

plan of treatment), or upon the recommendation of one of the professionals providing services.

(d) *Standard: Provision of services.* (1) All patients must be referred to the facility by a physician who provides the following information to the facility before treatment is initiated:

(i) The patient's significant medical history.

(ii) Current medical findings.

(iii) Diagnosis(es) and contraindications to any treatment modality.

(iv) Rehabilitation goals, if determined.

(2) Services may be provided by facility employees or by others under arrangements made by the facility.

(3) The facility must have on its premises the necessary equipment to implement the plan of treatment and sufficient space to allow adequate care.

(4) The services must be furnished by personnel that meet the qualifications of § 485.70 and the number of qualified personnel must be adequate for the volume and diversity of services offered. Personnel that do not meet the qualifications specified in § 485.70 may be used by the facility in assisting qualified staff. When a qualified individual is assisted by these personnel, the qualified individual must be on the premises, and must instruct these personnel in appropriate patient care service techniques and retain responsibility for their activities.

(5) A qualified professional must initiate and coordinate the appropriate portions of the plan of treatment, monitor the patient's progress, and recommend changes, in the plan, if necessary.

(6) A qualified professional representing each service made available at the facility must be either on the premises of the facility or must be available through direct telecommunication for consultation and assistance during the facility's operating hours. At least one qualified professional must be on the premises during the facility's operating hours.

(7) All services must be provided consistent with accepted professional standards and practice.

(e) *Standard: Scope and site of services*—(1) *Basic requirements.* The facility must provide all the CORF services re-

quired in the plan of treatment and, except as provided in paragraph (e)(2) of this section, must provide the services on its premises.

(2) *Exceptions.* Physical therapy, occupational therapy, and speech pathology services furnished away from the premises of the CORF may be covered as CORF services if Medicare payment is not otherwise made for these services. In addition, a single home visit is covered if there is need to evaluate the potential impact of the home environment on the rehabilitation goals.

(f) *Standard: Patient assessment.* Each qualified professional involved in the patient's care, as specified in the plan of treatment, must—

(1) Carry out an initial patient assessment; and

(2) In order to identify whether or not the current plan of treatment is appropriate, perform a patient reassessment after significant changes in the patient's status.

(g) *Standard: Laboratory services.* (1) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.

(2) If the facility chooses to refer specimens for laboratory testing, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.

[48 FR 56293, Dec. 15, 1982, as amended at 56 FR 8852, Mar. 1, 1991; 57 FR 7137, Feb. 28, 1992]

§ 485.60 Condition of participation: Clinical records.

The facility must maintain clinical records on all patients in accordance with accepted professional standards and practice. The clinical records must be completely, promptly, and accurately documented, readily accessible, and systematically organized to facilitate retrieval and compilation of information.

(a) *Standard: Content.* Each clinical record must contain sufficient information to identify the patient clearly and to justify the diagnosis and treatment. Entries in the clinical record must be made as frequently as is necessary to insure effective treatment

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and must be signed by personnel providing services. All entries made by assistant level personnel must be countersigned by the corresponding professional. Documentation on each patient must be consolidated into one clinical record that must contain—

- (1) The initial assessment and subsequent reassessments of the patient's needs;
- (2) Current plan of treatment;
- (3) Identification data and consent or authorization forms;
- (4) Pertinent medical history, past and present;
- (5) A report of pertinent physical examinations if any;
- (6) Progress notes or other documentation that reflect patient reaction to treatment, tests, or injury, or the need to change the established plan of treatment; and
- (7) Upon discharge, a discharge summary including patient status relative to goal achievement, prognosis, and future treatment considerations.

(b) *Standard: Protection of clinical record information.* The facility must safeguard clinical record information against loss, destruction, or unauthorized use. The facility must have procedures that govern the use and removal of records and the conditions for release of information. The facility must obtain the patient's written consent before releasing information not required to be released by law.

(c) *Standard: Retention and preservation.* The facility must retain clinical record information for 5 years after patient discharge and must make provision for the maintenance of such records in the event that it is no longer able to treat patients.

§ 485.62 Condition of participation: Physical environment.

The facility must provide a physical environment that protects the health and safety of patients, personnel, and the public.

(a) *Standard: Safety and comfort of patients.* The physical premises of the facility and those areas of its surrounding physical structure that are used by the patients (including at least all stairwells, corridors and passageways) must meet the following requirements:

(1) Applicable Federal, State, and local building, fire, and safety codes must be met.

(2) Fire extinguishers must be easily accessible and fire regulations must be prominently posted.

(3) A fire alarm system with local (in-house) capability must be functional, and where power is generated by electricity, an alternate power source with automatic triggering must be present.

(4) Lights, supported by an emergency power source, must be placed at exits.

(5) A sufficient number of staff to evacuate patients during a disaster must be on the premises of the facility whenever patients are being treated.

(6) Lighting must be sufficient to carry out services safely; room temperature must be maintained at comfortable levels; and ventilation through windows, mechanical means, or a combination of both must be provided.

(7) Safe and sufficient space must be available for the scope of services offered.

(b) *Standard: Sanitary environment.* The facility must maintain a sanitary environment and establish a program to identify, investigate, prevent, and control the cause of patient infections.

(1) The facility must establish written policies and procedures designed to control and prevent infection in the facility and to investigate and identify possible causes of infection.

(2) The facility must monitor the infection control program to ensure that the staff implement the policies and procedures and that the policies and procedures are consistent with current practices in the field.

(3) The facility must make available at all times a quantity of laundered linen adequate for proper care and comfort of patients. Linens must be handled, stored, and processed in a manner that prevents the spread of infection.

(4) Provisions must be in effect to ensure that the facility's premises are maintained free of rodent and insect infestation.

(c) *Standard: Maintenance of equipment, physical location, and grounds.* The facility must establish a written preventive maintenance program to ensure that—