

demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—

- (i) Before performing any of the actions specified in this paragraph;
- (ii) As part of orientation; and
- (iii) Subsequently on a periodic basis consistent with hospice policy.

(2) *Training content.* The hospice must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

- (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

- (ii) The use of nonphysical intervention skills.

- (iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

- (iv) The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).

- (v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

- (vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the 1-hour face-to-face evaluation.

- (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

(3) *Trainer requirements.* Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

(4) *Training documentation.* The hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(p) *Standard: Death reporting requirements.* Hospices must report deaths associated with the use of seclusion or restraint.

(1) The hospice must report the following information to CMS:

- (i) Each unexpected death that occurs while a patient is in restraint or seclusion.

- (ii) Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

- (iii) Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

(3) Staff must document in the patient's clinical record the date and time the death was reported to CMS.

(q) 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 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](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](http://www.nfpa.org), 1.617.770.3000.

(i) NFPA 99, Standards for Health Care Facilities Code of the National

Fire Protection Association 99, 2012 edition, issued August 11, 2011.

(ii) 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.

(2) [Reserved]

[73 FR 32204, June 5, 2008, as amended at 81 FR 26879, May 4, 2016; 81 FR 64024, Sept. 16, 2016]

**§418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.**

In addition to meeting the conditions of participation at §418.10 through §418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by the following additional standards.

(a) *Standard: Resident eligibility, election, and duration of benefits.* Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/IID are subject to the Medicare hospice eligibility criteria set out at §418.20 through §418.30.

(b) *Standard: Professional management.* The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §§418.100 and 418.108.

(c) *Standard: Written agreement.* The hospice and SNF/NF or ICF/IID must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be

signed by authorized representatives of the hospice and the SNF/NF or ICF/IID before the provision of hospice services. The written agreement must include at least the following:

(1) The manner in which the SNF/NF or ICF/IID and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.

(2) A provision that the SNF/NF or ICF/IID immediately notifies the hospice if—

(i) A significant change in a patient's physical, mental, social, or emotional status occurs;

(ii) Clinical complications appear that suggest a need to alter the plan of care;

(iii) A need to transfer a patient from the SNF/NF or ICF/IID, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or

(iv) A patient dies.

(3) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(4) An agreement that it is the SNF/NF or ICF/IID responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.

(5) An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/IID resident were in his or her own home.

(6) A delineation of the hospice's responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the