may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

(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—

(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) 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 64036, Sept. 16, 2016; 81 FR 80594, Nov. 16, 2016, as amended at 84 FR 51826, Sept. 30, 2019]

§ 485.627 Condition of participation: Organizational structure.

(a) *Standard: Governing body or responsible individual.* The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

(b) *Standard: Disclosure.* The CAH discloses the names and addresses of—

(1) The person principally responsible for the operation of the CAH; and

(2) The person responsible for medical direction.

[58 FR 30671, May 26, 1993, as amended at 62 FR 46037, Aug. 29, 1997; 84 FR 51827, Sept. 30, 2019]

§ 485.631 Condition of participation: Staffing and staff responsibilities.

(a) *Standard: Staffing*—(1) The CAH has a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.

(2) Any ancillary personnel are supervised by the professional staff.

(3) The staff is sufficient to provide the services essential to the operation of the CAH.

(4) A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.

(5) A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

(b) *Standard: Responsibilities of the doctor of medicine or osteopathy*. (1) The doctor of medicine or osteopathy—

(i) Provides medical direction for the CAH's health care activities and consultation for, and medical supervision of, the health care staff;

(ii) In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH's written policies governing the services it furnishes.

(iii) In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; and

(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.

(v) Periodically reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants only to the extent required under State law where State law requires record reviews or co-signatures, or both, by a collaborating physician.

(2) A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral.

(c) *Standard: Physician assistant, nurse practitioner, and clinical nurse specialist responsibilities*. (1) The physician assistant, the nurse practitioner, or clinical nurse specialist members of the CAH's staff—

(i) Participate in the development, execution and periodic review of the written policies governing the services the CAH furnishes; and

(ii) Participate with a doctor of medicine or osteopathy in a periodic review of the patients' health records.

(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:

(i) Provides services in accordance with the CAH's policies.

(ii) Arranges for, or refers patients to, needed services that cannot be furnished at the CAH, and assures that adequate patient health records are maintained and transferred as required when patients are referred.

(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.

(d) *Standard: Periodic review of clinical privileges and performance*. The CAH requires that—

(1) The quality and appropriateness of the diagnosis and treatment furnished by nurse practitioners, clinical nurse specialist, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH.