18. Blood transfusions. SRE – Ensure process for prevention, identification/and or reporting of patient death or injury association with unsafe administration of blood products and procedure included for transfusion reaction.				
19. Policy and procedures for IV therapy and medications.				

INPATIENT ADMISSIONS/MED-SURG SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
20. Patient Call Systems.				
21. Important to describe the patient's response to treatment; all orders, reports of treatment and medications, nursing notes, documentation of complications, other information used to monitor the patients such as progress notes, lab tests, graphics. **(C-1116)**				
22. Policy/procedure On-call staffing.				
23. Procedure Management of Emergencies.				
24. Procedure Cardiac Monitoring.				
25. Policy/Procedure Restraint/Seclusion. SRE-Prevention, Identification, and/or reporting of death or serious injury to patient while in restraints of any type				
26. Procedure Patient Elopement. SRE – Prevention, Identification and/or reporting of a patient death or serious injury with patient elopement/disappearance from the health care setting				
27. Procedure Self-harm/Suicide. SRE – Prevention, Identification and/or reporting of a patient death or serious injury with patient self-harm or attempted suicide/suicide in the healthcare setting				
28. Procedure Pressure Ulcer prevention/precautions. SRE- Prevention, Identification and/or reporting of any stage 3 or 4 pressure ulcer acquired after admission presentation to a healthcare setting				

INPATIENT ADMISSIONS/MED-SURG SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
29. Important to be sure Medical Records are filed promptly.				
30. All Medical Records must contain all lab reports, radiology reports, all vital signs and reports of treatment include complications and hospital acquired infections, and all unfavorable reaction to drugs.				
31. Documentation standards for documentation within the medical record are implemented and all staff are educated on the expectations.				
32. Patient education program in place and executed for each patient, patient condition/treatment/therapy.				
33. Policy in place to govern discharge procedures and instructions. **(C-1149)**				
34. Patients discharged in company of a responsible adult unless exempted by doctor.				
35. Appropriate Discharge. SRE – Prevention, identification and/or reporting the discharge of any age patient who is unable to make decisions to anyone other than an authorized person				
36. Contracted services must have agreement or arrangement with one or more providers or suppliers participating under Medicare to provide service to in-patients and outpatients. **(C-1036)**				
37. Contracted services Must have at least one MD or DO on its staff who is responsible.				

INPATIENT ADMISSIONS/MED-SURG SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
38. If agreement(s) not in writing, CAH can provide evidence referred patients are accepted and treated.				
39. Need policy and procedures for referring patients it discharges who need additional care.				
40. Rehab services are provided by qualified staff, included PT, OT, and speech language pathology. **(C-1052)**				
41. Rehab is an optional service can be provided directly or through contracted services.				
42. Must have an order, policy and procedure, and be consistent with the (American PT Association, American OT Association etc.).				
43. Must do a Plan of Care (POC) before treatment is started. Can be done by MD/DO, PA, NP, and CNS. Can be done by PT, speech language pathologist or OT who is furnishing the service. Any change in plan must be in accordance with provider's policy and procedure.				
44. Organized integrated quality improvement, coordinated policies and procedures, professional licenses.				

INPATIENT ADMISSIONS/MED-SURG SERVICES	YES	NO	N/A	FINDINGS/COMMENTS

MEDICATION ADMINISTRATION - ALL SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. All drugs, biological and IV meds, must be administered by or under supervision of a RN, MD, DO, or PA- in accordance with written and signed orders, accepted standards of practice, federal and state laws. **(C-1049)**				
2. Orders for drugs & biologicals, including verbal orders, are legible, timed, dated & authenticated by practitioner (need signed order).				
3. Policy and procedure must specify who can administer medications.				
4. Policy that describes limitations or prohibitions on use of VO. Provide a mechanism to ensure validity/authenticity of the prescribers. List elements to be included in verbal orders. List and define the individuals who may send and receive VO and provide guidelines for clear and effective communication of VO.				
5. Computer Order Entry by Provider is the preferred method when using an electronic medical record.				

MEDICATION ADMINISTRATION - ALL SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
6. Policies and procedures for verbal and standing orders; • Practitioner must authenticate orders as soon as possible • Standing orders must include how it is developed, approved, monitored and updated • Must include when staff can initiate a standing order • Must include that the standing order is signed off • List of things that must be in the verbal order • Establish protocols for clear and effective communication and verification of verbal order. CMS expects nationally accepted read-back verification practice to be implemented for every verbal order.				
7. Telephone and verbal orders must be used infrequently and limited to urgent situations.				
8. Medication passes-policy/procedure approved by MEDICAL STAFF as to who can pass medications.				
9. Need QA plan to see if administration of drugs is regularly monitored.				

MEDICATION ADMINISTRATION - ALL SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
10. CAH must assure compliance with the following requirements concerning minimum content of medication orders: • Name of patient • Age and weight of patient- policy and procedure must address weight-based dosing • Date and time of the order • Drug name • Exact strength or concentration • Dose, frequency and route • Dose calculation requirements, when applicable • Quantity and/or duration when applicable • Specific instructions for use • Name of prescriber.				
11. Policy self-administration of medications, if the CAH permits this, need an order.				
12. Training; safe handling and preparation of drugs.				
13. Basic safe practices; five rights.				
14. Policy timing of medication administration; specify timeframes.				
15. Policies include what staff is to do when there are missed or late medications.				
16. Assessment/monitoring of patients receiving medications. Policy and procedure on how frequent to monitor patient. Factors that put patients at greater risk for adverse events and respiratory depression. Communicate in report and hand offs. High alert medications assess sedation level.				

MEDICATION ADMINISTRATION - ALL SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
17. Intravenous (IV) medications; Need correct choice of vascular access device to deliver blood and medications. Policy and procedure to address which ones can be given IV and via what type of access.				
18. Documentation IV Blood Administration Procedures.				
19. Policy and procedure to include how frequent you monitor the patient and do vital signs.				
20. How to identify and treat and report an adverse transfusion reaction.				
21. Two qualified persons, one who is administering the transfusion; document, verify correct blood product, confirm correct patient.				
22. A hospital pharmacy must have a pharmacist review all medication order prior to the first dose being administered to the patient. Policies and procedures must be put into place to ensure this compliance. **(KAR 68-7-11 (I))**				
23. Either a pharmacist onsite or the use of hospital tele pharmacy services will be sufficient to comply with the requirement.				
24. All prescribers' medication orders (except in emergency situations) should be reviewed for appropriateness by a pharmacist before first dose is dispensed.				

SOCIAL & REHABILITATION SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. The department shall be under the guidance of a qualified social worker**. (KS Hosp Regs 28-34-24)**				
2. Appropriate facilities and personnel shall be provided in accordance with the hospital's program.				
3. Records shall be kept of the social services provided.				
4. Assessment and services provided per patient requirement, need or request.				
5. Discharge policies in place to govern discharge procedures, instructions, post-discharge services set up.				
6. Physical therapy services shall be under the direction of a physician. **(KS Hosp Regs 28-34-22)**				
7. At least one registered physical therapist shall be employed for the department. In hospitals where the day-to-day services are provided by a physical therapy assistant or other supportive personnel, a part-time or consulting physical therapist shall be utilized to provide general supervision of the department.				
8. Other professional or supportive personnel shall be included as required to assure adequate patient care. All personnel shall be qualified by training or experience for the services they are rendering.				
9. Policies for the physical therapy department shall be written and shall be reviewed and revised as necessary.				
10. When a patient is referred to the physical therapy department, the treatment to be administered shall be recorded on the patient's chart, including all pertinent details of the treatment procedure.				

SOCIAL & REHABILITATION SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
11. Records of inpatients and outpatients treated in the physical therapy department shall be maintained. The date of each patient visit shall be recorded as well as modalities employed, and the area or areas treated. Patient progress notes shall be maintained.				
12. Facilities, space, and equipment required shall depend upon the physical therapy services provided but shall be sufficient to assure adequate care. The equipment shall be maintained in proper working condition to assure adequate patient benefit.				
13. The department shall be under the guidance of a qualified occupational therapist. **(KS Hosp Reg 28-34-25)**				
14. The department shall be under the guidance of a qualified occupational therapist.				
15. Facilities and personnel shall be provided commensurate with the hospital's program.				
16. Records shall be kept on the services provided				
17. Rehab services are provided by qualified staff, included PT, OT, and speech language pathology. **(C-1052)**				
18. Rehab is an optional service can be provided directly or through contracted services.				
19. Must have an order, policy and procedure, and be consistent with the. (American PT Association, American OT Association etc.)				
20. Must do a Plan of Care (POC) before treatment is started. Can be done by MD/DO, PA, NP, and CNS. Can be done by PT, speech language pathologist or OT who is furnishing the service. Any change in plan must be in accordance with provider's policy and procedure.				

SOCIAL & REHABILITATION SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
21. Organized integrated quality improvement, coordinated policies and procedures, professional licenses.				

VISITATION	YES	NO	N/A	FINDINGS/COMMENTS
1. Includes inpatients and outpatients. **(C-1054)**				
2. Role of support person for both inpatient and outpatient.				
3. Patient may want support person present during pre-op preparation or post- op recovery.				
4. Reasonable Restrictions • Infection control issues • Can interfere with the care of other patients • Court order restricting contact • Disruptive or threatening behavior • Roommate needs rest or privacy • Substance abuse treatment plan • Patient undergoing care interventions • Restriction for children under certain age.				
5. Need to train staff on the visitation policy and procedure.				
6. Need to determine role staff will play in controlling visitor access and can describe the policy for a surveyor.				
7. Written policy includes clear explanation of visitation restriction/limitations.				
8. Document that staff are trained.				
9. Inform each patient or their support person, when appropriate, of their visitation rights.				

VISITATION	YES	NO	N/A	FINDINGS/COMMENTS
10. Include notifying patient of any restrictions. **(C-1056)**				
11. Patient gets to decide who their visitors are.				
12. Cannot discriminate against same sex domestic partners, friend, family member etc.				
13. Support person does not have to be the same person as the durable power of attorney (DPOA). **(C-1058)**				
14. Support person can be friend, family member or other individual who supports the patient during their stay (patient advocate).				
15. Support person can exercise patient's visitation rights on their behalf if patient unable to do so.				
16. Hospitals must accept patient's designation of an individual or a support person 1. Whether orally or in writing 2. Suggestion to get this in writing from the patient.				
17. When patient is incapacitated and no advance directives on file then must accept individual who tells you they are the support person.				
18. Hospital expected to accept this unless two individuals claim to be the support person then can ask for documentation 1. This includes same sex partners, friends or family members 2. Need a policy on how to resolve this issue.				

VISITATION	YES	NO	N/A	FINDINGS/COMMENTS
19. Any refusal to be treated as the support person must be documented in the medical record along with specific reason for the refusal.				
20. Patient can withdraw consent and change their mind.				
21. Must document in the medical record that the notice was given.				
22. Educate staff on what a support person is and what it means.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Must identify the qualifications for and designate an individual who has overall responsibility for the CAH's pharmacy services, including development of the rules governing pharmacy services. **(C-1016)**				
2. A single pharmacist must be responsible for the overall administration of the pharmacy.				
3. Policy and procedure must identify qualification of pharmacy director; including who can perform pharmacy services, supervision of pharmacy staff and identify standards used in developing policy and procedures (can site references).				
4. The pharmacist must be responsible for developing, supervising, coordinating all the activities of the CAH wide pharmacy services and be knowledgeable about CAH pharmacy practice and management.				
5. Pharmacy must have sufficient staff in types, numbers, and training to provide quality services, including 24-hour, 7-day emergency coverage.				
6. Need to have enough staff to provide accurate and timely medication delivery, ensure accurate and safe medication administration.				
7. Storage of drugs and biologicals, including the location of storage areas, medication cars, and dispensing machines. **(C-0922)**				
8. Must have rules for drug storage, handling, dispensation and administration of drugs and biologicals area in accordance with accepted professional practices.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
9. Drugs stored according to manufacturer's directions & state/federal law. Proper environmental conditions; follow manufacturer's recommendation such as keep refrigerated, room temperature, out of light etc.				
10. Drugs stored in locked room or container. **(C-0922)**				
11. CAH rules and policy and procedures must be consistent with standards or guidelines for pharmaceutical services and medication administration, such as USP, ASHP, ISMP, Infusion Nurses Society, IHI and National Coordinating Council and consistent with state and federal law.				
12. Consistent with state and federal law to address who is authorized access to the pharmacy or drug storage area.				
13. Must have policies and procedures consistent with state and federal law of who has access and keys to drug and storage areas. (Housekeeping, security, or maintenance usually not given unsupervised access). Area restricted to personnel only are generally considered secure.				
14. Given flexibility in non-controlled drugs such as do not have to be locked up when setting up for a procedure (OR would lock up when area not staffed).				
15. Medication carts, anesthesia carts, epidural carts and non-automated medication carts with medications must be secure when not in use. **(C-0922)**				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
16. Policies and procedures are expected to address the security and monitoring of carts, locked or unlocked, containing drugs and biologicals in all patient care areas**. (C-0922)**				
17. Handling medications that include mixing or reconstituting according to manufacture recommendation. Includes compounding or admixing of sterile IVs or other drugs.				
18. Only pharmacy can reconstitute, mix, or compound a drug.				
19. Compounding used or dispensed must be consistent with acceptable principles such as those described in USP/NF chapter.				
20. Must be administered in accordance with accepted professional principles.				
21. Must be able to demonstrate how all sterile and non-sterile compounded preparations dispensed and/or administered.				
22. Must be able to provide evidence that standard operating procedures for compounding, if performed in-house, and for quality oversight of compounding, regardless of source, are consistent with accepted professional principles.				
23. Included is compliance with USP 797 and USP 795 (preparation, storing, and transporting).				
24. All compounded forms must be sterile including wound irrigation, eye drops and ointments, injections, infusions, nasal inhalation, etc.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
25. Outsourcing facilities who compound drugs register and must comply with section 503B of the FDCA and other requirements such as the FDA's current good manufacturing practice (CGMP).				
26. Must meet certain other conditions including reporting adverse drug events to the FDA.				
27. If CAH obtains compounded medications from compounding pharmacy rather than a manufacturer or a registered outsourcing facility, then must demonstrate that medicine received have been prepared in accordance with acceptable principles.				
28. Contract with the vendor would want to ensure CAH access to their quality data verifying their compliance with USP standards.				
29. Should document you obtain and review this data.				
30. Dispensing medications, dispensed timely, follow all state laws.				
31. Enough staff to provide accurate and timely medication delivery.				
32. Pharmacist reviews all orders and verifies accuracy of order prior to releasing to automated dispensing system.				
33. A hospital pharmacy must have a pharmacist review all medication order prior to the first dose being administered to the patient. Policies and procedures must be put into place to ensure this compliance.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
34. Either a pharmacist onsite or the use of hospital tele pharmacy services will be sufficient to comply with the requirement.				
35. All prescribers' medication orders (except in emergency situations) should be reviewed for appropriateness by a pharmacist before first dose is dispensed.				
36. Therapeutic appropriateness of a patient's medication regimen.				
37. Therapeutic duplication.				
38. Appropriateness of the route and method of administration.				
39. Medication-medication, medication-food, medication-laboratory test and medication-disease interactions.				
40. Clinical and laboratory data to evaluate the efficacy of medication therapy to anticipate or evaluate toxicity and adverse effects.				
41. Physical signs and clinical symptoms relevant to the patient's medication therapy.				
42. Preparation of sterile products in appropriate environment, labeled by appropriately trained and qualified personnel.				
43. Pharmacy should participate in CAH decisions about emergency medication kits i.e., stroke ER toolkit.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
44. Supply and provision of emergency medication stored in the kits must be consistent with standards of practice and appropriate for a specified age group or disease treatment.				
45. Pharmacy participation in evaluating, use and monitoring drug delivery systems, administration devices, drug-dispensing machines.				
46. Medication preparation procedures.				
47. Using a laminar airflow hood or other appropriate environment while preparing any intravenous (IV) admixture in the pharmacy, any sterile product made from non-sterile ingredients, or any sterile product that will not be used within 24 hours; and visually inspecting the integrity of the medications.				
48. System so medications orders get to pharmacy promptly and are available when needed by the patient; (automated dispensing units outside the pharmacy, night cabinets, contracted services after hours via tele pharmacy contracting, on-call pharmacists, etc.).				
49. Can use unit dose or floor stock system; Automated dispensing cabinets are secure option.				
50. Need policy and procedures for who can access medications after hours (night cabinet standard) Policy for single dose to patient: The Kansas Board of Pharmacy prohibits dispensing by anyone but a pharmacist. Retrieving a single dose for a single patient is appropriate.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
51. Policy and procedure on • Do not use abbreviations, • High alert drug list, • Safety recommendation for high alert medications, Quantities of medications dispensed to minimize diversion, • Limit overrides, • Return all meds in secure one-way return bin, etc.				
52. All Staff not just pharmacy MUST comply with applicable state law that governs the qualifications, certification, or licensure of staff who administer drugs and biologicals and must adhere to accepted standards of practice for medication administration.				
53. Current, accurate records of receipt & disposition of scheduled drugs; a policy covers control of distribution, use and disposition from entry to disposition; can readily identify loss/diversion; records available.				
54. Pharmacy records detail flow of drugs from entry to disposition.				
55. Pharmacy maintains control over drugs in all locations, including floor stock.				
56. Maintaining records related to requisitioning and dispensing drugs.				
57. Locked storage of scheduled drugs when not in use; keep accurate counts to show use; Reconcile any discrepancies in the counts.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
58. Ensure drugs are dispensed only by licensed pharmacist. Policy and procedure of oversite of pharmacist when Pharmacy Nurse is used. Only pharmacists or pharmacy-supervised staff compound, label and dispense drugs.				
59. Must have pharmacy labeling, inspection, and inventory management.				
60. Need to make sure no outdated drugs or mislabeled drugs. Each individual drug must be labeled with name, strength of drug, lot and control number and expiration date, including “beyond use date” as applicable.				
61. If multidose vial is opened, must have expiration date of 28 days on the label unless otherwise specified by the manufacturer.				
62. CAH must have a system for all staff to report adverse drug reactions and medication administration errors.				
63. Pharmacy services should be requested to assess all medication related incident reports to determine if problems or errors in pharmacy services caused or contributed to the adverse reaction or medication administration error.				
64. If a contracted service, how on-premises supervision is accomplished.				
65. If a contracted service, MEDICAL STAFF approves the contract.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
66. Pharmacist job description includes development, supervision, and coordination of all pharmacy services activities.				
67. Pharmacists and pharmacy technicians perform only those duties within the scope of their license/education.				
68. Pharmaceutical services can be provided as direct services or through an agreement. Does not require continuous on-premises supervision at the CAH's pharmacy. May be accomplished through regularly scheduled visits, and/or telemedicine in accordance with law and regulation and accepted professional principles.				
69. Emergency kit with adequate contents – not outdated.				
70. Policy and procedure for Medication Recalls including reporting of contaminated medications.				
71. Process for air-embolism Facility wide. SRE- Process for prevention, identification and/or reporting of death or serious injury associated with intravascular air embolism in the healthcare setting.				

PHARMACY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS

CLINICAL RECORDS/HEALTH INFORMATION MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
1. Health Information Management services should be under the direction of staff with ART or RRA. Unable to employ – the consultant/contract person should also hold above degree/certification. **(C-1106)**				
2. Must maintain clinical medical records system in acc ordance wit policy/procedures. **(C-1102 & C-0300)**				
3. Medical records policies review and revision periodically.				
4. Medical Records system ensures integrity of authentication and protects security of record entries.				
5. Medical Records department staff qualified & can comply with state federal law.				
6. Promptly completed in accordance with state, federal law. Have current list of authenticates signatures, computer codes and signature stamps. Protected and authorized by governing body, cross reference inpatient and outpatients.				
7. Limit access to only those authorized persons.				
8. What specific actions will constitute a security breech?				
9. How breech will be documented, including what information should be contained in the documentation.				

CLINICAL RECORDS/HEALTH INFORMATION MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
10. What breech events must be reported? How often and to whom? What information reports should include.				
11. Must cross reference inpatients and outpatients.				
12. If transfer to swing bed can use one medical record but need divider for coding/billing purposes a new encounter number must be provided for the SNF admission.				
13. Both inpatient and swing bed must have medical record- admission, discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries.				
14. Have a system that you are able to pull any old MEDICAL RECORD when past 10 years, 24/7 for inpatient and outpatient.				
15. Protect MEDICAL RECORD confidentiality and from damage, flood, fire etc.				
16. MEDICAL RECORD is legible, complete, accurate, readily accessible, systematically organized. **(C-1104)**				
17. Ensure accurate and complete documentation of all orders, test results, evaluation.				

CLINICAL RECORDS/HEALTH INFORMATION MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
18. Must have record of every patient encounter. Must maintain a record of each patient that includes dated signatures of the MD/DO or other health care professional. **(C-1118)**				
19. All orders authenticated within 72 hours.				
20. History and physical in medical record within 48 hours of admission.				
21. All procedures and tests are performed as ordered.				
22. Medical Record is complete within 30 days after patient discharge.				
23. Approved abbreviation list is updated and accessible to all who document in medical record.				
24. Entries in medical record- only done by those specified in the medical staff Policy/procedure can write in the medical record- need date, time and authenticated.				
25. If rubber stamp used- person must sign they will be the only one who uses it; must have sanctions for improper use of stamp, computer key or code signature.				
26. Computer or other code signatures are authorized by governing body.				
27. List of codes is maintained using adequate safeguards.				
28. Policies and procedures are in place and provide for appropriate sanctions for unauthorized/improper use of computer codes.				

CLINICAL RECORDS/HEALTH INFORMATION MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
29. Confidentiality, safeguards against loss, destruction or unauthorized use. **(C-1120)**				
30. Access to information limited to those who need to know.				
31. Safeguard medical record, videos, audio.				
32. Only authorized people can access medical record contained in department medical record				
33. Precautions are taken to prevent physical/electronic altering, damage/deletion/destruction of records or information in the record.				
34. Written policy/procedure govern the use and removal of medical record. **(C-1122)**				
35. Written policy/procedure govern release of information in medical record.				
36. Patient's written consent required for release of MEDICAL RECORD information not required by law. **(C-1124)**				
37. Ensure that records will be retained (i.e., through a written procedure) for at least 10 years from date of last entry. **(C-1126)**				
38. Is there a system in place to document the summary of all records destroyed.				

CLINICAL RECORDS/HEALTH INFORMATION MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
PATIENT CONFIDENTIALITY (C-1122)	YES	NO	N/A	FINDINGS/COMMENTS
1. Are patient records stored and maintained in a way and in a place to protect confidentiality?				
2. Are daily patient schedules located in a place the public cannot view?				
3. Is there a private area available for confidential discussions with patients?				
4. Is patient privacy ensured in patient rooms, exam rooms and treatment areas?				
5. Are the minimum necessary access standards used when granting access to PHI?				
6. Is there a double entry phone number process in place to protect confidentiality when faxing patient information?				
7. When Faxing information, is there a confidentiality statement included on the front page or cover sheet?				
8. Is faxing patient information done at a minimum?				
9. Is a written notice of privacy practices available to all patients?				
10. Do patients sign an acknowledgement stating they received the notice of privacy practices?				
11. Are all staff members given education on HIPAA and HITECH privacy requirements at the time of their hire and annually thereafter?				
12. Are up-to-date and signed business associate agreements on file with all venders who have access to patient information?				
13. When emailing PHI, is it sent via a secure email or through the patient portal?				

CLINICAL RECORDS/HEALTH INFORMATION MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS

HOSPITAL PERSONNEL	YES	NO	N/A	FINDINGS/COMMENTS
1. See the Kansas Hospital Regulations pg. 14				
2. There will be an adequate administrative staff to provide effective management of the hospital.				
3. Chief executive officer shall be appointed by the governing body/board of trustees.				
4. Policies and procedures for personnel that adequately support sound patient care. • Policies and Procedures will be reviewed and signed every two years. • Policies and procedures are available to all employees • A procedure is in place to advise and educate employees on changes to policies and procedures.				
5. Personnel Records for each employee shall be accurate, complete and contain at a minimum: • Employee's education, training and experience to verify the qualifications for the employee's job/position including professional licensure status as required. • Periodic performance evaluations • Record of initial health examination, subsequent health services and periodic health evaluations related to employment.				
6. Orientation and in service training programs provided to allow personnel to improve and maintain skills. Education in new healthcare techniques, knowledge, procedures is provided.				
7. Competency and skills testing ensures all staff are competent for duties upon hire and as required with new/ongoing assignments, equipment, tasks, or guideline updates/best practice standards – facility wide.				

HOSPITAL PERSONNEL	YES	NO	N/A	FINDINGS/COMMENTS
8. Upon employment all hospital personnel will have a medical evaluation which is appropriate to the duties of the job description and to include a tuberculin skin test or chest x-ray. Subsequent medical examinations or health assessments given periodically in accordance with hospital policies.				
9. Policies and procedure for control of communicable disease including maintenance of immunization histories and the provisions of educational materials for patient care staff.				
10. Assist Employee health and Infection control in development and implementation policies to ensure that all staff are fully vaccinated for COVID-19 as appropriate. See CMEDICAL STAFF Memo to Surveyors QSO 23-02-All **(C-1260)**				
11. Policy Social Media Expectations. All staff are trained in the appropriate use of social media in relationship to the facility and or their job duties that will not unnecessarily expose the facility to liabilities.				
12. Policy Compliance training. All staff are trained on compliance modules including but not limited to: • HIPAA Privacy & Security for Covered Entities • Back Care / Ergonomics • Bloodborne Pathogens for Healthcare Workers • Fire Safety and Emergency Evacuation • Hazard Communication for Healthcare • Personal Protective Equipment (PPE) for Healthcare Workers • Preventing Workplace Violence in Healthcare Settings.				

INFORMATION TECHNOLOGY	YES	NO	N/A	FINDINGS/COMMENTS
1. HITECH-Cyber security policies & procedures. (**C-1122)** (KAMMCO – Breach Solutions website)				
2. Purpose and governance.				
3. Assess the state of facility program.				
4. Create and/or update policies.				
5. Cyber/HIPAA incident response plans.				
6. Employee education and training.				
7. Vendor management.				
8. Data Collection and transfer.				

FOOD & DIETARY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Director is Licensed Dietician. If contracted service – consultant must be Licensed Dietician. **(C-1020 & KS Hosp Regs 28-34-14)**				
2. Individual principally responsible for the CAH's operations are responsible for agreements and oversight of those services.				
3. All agreements require the contractor to provide services in compliance with CoPs.				
4. Agreement for food, nutritional services not provided directly by the CAH is available. **(C-1040)**				
5. Keep a list of all contracted/agreement services is maintained, current, describes scope.				
6. Must include services offered, individual or entity that is providing it, and whether on or off-site.				
7. Must include if any limit on the volume or frequency of the services provided.				
8. Update list each time services added or removed.				
9. USDA dietary guidelines http://www.health.gov/dietaryguidelines. **(C-1020)**				
10. If the CAH furnishes inpatient services, procedures must be in place that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practice.				

FOOD & DIETARY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
11. All diets are ordered by a practitioner responsible for patient OR qualified dietician or nutrition professional authorized by medical staff and per state law.				
12. Dietary P&Ps are reviewed biennially by group of professional personnel per requirements.				
13. Policy and procedures for services provided. Must include storage, service and preparation, safety of patient and staff. All food items inspected, and FDA approved.				
14. Food item storage areas. Separate from preparation/serving areas, must be off floor and off refrigerator/freezer/walk in cooler floors.				
15. Storage areas are stocked properly and securely stacked, stored racks, shelves, or pallets.				
16. Storage areas are maintained with aisles clear, storage room orderly, floor free from debris, storage has proper clearances from hot water heater, electrical panels, and sprinkler heads.				
17. Shelving and racks in good repair and secured to avoid tipping.				
18. Step ladders/step stools provided and in good repair.				
19. Food item temperatures monitored. Refrigeration must be monitored for consistency. Food in freezers may not rise above $0^{o}F$.				
20. Refrigeration and air conditioning compressors clean, well ventilated, kept clear of combustibles.				
21. Walk in cooler and freezer doors provided with operable inter release mechanisms.				

FOOD & DIETARY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
22. Walk in cooler and freezer provided with moister-proof lighting globes and wiring conduit				
23. When restocking, new stock placed at rear and older stock moved up to front for use first				
24. Cartons are inspected for damage; expiration dates are checked regularly. Spoiled/damaged food is disposed of promptly and properly				
25. Waste containers cleaned daily, area is free of debris, spilled food, grease etc.…				
26. Waste materials stored in containers with tight fitting lids and kept in designated areas. Waste is removed daily.				
27. Preparation and serving areas kept in sanitary manner. Separate handwashing facilitates in food prep/serving area.				
28. Storage of toxic agents shall be prohibited in food prep/serving areas.				
29. Dishwashing Temperatures. Washed at 140°F and rinsed at 180°F				
30. Food Transport - Containers/carts clean and held at appropriate temperatures.				
31. Appropriate attire in food prep/serving areas • washable garments, • hairnets/clean caps, • hands and fingernails clean at all times • Personal protective equipment used where determined necessary, i.e., gloves, Kevlar cutting gloves, safety shoes.				
32. Dishes and utensils taken out of service or discarded when chipped, cracked, or broken.				
33. Work areas free from glass materials.				
34. Electrical systems and equipment provide adequate overload protection and grounding and wiring in good condition.				

FOOD & DIETARY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
35. Dollies or other handling/transport equipment available for moving heavy loads.				
36. Power equipment guarded and maintained.				
37. Proper number, size, and type of fire extinguisher clearly marked and mounted and accessible.				
38. Adequate outlets and covers provided with controlled use of gang plugs.				
39. Proper storage of knifes.				
40. Knifes properly sharpened.				
41. Cutting boards used for cutting.				
42. Slicers have guards in place and unplugged when not in use.				
43. Mixer bolted to stable counter/floor as appropriate with movable parts able to move freely.				
44. Food chopper with guard in place and unplugged when not in use.				
45. Tilting Fry pan direct circuit electrical connections.				
46. Dishwashing Machine free from water leaks.				
47. Food warmers with casters in locked position and located in non-traffic areas.				
48. Steamer pans water at safe level, doors open and close freely, doors lock properly.				
49. Ovens pilot lights in operation and oven doors open and close properly.				
50. Deep Fat Fryer controls in good condition and appropriate temperatures with basket handles at appropriate lengths for safe handling.				

FOOD & DIETARY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
51. Emergency Policy available and staff educated on policy. Emergency phone numbers available, fire, police, safety officer.				
52. First Aid kit available and contents replenished as used.				
53. Accidents/injuries investigated promptly by safety officer/employee health personnel.				

LAUNDRY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
1. Individual principally responsible for the CAH's operations is responsible for agreements and oversight of those services. **(KS Hosp Reg 28-34-15)**				
2. All agreements require the contractor to provide services in compliance with CoPs.				
3. Keep a list of all contracted/agreement services is maintained, current, describes scope. Must include services offered, individual or entity that is providing it, and whether on or off-site.				
4. Update list each time services added or removed.				
5. Clean linen storage separates from other storage.				
6. Clean linen covered during transport.				
7. Dirty linen area separates from clean areas and identified to all staff.				
8. Infectious/Isolation linen labeled.				
9. Infectious/Isolation linen washed at appropriate temperatures per facility infection control policy.				
10. Appropriate personal protective equipment available and used by staff.				
11. Laundry washed/dried at appropriate temperatures. Wash temperature at a minimum of 165^{o}F for 25 minutes.				
12. Maintenance of laundry equipment.				
13. Electrical systems and equipment provide adequate overload protection and grounding and wiring in good condition.				
14. Washers free from leaks.				

LAUNDRY SERVICES	YES	NO	N/A	FINDINGS/COMMENTS
15. Storage areas are stocked properly and securely stacked, stored racks, shelves, or pallets.				
16. Storage areas are maintained with aisles clear, storage room orderly, floor free from debris, storage has proper clearances from hot water heater, electrical panels, and sprinkler heads.				
17. Shelving and racks in good repair and secured to avoid tipping.				

CONSTRUCTION & MAINTENANCE	YES	NO	N/A	FINDINGS/COMMENTS
1. Building & equipment maintenance part of the QA program, this applies to all campuses, satellites, inpatient and outpatient locations. (C-0910)				
2. CAH is constructed, arranged, and maintained to ensure access to and safety of patients and provides adequate space for the provision of direct services. **(C-0912)**				
3. There is adequate space for the scope of services required to be provided on-site.				
4. Buildings are maintained to ensure safety and well-being of patients.				
5. Design of the facility assures staff can reach patients readily.				
6. Individual principally responsible for the CAH's operations is responsible for agreements and oversight of those services.				
7. Must have housekeeping and preventative maintenance programs: routine, preventive, handling spills. **(C-0914)**				
8. There is a list of all facility and medical equipment including specific equipment information, such as ID number, manufacturer, serial number, etc.				
9. Equipment used for the first time is inspected and tested.				
10. Individual responsible for overseeing the equipment maintenance program and activities are qualified.				

CONSTRUCTION & MAINTENANCE	YES	NO	N/A	FINDINGS/COMMENTS
11. All essential mechanical, electrical and patient-care equipment is maintained in safe operating condition. (supplies and equipment must be maintained)				
12. Building maintenance program: routine, preventive and inspections.				
13. Patient care equipment maintenance program: routine, preventive, storage.				
14. How do you ensure your equipment is maintained properly (boilers, elevators, air compressors, ventilators, X-ray equipment, IV pumps, kitchen freezer/refrigerator, laundry equipment)?				
15. Have a policy and procedures which address the effectiveness of the CAHs alternative equipment maintenance (AEM) program.				
16. AEM Program- demonstrate that CAH is performing risk-based assessments, preventative maintenance, or establishing the AEM program.				
17. Maintain a written inventory of all medical equipment or written inventory of selected equipment categorized by risk assessment.				
18. Identify in writing how to maintain, inspect and test the medical equipment on the inventory. Could a malfunction have been prevented? What steps needed to prevent future malfunctions? How a determination is made whether or not the malfunction resulted from the use of an AEM strategy.				

CONSTRUCTION & MAINTENANCE	YES	NO	N/A	FINDINGS/COMMENTS
19. What is the process for removal from service of equipment determined to be unsafe or no longer suitable for its intended application.				
20. The use of performance data to determine if modification is in the AEM program procedures are required				
21. Maintenance/Safety: Waste disposal must be disposed of in accordance with standards (EPA, OSHA, CDC, environmental and safety), includes radioactive materials				
22. There must be proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas. **(C-0926)**				
23. Building Exterior/parking area well maintained.				
24. Backup power supply. (At a minimum back up power supply to critical care areas and critical infrastructure areas.)				
25. Maintenance/Safety: Smoking Policies (Staff, visitors, patients' safeguards in place.)				
26. Maintenance/Safety: Slip/Trip/Fall prevention (Are safeguards, reporting and active surveillance in place?) (Death or serious injury associated with fall.)				
27. Maintenance/Safety: Process for Injury due to Device malfunction or misuse. (Processes for prevention, identification and reporting patient death or serious injury due to the malfunction or misuse of devices provided in the healthcare setting including burns, electric shock and electrocution.)				

CONSTRUCTION & MAINTENANCE	YES	NO	N/A	FINDINGS/COMMENTS
28. Maintenance/Safety: Medical gases administered (Prevention, identification and/or reporting when systems designated for medical gases administration is corrupt or contain the wrong gas.)				
29. Maintenance/Safety: Criminal events (Prevention, identification and/or reporting when a patient or staff member impersonates a licensed professional, abducts another patient or staff member, commits sexual assault or assaults someone in the healthcare setting.)				

HOUSEKEEPING SERVICES & GENERAL SANITATION	YES	NO	N/A	FINDINGS/COMMENTS
1. Individual principally responsible for the CAH's operations is responsible for agreements and oversight of those services.				
2. Must have housekeeping and preventative maintenance programs: routine, preventive, handling spills.				
3. Need policies for proper routine storage and prompt disposal of trash. (includes biohazardous waste) **(C-0920)**				
4. Premises clean and orderly and uncluttered with equipment not stored in corridors, spills not left unattended, no peeling paint et al. **(C-0924)** Will look at walls, ceilings and floors, maintenance log.				
5. Suitable equipment shall be provided for the regular cleaning of all interior surfaces. **(KS Hosp Regs 28-34-31)**				
6. Operating and delivery rooms shall be thoroughly cleaned after each operation or delivery.				
7. Patient rooms shall be thoroughly cleaned after discharge.				
8. No wax shall be applied to conductive floors which will render them nonconductive.				
9. Adequate and conveniently located spaces shall be provided for the storage of janitorial supplies and equipment.				
10. Housekeeping procedures shall be written.				

HOUSEKEEPING SERVICES & GENERAL SANITATION	YES	NO	N/A	FINDINGS/COMMENTS
11. All garbage and waste shall be collected, stored, and disposed of in a manner that will not encourage the transmission of contagious disease.				
12. Containers shall be washed and sanitized before being returned to work areas or shall be disposable.				
13. All openings to the outer air shall be effectively protected against the entrance of insects and other animals by self-closing doors, closed windows, screening, controlled air currents, or other effective means.				
14. A sufficient supply of cloth or disposable towels shall be available so that a fresh towel can be used after every handwashing. Common towels are prohibited.				
15. There shall be adequate handwashing facilities conveniently located.				
16. Common drinking cups shall be prohibited.				
17. Dry sweeping and dusting shall be prohibited. Use of a rotary buffer shall be prohibited in areas such as isolation to aid in reducing the spread of pathogenic bacteria.				
18. Adequate and conveniently located toilet facilities shall be provided.				
19. Periodic checks shall be made throughout the buildings and premises to enforce sanitation procedures. The times and results of such checks shall be recorded.				

HOUSEKEEPING SERVICES & GENERAL SANITATION	YES	NO	N/A	FINDINGS/COMMENTS

INFECTION PREVENTION	YES	NO	N/A	FINDINGS/COMMENTS
1. Infection Preventionist who is qualified by education and experience to be responsible for (include in job description); for CAH Infection Control Program. **(C-1200)**				
2. Infection Preventionist is appointed by the Board upon recommendations of medical staff and nursing leadership. **(C-1204**)				
3. The infection prevention and control professional(s) is responsible for all documentation, written or electronic of the infection prevention and control program and its surveillance, prevention and control activities. **(C-1235**)				
4. The infection prevention and control professional(s) is responsible for communication and collaboration with the CAH's QAPI program on infection prevention and control issues. **(C-1237)**				
5. The infection prevention and control professional(s) is responsible for competency-based training and education of the CAH personnel and staff, including medical staff and as applicable personnel providing contracted services in the CAH on the practical applications of infection prevention and control guidelines, policies and procedures. **(C-1239)**				
6. Program has policies and procedures documenting methods used for preventing and controlling transmission of infections within and between healthcare settings. **(C-1206)**				

INFECTION PREVENTION	YES	NO	N/A	FINDINGS/COMMENTS
7. Establish a written infection control plan – Aseptic techniques, universal precautions. Inspect and clean air-intake sources, screens, and filters following manufacturer's recommendations and hospital policy. **(C-1200)**				
8. CAH has an active facility-wide program for surveillance, prevention and control of HAIs and other infectious diseases. **(C-1231)**				
9. Must follow nationally recognized infection control practices or guidelines. (CDC, APIC, SHEA, AORN and OSHA)				
10. Program addresses optimization of antibiotic use.				
11. Infection prevention and control and antibiotic use issues are addressed in QAPI program.				
12. Program includes surveillance, prevention, and control of HAI. **(C-1208)**				
13. Program includes maintaining a clean and sanitary environment to avoid transmission of infection.				
14. Program includes infection control issues identified by public health authorities.				
15. Infection prevention and control program reflects scope and complexity of service provided. **(C-1210)**				

INFECTION PREVENTION	YES	NO	N/A	FINDINGS/COMMENTS
16. Healthcare associated infections are monitored in All patient care services and other services affecting patient health & safety.				
17. Evaluate the quality of care of allied staff (NP, PA, CNS) by doctor on MEDICAL STAFF or under contract.				
18. Does CAH evaluate nosocomial infections?				
19. Is there an infection control program established, meetings held, findings discussed and problems addressed?				
20. Does the CAH evaluate medication therapy in relationship to treatment of infectious processes and disease?				
21. Committee established, meetings held, findings discussed, problems addressed (e.g. med errors)?				
22. Does the facility have an environmental cleaning program that consists of written policies and procedures for routine cleaning and disinfection of environmental surfaces?				
23. Are clinical staff involved in planning for and implementing the environmental cleaning program?				
24. Does the facility have clearly written expectations for health care employees on performing the cleaning tasks outlined in the environmental cleaning plan?				
25. Are procedure areas terminally cleaned after the last procedure of the day with a wet vacuum or single-use mop and an EPA-registered hospital-grade disinfectant?				

INFECTION PREVENTION	YES	NO	N/A	FINDINGS/COMMENTS
26. Are high-touch surfaces in patient care areas cleaned and disinfected with an EPA-registered disinfectant after each procedure in rooms where surgical or other invasive procedures are performed?				
27. Do facility employees who perform environmental cleaning wear appropriate personal protective equipment (e.g., gloves, gowns, masks, and eye protection) to prevent exposure to infectious agents and chemicals?				
28. Are sharps containers properly maintained, labeled and puncture resistant?				
29. Do staff members follow universal precautions and wash their hands or using alcohol-based products between patients?				
30. Are alcohol-based hand rubs available in-patient care areas?				
31. Are biohazard bags readily available and used appropriately for handling and disposing of hazardous materials?				
32. Are linen carts covered or is the linen storage door closed at all times?				
33. Are specimens, medications, and food refrigerated per policy?				
34. Is the temperature of refrigerators and freezers checked daily?				
35. No patient supplies or linens are stored under the sink.				
36. Are employees able to identify and describe the correct procedure for reporting blood-borne pathogen exposure?				

INFECTION PREVENTION	YES	NO	N/A	FINDINGS/COMMENTS

INFECTION PREVENTION – VACCINATION STATUS	YES	NO	N/A	FINDINGS/COMMENTS
Please see full set of requirements at: www.cms.gov/files/document/qs0-23-02-all.pdf				
1. Standard: COVID-19 Vaccination of CAH staff. The CAH must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID19. **(C-1260)**				
2. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.				
3. Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following CAH staff, who provide any care, treatment, or other services for the CAH and/or its patients: (i) CAH employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the CAH and/or its patients, under contract or by other arrangement.				

INFECTION PREVENTION – VACCINATION STATUS	YES	NO	N/A	FINDINGS/COMMENTS
4. The policies and procedures of this section do not apply to the following CAH staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the CAH setting and who do not have any direct contact with patients and other staff specified in paragraph (f)(1) of this section; (ii) Staff who provide support services for the CAH that are performed exclusively outside of the CAH setting and who do not have any direct contact with patients and other staff specified in paragraph (f)(1) of this section.				
5. The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the CAH and/or its patients.				
6. A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by CDC, due to clinical precautions and considerations.				

INFECTION PREVENTION – VACCINATION STATUS	YES	NO	N/A	FINDINGS/COMMENTS
7. A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19.				
8. A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified.				
9. A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by CDC.				
10. A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law.				
11. A process for tracking and securely documenting information provided by those staff who have requested, and for whom the CAH has granted, an exemption from the staff COVID-19 vaccination requirements based on recognized clinical contraindications or applicable Federal laws.				
12. A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains required information.				
13. All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications.				

INFECTION PREVENTION – VACCINATION STATUS	YES	NO	N/A	FINDINGS/COMMENTS
14. A statement by the authenticating practitioner recommending that the staff member be exempted from the CAH's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications.				
15. A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment.				
16. Contingency plans for staff who are not fully vaccinated for COVID-19.				

FIRE & LIFE SAFETY	YES	NO	N/A	FINDINGS/COMMENTS
1. Life safety plan. Meet Life Safety Code of the National Fire Protection Association (2-hour fire wall). (C-0930)				
2. Corridor doors and doors to rooms containing flammable/combustible maters have only positive latching hardware, no roller latches. (C-0930)				
3. CMS waiver provided – when application resulted in unreasonable hardship and does not adversely affect health and safety of patients. **(C-0932)**				
4. Maintain written evidence of regular inspection and approval by state and or local fire control agencies. **(C-0934)** Surveyor will examine copies of inspection and approval reports from State and local fire control agencies.				
5. Alcohol-based hand rub dispensers are installed to protect against inappropriate access. (NEW) **(C-0936)**				
6. When sprinkler systems are down for more than 10 hours the building/portion affected are evacuated or fire watch is instituted. (NEW) (**C-0938)**				
7. Every sleeping room has an outside window/door. (NEW) **(C-0940)**				
8. Sill height do not exceed 36 inches above the floor; do not apply to nursery and rooms occupied less than 24 hours; special nursing care nursing does not exceed 60 inches. (NEW)				

FIRE & LIFE SAFETY	YES	NO	N/A	FINDINGS/COMMENTS
9. Waiver present – specific provisions of Life Safety Code resulted in unreasonable hardship and no adverse effect to health/safety of patients. (NEW) **(C-0942)**				
10. Applicable provisions and steps to meet requirements of Health Care Facilities Code are met unless waiver provided. (NEW) **(C-0944)**				
11. Are all fire exits clearly marked and free of obstructions? **(K-0293)**				
12. Are all fire exits unlocked from the inside?				
13. Maintenance, Inspection and Testing of Fire/Smoke doors. Logs are kept. **(K-0761)**				
14. Are doors free of obstructions and not propped open? **(K-0211)**				
15. Do all fire doors close properly? **(K-0222)**				
16. Is the fire plan, including the emergency evacuation routes and maps, posted?				
17. Are fire extinguishers inspected per schedule?				
18. Does storage conform to the fire code: 18 inches below sprinkler heads and 12 inches below ceiling grade in non-sprinkled areas?				
19. Are oxygen and medical gas shut off valves clearly labeled?				
20. Do staff members understand and can they verbalize the procedure for emergency oxygen and medical gas shut off?				
21. Are oxygen tanks secured in storage?				
22. Is equipment is stored appropriately (i.e., not in stored in hallways)?				

FIRE & LIFE SAFETY	YES	NO	N/A	FINDINGS/COMMENTS
23. Can staff members correctly identify and verbalize the RACE process? (RACE: Rescue, Alarm, Contain, Extinguish or Evacuate)				
24. Can staff members correctly identify and verbalize the PASS process? (PASS: Pull, Aim, Squeeze & Sweep)				
25. Is the building equipped with smoke detectors, pull stations, and fire extinguishers, and are they all checked and tagged within the last year?				
26. Ensure the Fire Safety Survey Report is reviewed in its entirety and all areas addressed below are areas routinely cited. https://firemarshal.ks.gov/DocumentCenter/View/641/Fire-Safety-Survey-Report-2012-Code-PDF				
27. Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. **(K-0291)**				
28. Fire Alarm – Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. **(K-0344)**				
29. Fire Alarm System – Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. **(K-0345)**				

FIRE & LIFE SAFETY	YES	NO	N/A	FINDINGS/COMMENTS
30. Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection, and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. _____ b) Who provided system test. _____ c) Water system supply source. _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. **(K-0353)**				
31. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms**. (K-0712)**				
32. Gas and Vacuum Piped Systems – Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. **(K-0908)**				

FIRE & LIFE SAFETY	YES	NO	N/A	FINDINGS/COMMENTS
33. Electrical Systems – Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. **(K-0914)**				

FIRE & LIFE SAFETY	YES	NO	N/A	FINDINGS/COMMENTS
34. Electrical Systems – Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. **(K-0918)**				

FIRE & LIFE SAFETY	YES	NO	N/A	FINDINGS/COMMENTS
35. Electrical Equipment – Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.**(K-0920)**				

HAZARD CONTROL	YES	NO	N/A	FINDINGS/COMMENTS
1. For the full review of Hazard Control see https://firemarshal.ks.gov/DocumentCenter/View/641/Fire-Safety-Survey-Report-2012-Code-PDF And https://www.osha.gov/healthcare/standards				
2. Are material safety data sheet (MEDICAL STAFFDS) signs posted and is MEDICAL STAFFDS information available for each chemical used in the clinic or facility?				
3. Are ceiling tiles free from stains and discoloration?				
4. Are bio-medical stickers present on all equipment?				
5. Can staff members correctly identify the procedure for handling defective equipment or equipment involved in patient incidents?				
6. Are stocked products within their use date?				
7. Are stairwell doors closed, and are stairwells clean and free of debris?				
8. Are areas of construction or remodeling secured, and are appropriate barriers in place for infection control?				
9. Are surgical gases stored in a locked area?				
10. Is contaminated waste labeled BIOHAZARD or deposited in a red bag or appropriate container?				
11. Are all sterilized items labeled and dated?				
12. Are clean and dirty equipment kept in separate areas?				
13. Are all medical supplies audited and with their use date?				
14. Are disinfectant containers properly labeled?				
15. Is there a plan and procedure for biomedical waste disposal?				
16. Procedures for Respiratory infection.				

HAZARD CONTROL	YES	NO	N/A	FINDINGS/COMMENTS
17. Procedures for eye and face protection, chemical and biohazard.				
18. Procedures for occupational hazards to chemicals in laboratories.				
19. Policies and procedures for Tuberculosis testing, employee protection.				

EMERGENCY PREPAREDNESS	YES	NO	N/A	FINDINGS/COMMENTS
1. CMS Emergency Preparedness final rules can be found in CoP's Appendix Z				
2. Facilities that also have LTC should review this checklist for that unit. **(C-0950)** CMEDICAL STAFF Emergency preparedness checklist http://www.cMedical Staff.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/HealthCareProviderGuidance.html				
3. Emergency preparedness plan developed, maintained, reviewed and updated every 2 years.				
4. Documented, facility-based and community-based risk assessment utilizing an all hazards approach.				
5. Includes strategies to address emergency events per the risk assessment.				
6. Addresses patient populations.				
7. Includes process for cooperation and collaboration with local, tribal, regional, state and federal emergency officials.				
8. Policies and procedures are in place and reviewed/updated every 2 years.				
9. Provisions for subsistence needs for all.				
10. Tracking of staff and patients.				

EMERGENCY PREPAREDNESS	YES	NO	N/A	FINDINGS/COMMENTS
11. Safe evacuation from facility.				
12. Means to shelter in place.				
13. System for medical documentation to maintain confidentiality.				
14. Use of volunteer or other emergency staff.				
15. Arrangement with other CAH/providers to receive patients.				
16. A communication plan is developed and in place and reviewed every 2 years.				
17. Training and testing of the plan are completed every 2 years with supporting documentation along with.				
18. Annual exercises are conducted annually – full-scale and one additional exercise.				
19. Assure safety of patient in non-medical emergencies.				
20. Emergency and standby power systems are in place.				
21. If part of an integrated health system – each facility is complying.				
22. Staff trained in handling emergencies such as reporting and extinguishing of fires, evacuations, et al. Validate training with in- service records.				

EMERGENCY PREPAREDNESS	YES	NO	N/A	FINDINGS/COMMENTS
23. Report all fires to state officials.				
24. Surveyor will interview staff to make sure they know what to do in case of a fire, tornado, blizzard.				
25. Emergency power and lighting – National Fire Protection Amendments (NFPA) 101, 2000 Edition and applicable Facilities, for emergency lighting and emergency power in ED and for battery lamps or flashlights in other areas.				
26. Must comply with the applicable provisions of the Life Safety Code.				
27. Emergency fuel and water supplies, have a plan to and to other persons who may come to the CAH in need of care.				
28. Includes making arrangements with local utility companies and others for the provision of emergency source of water and gas.				
29. Have a plan for prioritizing their use until adequate supplies are available.				
30. Policy & procedure addressing specific conditions (snowbound facility, spring flooding, etc.) in comprehensive emergency preparedness plan.				
31. Must develop a comprehensive plan to ensure that the safety and wellbeing of patients are assured during an emergency situation.				
32. Coordinate with federal, state, and local emergency preparedness and health authorities to identify likely risks for the area.				

EMERGENCY PREPAREDNESS	YES	NO	N/A	FINDINGS/COMMENTS
33. Considerations when developing the comprehensive emergency plan; • Differences needed for each location where the certified CAH operates, • special needs of patient populations treated at the CAH (e.g., patients with psychiatric diagnosis, patients on special diets, newborns, etc.) • Security of patients and walk in patients • Security of supplies from misappropriation • Pharmaceuticals, food, other supplies and equipment that may be needed during emergency/disaster situations • Communication to external entities if telephones and computers are not operating or become overloaded • Communication among staff within the CAH itself • Qualifications and training needed by personnel, including healthcare staff, security staff, and maintenance staff, to implement and carry out emergency procedures • Identification, availability and notification of personnel that are needed to implement and carry out the CAHs emergency plan • Identification of community resources, including lines of communication and names and contact information for community emergency preparedness coordinators and responders • Provisions for gas, water, electricity supply is access is shut off to the community • Transfer of discharge of patients to home or other healthcare settings. • Methods to evaluate repairs needed and to secure various likely materials and supplies to effectuate repairs.				

EMERGENCY PREPAREDNESS	YES	NO	N/A	FINDINGS/COMMENTS

ORGAN DONATION	YES	NO	N/A	FINDINGS/COMMENTS
1. Must have written policies/procedures that address organ procurement responsibilities. **(C1500)**				
2. Written agreement with OPO & OPO's responsibilities. **(C-1503)**				
3. Written agreement includes criteria for referral, definition of imminent death, timely notification. Survey and Certification 13-48-OPO CMS July 26, 2013 all hospitals have written agreements in place with their OPO to notify them of an imminent death or of a death which has occurred. OPO regulations at §486.322 (a) require that OPOs have a written agreement in place with 95 percent of all participating Medicare and Medicaid hospitals and Critical Access Hospitals that have both a ventilator and an operating room.				
4. Includes agreement with at least one tissue bank and at least one eye bank. **(C1505)**				
5. Ensures the family of each potential donor is informed of the option of donating- designated requestor. **(C-1507)**				
6. Encourages discretion, sensitivity to family. **(C-1509)**				
7. Works with OPO in death records review to improve identification of potential donors.**(C-1511)**				
8. This standard includes staff training on donation issues and their duties/roles- see the interpretation guidelines for all required elements of staff training.				

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT PROGRAM	YES	NO	N/A	FINDINGS/COMMENTS
1. A CHA-wide data-driven quality assessment and performance improvement program has been developed, implemented, and maintained. There is evidence of the effectiveness of the QAPI program. **(C-1300/C-0330)**				
2. The complexity of the QAPI is appropriate to the CAH's size and services provided. **(C-1302/C-0331)**				
3. The QAPI program is ongoing. **(C-1306/C-0332)**				
4. The program includes all department of the hospital.				
5. Not less than 10% of both active and closed patient records. **(C-0333)**				
6. Health care policies evaluated, reviewed and/or revised as part of Evaluation. **(C-0334)**				
7. Determine whether utilization appropriate, policies followed, and changes needed. **(C-0335)**				
8. Quality Assurance: program is effective, ongoing, evaluation the quality and appropriateness of diagnosis and treatment furnished and treatment outcomes. **(C-1309/C-0336)**				
9. Can be done under contract if communication channels established. **(C-1311)**				
10. Includes ongoing monitoring and data collection.				
11. Problem prevention, identification, and data analysis.				
12. Identification of corrective actions.				
13. Implementation of corrective actions.				

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT PROGRAM	YES	NO	N/A	FINDINGS/COMMENTS
14. Evaluation of corrective actions.				
15. Measures to improve quality continuously.				
16. QA program to evaluate appropriateness of diagnosis and treatment and in treatment outcomes.				
17. Facility wide QA/QI program; Can have QA by arrangement; QI plan and mention in QI minutes.				
18. Governing body ensures the program meets all the CoPs. **(C-1313)**				
19. The program sets priorities for PI considering either high volume, high-risk services, or problem-prone areas. **(C-1315)**				
20. MD/DO care evaluated by hospital who is a member of the network; QIO or equivalent entity; appropriate & qualified entity identified in the state rural health care plan. **(C-0340)**				
21. CAH have an arrangement for outside entity to review the appropriateness of the diagnosis and treatment provided by each MD/DO providing services; This includes doctors providing telemedicine services.				
22. Some CAHs may also prefer to conduct their own internal review in addition to the outside review but not required.				
23. Staff consider the findings and evaluations and recommendations of the evaluations and take corrective action. **(C-0341)**				
24. Take steps to remedial action to address deficiencies found through quality assurance, performance improvement.				
25. Identify who is responsible for implementing actions.				

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT PROGRAM	YES	NO	N/A	FINDINGS/COMMENTS
26. CAH takes appropriate remedial action to address deficiencies found thru QI Process**. (C-0342)**				
27. CAH documents the outcome of all remedial actions. **(C-0343)**				

CRITICAL ACCESS HOSPTIAL RISK ASSESSMENT

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
1. Risk Professional directs the risk management program. **(KS Hosp Reg 28-52-1)**				
2. Risk Management Plan -review the KDHE RM Plan checklist to ensure required criteria is met. (The actions of the facility follow the plan)				
3. Risk Management plan is updated annually and approved by the Board of Trustees/Governing Body.				
4. Risk Management plan is approved by KDHE Risk Management department – submit plan to KDHE at least 60 days prior to the due date.				
5. Amendments and additions/subtractions are submitted to KDHE for approval after facility Board of Trustees/Governing Body approval. Must occur within 60 days of changes.				
6. All facility staff, medical staff, contract staff have access to the Risk Management plan and have received education on the plan.				
7. Mandatory Quarterly reports are submitted to KDHE as required.				
8. Description of Risk Mitigation – What measures does the facility use to minimize patient safety occurrences?				
9. Contracted services and providers are reviewed. All services must be reviewed for appropriate care – this can be completed through QA.				
10. All staff, medical staff and contracted staff know how to report an incident or who to report an incident to (the risk manager, CEO or chief of medical staff).				
11. Reports are sent to the correct committees for review.				

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
12. Committee reports of standard of care (SOC). All risk management committees report SOC 3 and SOC 4 to the licensing agencies appropriately and take appropriate actions				
13. Confidential Information – All incident report investigations, SOC, corrective actions, and committee proceeding relating to the incident are held confidential and privileged.				
14. An Incident reporting system is in place. All incidents go directly to the correct person. Acknowledgement of the incident report is documented – The Risk Manager, CEO or Chief of Staff will ensure an electronic time stamp or file stamp is documented on each report, maintain a chronological risk management report log, sign/initial/enter into a data base reporting system.				
15. Risk Management Record Retention. (Risk Management protected information will be maintained in the facility for not less than 1 year following completion of the risk process, including completed corrective action plans). If there is a potential for a claim related to an incident the incident/investigation/outcome/actions should be kept until either a claim is brought forth or the statute of limitations is past.				
16. Risk Management Committees are functioning per the Risk Management Plan.				
17. RM Committees meet at least quarterly. (Documentation of meeting minutes – Keep minutes at least from survey to survey)				

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
18. Standard-of-care determinations. (a) Each facility shall assure that analysis of patient care incidents complies with the definition of a "reportable incident" set forth at K.S.A. 65-4921. Each facility shall use categories to record its analysis of each incident, and those categories shall be in substantially the following form: (1) Standards of care met; (2) standards of care not met, but with no reasonable probability of causing injury; (3) standards of care not met, with injury occurring or reasonably probable; or (4) possible grounds for disciplinary action by the appropriate licensing agency. (KS Hosp Reg 28-52-4) (What happens with non-clinical incident reports?)				
19. A description of the system implemented by the facility for investigation and analysis of the frequency and causes of reportable incidents within the facility.				
20. Findings, conclusions, recommendations, actions taken, and results of actions taken shall be documentation and reported through procedures established within the Risk Management Plan.				
21. SOC assignments Each reported incident shall be assigned an appropriate standard-of-care determination under the jurisdiction of a designated risk management committee. Separate standard-of-care determinations shall be made for each involved provider and each clinical issue reasonably presented by the facts. Any incident determined by the designated risk management committee to meet category (a) (3) or (a) (4) shall be considered a “reportable incident” and reported to the appropriate licensing agency in accordance with KSA 65 -4923.				

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
22. Each standard-of-care determination shall be dated and signed by an appropriately credentialed clinician authorized to review patient care incidents on behalf of the designated committee. In those cases, in which documented primary review by individual clinicians or subordinate committees does not occur, standard-of-care determinations shall be documented in the minutes of the designated committee on a case-specific basis. Standard-of-care determinations made by individual clinicians and subordinate committees shall be approved by the designated risk management committee on at least a statistical basis. (Authorized by and implementing K.S.A. 65-4922; effective February 27, 1998.) (Each incident report is investigated and the name of the individual along with the risk manager will be on the incident report in the reporting system or signed on the investigation.)				
23. MD/DO evaluations quality & appropriateness of PA, NP, or CNS. How is this documented for the evaluation? **(C-0339)**				
24. How does the physician inform the CAH of any problems with the care provided by the advanced practitioners?				
25. Are CRNA's evaluated by physician with anesthesia experience/training?				
26. Procedures for reporting adverse drug reactions and errors (ADEs) in the administration of drugs is voluntary, non-punitive; include definitions. **(C-1018)**				
27. Adverse Drug Reaction (ADR) and medication errors that reach the patient must be reported to the practitioner.				
28. Staff must report ADR and errors; the report must be made immediately if it causes harm to the patient such as a phone call; if harm is not known then must report immediately; if no harm then can inform practitioner in the morning.				

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
29. Documentation of the error and notification of the practitioner must be made in the medical record.				
30. Must educate staff on medication errors and ADEs to facilitate reporting; Must include reporting of near misses.				
31. Consider taking other steps to identify errors and ADRs; can't just rely on incident reports; trigger drug analysis, observe medication passes, concurrent and retrospective reviews, medication usage evaluations for high alert drugs etc.				
32. Nursing staff should know what to do if there is a medication error or adverse drug event (ADE).				
33. Process for reporting administration errors, adverse reactions, and drug incompatibilities immediately to the attending physician.				
34. Process for review and amendment of policy/procedures following reports of adverse events.				
35. Process for reporting serious adverse drug reactions to the federal Med-Watch program.				
36. QA/PI activities for errors/reactions include identifying potential corrective actions and are implemented, if appropriate.				
37. Consider non-punitive reporting system or people will not report errors (may balance with Just Culture).				
38. Pharmacist should be readily available by telephone or other means to discuss drug therapy, interactions, side effects, dosage etc.				
39. Know how drug information will be available at the nursing stations.				

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
40. Pharmacy policy and procedure, formulary; pharmacy and therapeutic committee, record minutes of the committee meetings. Policies should include: • High alert medications with dosing limits, administration guidelines, packaging, labeling and storage, • Limiting the variety of medication related devices and equipment, • Availability of up to date medication information.				
41. Availability of pharmacy expertise such as having a pharmacist available on call when pharmacy does not operate 24 hours a day.				
42. Standardization of prescribing and communication practices.				
43. Beer's list of inappropriate medications; drugs that should be avoided in patients who are over 65, includes drugs not to be used for certain diseases; American Geriatric Society- Beers List http://www.americangeriatrics.org/ (informational purposes only).				
44. Written policy/procedure to require ADE be reported immediately to practitioner who ordered the drug.				
45. Method to measure effectiveness of the reporting system; benchmark.				
46. Proactively identify potential and actual ADEs: includes direct medication pass observe, MEDICAL RECORD review, ADR surveillance team, medication use evaluation for high-alert drugs; or noted automatically generate a drug regimen review. Review for specified drugs/patient (sole reliance on incident reports does not meet the intent of this element).				
47. Availability of up-to-date medication use information, resources.				

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
48. Availability of pharmacy expertise 24/7.				
49. Investigation of cause for return of unused medications to pharmacy.				
50. High-alert meds with dosing limits, etc.				
51. Policy limiting the variety of medication-related devices & equipment.				
52. Alert system for “look alike” and “sound alike” drugs.				
53. Policy standardization of prescribing and medication communication practices.				
54. DO NOT USE abbreviations list.				
55. Requirements for “complete” orders.				
56. Use of pre-printed/EHR template orders whenever possible.				
57. How CAH incorporates external alerts/recommendations re: medication use safety.				
58. Preparation, distribution, administration, and proper disposal of hazardous medications.				
59. Handling of medication recalls.				
60. Final Standard of Care Determinations (The Risk Management committee will approve the peer reviewed SOC’s at least on a statistical basis.)				
61. Who monitors new guidelines and alerts? (How is this information disseminated to the appropriate committees for evaluation and consideration?)				

RISK MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
62. Insurance Policies • Declaration Page(s) on File. • Policy (s) on file for each • Endorsements to Policy(s) on file • Basic understanding of the Declaration Page, Policy, • Endorsements. Coverage Evaluation Performed regularly?				
63. KAMMCO Web Site navigation/location of resources www.KAMMCO.com				
64. Current digital copy of the KAMMCO Loss Prevention Guide.				
65. Claims Management • Submitting a Claim • Monitoring a Claim				
66. Process for responding to legal requests and subpoenas. Is there a procedure and are all staff education on the procedure?				
67. Association Memberships (recommended not required)				
68. Kansas Association of Risk and Quality Managers (KARQM)				
69. American Society of Healthcare Risk Management (ASHRM)				

SKILLED NURSING FACILITY (SNF) SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
1. Requirements to be granted approval to provide post-CAH SNF level- of-care. **(C-1600)**				
2. Must be certified by CMS.				
3. 3-day rule only applies to Medicare patients.				
4. No LOS restriction for CAH-SB patients.				
5. No requirement to use MDS for patient access/care planning.				
6. Must be certified as a CAH.				
7. Have no more than 25 inpatient beds.				
8. CAH has a Medicare provider agreement. **(C-1602)**				
9. Payment for inpatient rural primary care hospital and SNF-level of care services. **(C-1606)**				
10. Resident rights- exercise of, notice of their rights to request, refuse. **(C-1608)**				
11. Right to be informed in advanced of changes to the plan of care.				
12. Right of choice of attending physician.				
13. Right to retain and use personal possessions include furnishings and clothing as space permits.				
14. Right to share room with spouse and both consent to arrangement.				
15. Access to immediate family and friends and resident can change mind.				
16. Right to receive and send mail including means other than the post office.				

SKILLED NURSING FACILITY (SNF) SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
17. Must notify of any charges not covered by Medicare/Medicaid at time of admission and periodically and if resident becomes eligible for Medicaid.				
18. Has right to personal privacy and confidentiality				
19. Right to receive written and telephone communication.				
20. Right to secure medical records and to refuse release of records. Refer to Appendix PP (749 pages) for the interpretive guidelines.				
21. Also refer to Appendix PP for survey procedure on patient rights □ Appendix PP is the interpretive guidelines for long term care facilities.				
22. Admission, transfer, and discharge rights. **(C-1610)**				
23. Timing of transfer/discharge notice.				
24. Resident behavior and facility practices: restraints. **(C-1612)**				
25. Freedom from abuse, neglect, and exploitation.				
26. CAH conducts proper investigation, completes reporting requirements, has written policies and procedures that prevent abuse, neglect, and exploitation of patients.				
27. Medically related social services are provided to attain/maintain highest practicable physical, mental, and psychosocial well-being of patient. **(C-1616)**				
28. Comprehensive assessment, care plan and discharge planning, but no MDS/RAI. (**C-1620)**				
29. Assessment if significant change- excludes readmissions if no significant change in condition.				

SKILLED NURSING FACILITY (SNF) SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
30. Assessment should include: • Identification and demographic information • Customary routine • Cognitive patterns • Communication and vision • Mood and behavior patterns • Psychosocial well-being • Physical functioning and structural problems • Continence • Disease diagnoses and health conditions • Dental and nutritional status • Skin condition • Activity pursuit • Medications • Special treatments and procedures • Discharge planning • Documentation of summary information regarding the additional assessment performed by completion on the MDS or Minimum Data Sheet • Documentation of participation in assessment • Must do direct observation and communicate with resident and licensed members on all shifts.				
31. Must do a comprehensive care plan that include measurable objectives to meet patient's needs.				
32. Care plan to include: • If patient refuses treatment • Include any specialized services as result of the PASARR recommendations (Preadmission Screening and Resident Review Process) • Goals for admission and desired outcomes • Preferences and potential for discharge- must document whether wants to return to the community and document any referrals to local contact agencies and include discharge plans • Care plan must be developed within 7 days after comprehensive assessment done.				
33. Interdisciplinary team should develop objectives to attain highest level of functioning.				

SKILLED NURSING FACILITY (SNF) SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
34. Review and revise as necessary, such as after each assessment.				
35. Services provided by staff who are culturally competent, qualified and who meet standards of quality.				
36. Discharge Summary to include: • Recapitulation of the resident's stay • Includes diagnosis, course of illness and treatment, pertinent lab, x-rays, or consult results, • Final summary of the resident's status of Medication reconciliation.				
37. Care plan and discharge planning, refer to Appendix PP of the SOM for interpretive guidelines and survey procedure.				
38. Specialized rehab services- provided directly or contracted, such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity. **(C-1622)**				
39. Facility must provide the required service: • May get from outside source, • Need physician order. Refer to Appendix PP of the SOM for interpretive guidelines and survey procedure.				
40. Dental services- CAH assist residents in obtaining routine and 24-hour emergency dental care. **(C-1624)**				
41. May charge a Medicare resident for routine and emergency dental services.				
42. Must have a policy identifying when loss or damage to dentures is facility's responsibility so may not charge a resident.				

SKILLED NURSING FACILITY (SNF) SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
43. Must refer residents within 3 days for lost or damaged dentures and document what they eat or drink in the meantime. Refer to Appendix PP of the SOM for interpretive guidelines and survey procedure.				
44. Assisted nutrition and hydration. Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids. **(C-1626)**				
45. Based on assessment must make sure maintains usual body weight and electrolyte balance.				
46. Is offered sufficient fluid intake. Refer to Appendix PP of the State Operations Manual (SOM) for interpretive guidelines and for survey procedure				
47. Respect and Dignity (Updated 2/3/23) The patient has the right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.				

OBSTECTRICAL/LABOR & DELIVERY/NEWBORN NURSERY SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
1. Under Direction of Medical Doctor. (Performs Obstetrical/Newborn services.)				
2. Delineation of privileges. (Roster with all physicians who hold OB privileges)				
3. Qualified Nursing Supervisor. (OB, L&D, Newborn & Pediatric experience with appropriate certifications/training.)				
4. Qualified Nursing staff. (Appropriate certifications/training – with qualified RN immediately available in not an RN in attendance with OB/Nursery pt.)				
5. Refer to Appendix A of the State Operations Manual (SOM) for interpretive guidelines and for survey procedure				
6. Staff access up to date clinical guidelines.				
7. Surgery Services. (Must be readily available.)				
8. Communication Training. (Effective communication within teams and across departments especially critical or emergency communication.)				
9. Labor Room(s) equipped according to state Regulations Kansas Hospital Regulation **28-34-18 c 1), (2), (3)**				
10. Delivery room(s) equipped according to state Regulations Kansas Hospital **Regulation 28-34-18 c (1), (2), (3)**				
11. Nursery or NICU equipped according to state Regulations Kansas Hospital Regulation **28-34-18 c (1), (2), (3)**				
12. OB infection control procedures.				
13. Nursery Infection control procedures.				

OBSTECTRICAL/LABOR & DELIVERY/NEWBORN NURSERY SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
14. Appropriate oxygen administration. (Equipment available to suit the needs of the patients in L&D, OB and nursery?)				
15. ID/Security for Mother/Infant.				
16. PKU testing after 24 hours of birth and prior to discharge.				
17. Policies & Procedures: (Minimum POLICY & PROCEDURE stated in **Kansas Hospital Regulation 28-34-18e (6) a-m)**				
18. Procedure for obtaining newborn blood samples.				
19. Specific policies on High-risk medication Administration. (Use of Oxytocic drugs and the administration of anesthetics, sedatives, analgesics and other drugs.)				
20. Care of the high-risk newborn. (Facilities to care for the newborn at an appropriate level or plan to transfer to appropriate NICU.)				
21. Neonatal Bilirubin Monitoring. SRE - Procedures for identification, monitoring and treating hyperbilirubinemia.				
22. Staff flow between departments.				
23. Procedure for communication with observer/support person in room. (Especially when an emergency occurs.)				
24. Policy for transport of the newborn. (Must be in a bassinet.)				
25. Perinatal Committee. (Are there minutes of committee meetings at least quarterly to include providers, nursing?)				

OBSTECTRICAL/LABOR & DELIVERY/NEWBORN NURSERY SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
26. Process for reporting Maternal Injury or death. SRE - Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.)				
27. Process for reporting Neonatal injury or death. SRE - Neonatal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.				
28. Policy & Procedure for Video of Birth. (if permitted)				
29. Procedure for Emergency Response in the L&D, OB, or Nursery area.				
30. Policy & Procedure for Shoulder Dystocia prevention/management.				
31. Policy & Procedure for VBAC.				
32. Trending of Incidents (Does RM work with OB director on identified/trending spikes – especially "failure to; supervise staff, perform resuscitation, perform procedure, consult/refer to specialist, diagnose, L&D to C-Section time, medication errors, infant transfers, injuries, and complaints?)				

SHORT TERM INTENSIVE CARE/CARDIAC CARE UNIT SERVICES *OPTIONAL SERVICE	YES	NO	N/A	FINDINGS/COMMENTS
1. Refer to Appendix A of the State Operations Manual (SOM) for interpretive guidelines and for survey procedure.				
2. Multibed-distinctly identifiable.				
3. Must have RN supervisor. (Appropriate training, certification, and experience.)				
4. Qualified Staff when occupied.				
5. Appropriate critical care equipment.				
6. ICU or CCU Committee. Committee must develop and monitor policies and procedures of unit with minutes available for review. Kansas Hospital Regulations.				
7. Ventilator Safety Procedures. (Qualified staff, training, experience, infection control.)				
8. Sedation Evaluations Performed.				
9. HOB Elevated 30 degrees – 40 degrees.				
10. Peptic Ulcer Disease Prophylaxis.				
11. DVT Prophylaxis (when indicated).				
12. Infection control procedures for the ICU/CC.				
13. QA/PI Ventilator Associated Infections.				
14. Trending of Incidents Does RM work with ICU/CCU director on identified/trending spikes especially “failure to follow procedures, communication issues, staff proficiency/training, distractions, alarm overload, medication errors, patient compliance, patient understanding, injuries and complaints?				

REVENUE CYCLE MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
1. Contract Review – process for renegotiating outdated contracts annually or upon renewal.				
2. Contract compliance (insurance, equipment, services, etc.…).				
3. Up to date Charge Master (policy for how often the charge master will be reviewed and updated).				
4. Transparency of Charges – No Surprises Act requirements.				
5. Coding claims are clean and timely. Review days in accounts receivable and denial resolution.				
6. Medical record documentation is accurate/complete to reflect correct coding assignments on each encounter.				
7. Internal/External Coding Audits are performed and followed up with education for staff and medical staff.				
8. Training to keep coding and billing staff up to date.				
9. Business Office practices meets compliance with applicable regulations and laws: • Compliance plan • Education • Training logs • Concerns and resolutions.				
10. Denial management program.				
11. Effective collections program.				
12. Collection Agency is effective, appropriate and meets regulatory requirements when performing for the facility.				
13. Charity Care Policy. (Up to date to reflect regulatory changes)				

REVENUE CYCLE MANAGEMENT	YES	NO	N/A	FINDINGS/COMMENTS
14. Bad Debt Write-Off policy. Consistent with all payers and no insurance.				
15. Admission processes are timely and consistent with each patient registration.				
16. Clean data entry – patient information is entered consistently and accurately.				

REFERENCES

Agency for Healthcare Research and Quality (AHRQ) Patient Safety Network (2019) Serious Reportable Events https://psnet.ahrq.gov/primer/never-events

Centers for Medicare and Medicaid (CMEDICAL STAFF) Conditions of Operation (CoP) State Operating Manual Appendix A – Acute Care Facilities https://www.cMedical_Staff.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_a_hospitals.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Conditions of Operation (CoP) State Operating Manual Appendix PP - Long Term Care Facilities https://www.cMedical Staff.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Conditions of Operation (CoP) State Operating Manual Appendix V – Responsibilities of Medicare participating Hospital in Emergency Cases (EMTALA) https://www.cMedical Staff.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Conditions of Operation (CoP) State Operating Manual Appendix W – Critical Access Hospitals (CAH) and Swing Beds in CAHs https://www.cMedical_Staff.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Conditions of Operation (CoP) State Operating Manual Appendix Z – Emergency Preparedness All Provider Types https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SOM%20Appendix%20Z%202019.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Memos to States and Regions, Quality, Safety and Oversite - QSO-21-15 Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual (SOM) https://www.cMedical Staff.gov/files/document/qso-21-15-all.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Memos to States and Regions, Quality, Safety and Oversite – QSO-21-22 Reinforcement of EMTALA Obligations during Pandemic, and updated 10/3/22 Specific to Patients who are Pregnant or are Experiencing Pregnancy Loss https://www.cMedical Staff.gov/files/document/qso-21-22-hospital-revised.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Memos to States and Regions, Quality, Safety and Oversite – QSO-23-02 Revised Guidance for Staff Vaccination Requirements https://www.cMedical Staff.gov/files/document/qs0-23-02-all.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Memos to States and Regions, Quality, Safety and Oversite – QSO-23-03 The Importance of Timely Use of COVID-19 Therapeutics https://www.cMedical Staff.gov/files/document/qso-23-03-all.pdf

Centers for Medicare and Medicaid (CMEDICAL STAFF) Memos to States and Regions, Quality, Safety and Oversite – QSO-23-04 Workplace Violence in Hospitals https://www.cMedical Staff.gov/files/document/qso-23-04-hospitals.pdf

ECRI Institute Plymouth Meeting, PA. Health care Risk Control Risk Analysis Emergency Department Liability. www.ecri.org

ECRI Institute Plymouth Meeting, PA. Health care Risk Control Risk Analysis Implants and Explants. www.ecri.org

REFERENCES CONTINUED

ECRI Institute Plymouth Meeting, PA. Health care Risk Control Risk Analysis Obstetrical Liability: An Overview. www.ecri.org

Kansas Department of Health and Environment, Health Facilities Program State Statues and Regulations https://www.kdhe.ks.gov/601/Health-Facilities-Program-State-Statutes

Kansas Department of Health and Environment, Health Facilities Program Presentation (5/2/2022) Most Cited C Tags. Kelly Rivera, CPTA, Health Facility Surveyor, Risk Manager

Kansas State Fire Marshall, Department of Health and Human Services, CMEDICAL STAFF, Fire Safety Survey Report 2012 Code – Healthcare Form
https://www.firemarshal.ks.gov/DocumentCenter/View/641/Fire-Safety-Survey-Report-2012-Code-PDF