

deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

(2) When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:

(i) Any death that occurs while a patient is in such restraints.

(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

(3) The staff must document in the patient's medical record the date and time the death was:

(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or

(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.

(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:

(i) Each entry must be made not later than seven days after the date of death of the patient.

(ii) Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c), medical record number, and primary diagnosis(es).

(iii) The information must be made available in either written or electronic form to CMS immediately upon request.

(h) *Standard: Patient visitation rights.* A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her

visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

[71 FR 71426, Dec. 8, 2006, as amended at 75 FR 70844, Nov. 19, 2010; 77 FR 29074, May 16, 2012]

§ 482.15 Condition of participation: Emergency preparedness.

The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:

(a) *Emergency plan.* The hospital must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address patient population, including, but not limited to, persons at-risk; the type of services the hospital has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

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(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the hospital's efforts to contact such officials and, when applicable, its participation in collaborative and cooperative planning efforts.

(b) *Policies and procedures.* The hospital must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients, whether they evacuate or shelter in place, include, but are not limited to the following:

(i) Food, water, medical, and pharmaceutical supplies.

(ii) Alternate sources of energy to maintain the following:

(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

(B) Emergency lighting.

(C) Fire detection, extinguishing, and alarm systems.

(D) Sewage and waste disposal.

(2) A system to track the location of on-duty staff and sheltered patients in the hospital's care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the hospital must document the specific name and location of the receiving facility or other location.

(3) Safe evacuation from the hospital, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

(6) The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(7) The development of arrangements with other hospitals and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospital patients.

(8) The role of the hospital under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.

(c) *Communication plan.* The hospital must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Other hospitals and CAHs

(v) Volunteers.

(2) Contact information for the following:

(i) Federal, State, tribal, regional, and local emergency preparedness staff.

(ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:

(i) Hospital's staff.

(ii) Federal, State, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the hospital's care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the hospital's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

(d) *Training and testing.* The hospital must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

(1) *Training program.* The hospital must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.

(ii) Provide emergency preparedness training at least annually.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(2) *Testing.* The hospital must conduct exercises to test the emergency plan at least annually. The hospital must do all of the following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the hospital experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospital's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospital's emergency plan, as needed.

(e) *Emergency and standby power systems.* The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

(1) *Emergency generator location.* The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

(2) *Emergency generator inspection and testing.* The hospital must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

(3) *Emergency generator fuel.* Hospitals that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

(f) *Integrated healthcare systems.* If a hospital is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the hospital may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected,

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the unified and integrated emergency preparedness program must—

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

(i) A documented community-based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

(g) *Transplant hospitals.* If a hospital has one or more transplant centers (as defined in § 482.70)—

(1) A representative from each transplant center must be included in the development and maintenance of the hospital’s emergency preparedness program; and

(2) The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the OPO for the DSA where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.

(h) The standards incorporated by reference in this section are approved for incorporation by reference by the

Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the FEDERAL REGISTER to announce the changes.

(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.

(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.

(ii) Technical interim amendment (TIA) 12–2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.

(v) TIA 12–5 to NFPA 99, issued August 1, 2013.

(vi) TIA 12–6 to NFPA 99, issued March 3, 2014.

(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.

(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.

(ix) TIA 12–2 to NFPA 101, issued October 30, 2012.

(x) TIA 12–3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.

(xii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.

(2) [Reserved]

[81 FR 64028, Sept. 16, 2016; 81 FR 80594, Nov. 16, 2016]