

(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.

(o) *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 reason-

able 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.

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

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/MR 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/MR 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/MR 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/MR before the provision of hospice services. The written agreement must include at least the following:

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(1) The manner in which the SNF/NF or ICF/MR 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/MR 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/MR, 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/MR 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/MR 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 palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

(7) A provision that the hospice may use the SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.

(8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.

(9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.

(d) *Standard: Hospice plan of care.* In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this hospice plan of care.

(1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.

(2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible.

(3) Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.

(e) *Standard: Coordination of services.* The hospice must:

(1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/MR. The designated interdisciplinary group member is responsible for:

(i) Providing overall coordination of the hospice care of the SNF/NF or ICF/

MR resident with SNF/NF or ICF/MR representatives; and

(ii) Communicating with SNF/NF or ICF/MR representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.

(2) Ensure that the hospice IDG communicates with the SNF/NF or ICF/MR medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.

(3) Provide the SNF/NF or ICF/MR with the following information:

(i) The most recent hospice plan of care specific to each patient;

(ii) Hospice election form and any advance directives specific to each patient;

(iii) Physician certification and recertification of the terminal illness specific to each patient;

(iv) Names and contact information for hospice personnel involved in hospice care of each patient;

(v) Instructions on how to access the hospice's 24-hour on-call system;

(vi) Hospice medication information specific to each patient; and

(vii) Hospice physician and attending physician (if any) orders specific to each patient.

(f) *Standard: Orientation and training of staff.* Hospice staff must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.

§418.114 Condition of participation: Personnel qualifications.

(a) *General qualification requirements.* Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally author-

ized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.

(b) *Personnel qualifications for certain disciplines.* The following qualifications must be met:

(1) *Physician.* Physicians must meet the qualifications and conditions as defined in section 1861(r) of the Act and implemented at §410.20 of this chapter.

(2) *Hospice aide.* Hospice aides must meet the qualifications required by section 1891(a)(3) of the Act and implemented at §418.76.

(3) *Social worker.* A person who—

(i)(A) Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or

(B) Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in paragraph (b)(3)(i)(A) of this section; and

(ii) Has 1 year of social work experience in a healthcare setting; or

(iii) Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.

(4) *Speech language pathologist.* A person who meets either of the following requirements:

(i) The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association.

(ii) The educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

(5) *Occupational therapist.* A person who—

(i)(A) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply;

(B) Graduated after successful completion of an occupational therapist