Final Accreditation Report

Newton-Wellesley Hospital
2014 Washington Street
Newton Lower Falls, MA 02462

Organization Identification Number: 5592
Unannounced Full Event: 11/12/2019 - 11/15/2019

Program Surveyed
Hospital

Final Report: Posted 12/19/2019

The Joint Commission
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The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Hospital	11/12/2019 - 11/15/2019	Requirements for Improvement	Unannounced Medicare Deficiency Survey	Survey within 45 Calendar Days from the last day of survey
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Hospital

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
EC.02.02.01	3	Low / Limited	§482.41 (a)	A-0701	✓	✓
	5	Moderate / Pattern	§482.41 (a)	A-0701	✓	✓
EC.02.03.01	9	Moderate / Limited	§482.15 (d)(1)(i)	E-0037		✓
EC.02.03.05	15	Low / Limited	§482.41 (d)(2)	A-0724	✓	✓
	27	Low / Limited	§482.41 (d)(2)	A-0724	✓	✓
	3	Moderate / Widespread	§482.41 (d)(2)	A-0724	✓	✓
	4	Moderate / Widespread	§482.41 (d)(2)	A-0724	✓	✓
EC.02.04.03	3	Low / Widespread	§482.41 (d)(2)	A-0724	✓	✓
EC.02.05.01	15	High / Limited	§482.42	A-0747	✓	✓
	16	Moderate / Limited	§482.41 (d)(4)	A-0726	✓	✓
	9	Low / Limited	§482.41 (a)	A-0701	✓	✓
EC.02.05.05	4	Moderate / Limited	§482.41 (d)(2)	A-0724	✓	✓
	5	Low / Widespread	§482.41 (d)(2)	A-0724	✓	✓
	8	Low / Limited	§482.41 (d)(2)	A-0724	✓	✓

The Joint Commission

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
EC.02.05.09	11	Low / Limited	§482.41 (d)(2)	A-0724	✓	✓
EC.02.06.01	1	Moderate / Widespread	§482.41 (a)	A-0701	✓	✓
EC.02.06.05	2	High / Limited	§482.42	A-0747	✓	✓
HR.01.01.01	2	Low / Limited				✓
IC.02.01.01	1	Low / Pattern	§482.42	A-0747	✓	✓
IC.02.02.01	1	Low / Pattern	§482.42	A-0747	✓	✓
	2	High / Widespread	§482.51	A-0940	✓	✓
			§482.42	A-0747	✓	✓
			§482.51 (b)	A-0951	✓	✓
LD.01.03.01	12	High / Widespread	§482.12	A-0043	✓	✓
LD.04.01.05	4	Moderate / Limited				✓
LS.01.02.01	14	Moderate / Limited				✓
LS.02.01.10	1	Low / Widespread	§482.41 (b)(1)(i)	A-0710	✓	✓
	14	Low / Widespread	§482.41 (b)(1)(i)	A-0710	✓	✓
LS.02.01.34	9	Low / Widespread				✓
LS.02.01.35	10	Low / Widespread	§482.41 (b)(1)(i)	A-0710	✓	✓
	4	Low / Widespread	§482.41 (b)(1)(i)	A-0710	✓	✓

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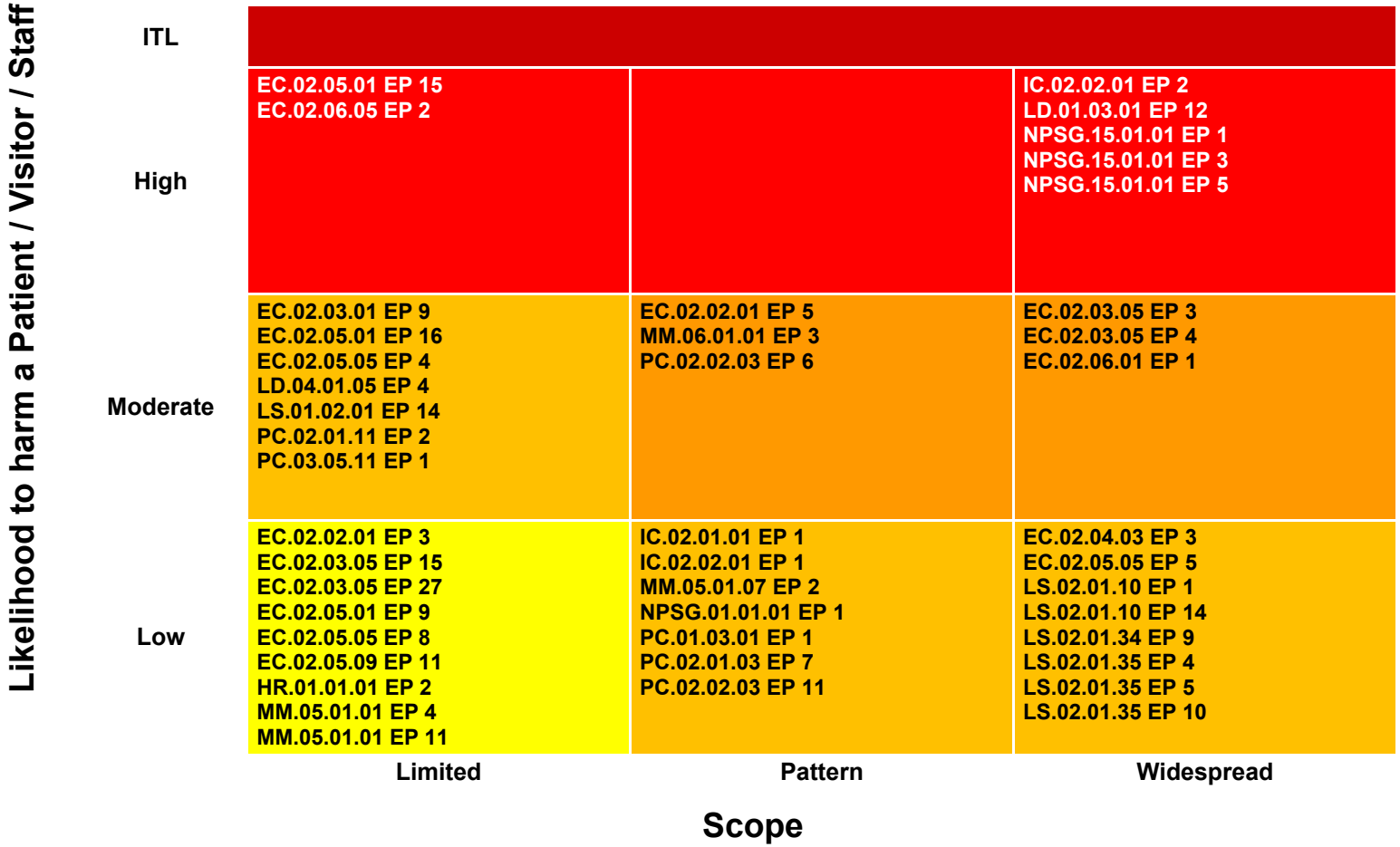
Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
	5	Low / Widespread	§482.41 (b)(1)(i)	A-0710	✓	✓
MM.05.01.01	11	Low / Limited				✓
	4	Low / Limited				✓
MM.05.01.07	2	Low / Pattern	§482.23 (c)	A-0405		✓
MM.06.01.01	3	Moderate / Pattern	§482.23 (c)	A-0405		✓
NPSG.01.01.01	1	Low / Pattern				✓
NPSG.15.01.01	1	High / Widespread	§482.13 (c)(2)	A-0144	✓	✓
	3	High / Widespread	§482.13 (c)(2)	A-0144	✓	✓
	5	High / Widespread	§482.13 (c)(2)	A-0144	✓	✓
PC.01.03.01	1	Low / Pattern	§482.23 (b)(4)	A-0396		✓
PC.02.01.03	7	Low / Pattern				✓
PC.02.01.11	2	Moderate / Limited				✓
PC.02.02.03	11	Low / Pattern				✓
	6	Moderate / Pattern				✓
PC.03.05.11	1	Moderate / Limited	§482.13 (e)(12)(i)(A)	A-0178	✓	✓

The Joint Commission
SAFER™ Matrix

Program: Hospital



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Hospital

CoP(s)	Tag	CoP Score	Corresponds to:
§482.13	A-0115	Condition	
§482.13(c)(2)	A-0144	Standard	HAP/NPSG.15.01.01/EP1 HAP/NPSG.15.01.01/EP3 HAP/NPSG.15.01.01/EP5
§482.13(e)(12)(i)(A)	A-0178	Standard	HAP/PC.03.05.11/EP1
§482.23	A-0385	Standard	
§482.23(b)(4)	A-0396	Standard	HAP/PC.01.03.01/EP1
§482.23(c)	A-0405	Standard	HAP/MM.05.01.07/EP2 HAP/MM.06.01.01/EP3
§482.41	A-0700	Condition	
§482.41(a)	A-0701	Standard	HAP/EC.02.02.01/EP5 HAP/EC.02.02.01/EP3 HAP/EC.02.05.01/EP9 HAP/EC.02.06.01/EP1
§482.41(b)(1)(i)	A-0710	Standard	HAP/LS.02.01.10/EP1 HAP/LS.02.01.10/EP14 HAP/LS.02.01.35/EP4 HAP/LS.02.01.35/EP5 HAP/LS.02.01.35/EP10
§482.41(d)(2)	A-0724	Standard	HAP/EC.02.03.05/EP3 HAP/EC.02.03.05/EP4 HAP/EC.02.03.05/EP15 HAP/EC.02.03.05/EP27 HAP/EC.02.04.03/EP3 HAP/EC.02.05.05/EP4 HAP/EC.02.05.05/EP5 HAP/EC.02.05.05/EP8 HAP/EC.02.05.09/EP11
§482.41(d)(4)	A-0726	Standard	HAP/EC.02.05.01/EP16

The Joint Commission

CoP(s)	Tag	CoP Score	Corresponds to:
§482.42	A-0747	Condition	HAP/IC.02.01.01/EP1 HAP/IC.02.02.01/EP1 HAP/IC.02.02.01/EP2 HAP/EC.02.05.01/EP15 HAP/EC.02.06.05/EP2
§482.51	A-0940	Condition	HAP/IC.02.02.01/EP2
§482.51(b)	A-0951	Standard	HAP/IC.02.02.01/EP2
§482.12	A-0043	Condition	HAP/LD.01.03.01/EP12
§482.15	E-0001	Standard	
§482.15(d)(1)(i)	E-0037	Standard	HAP/EC.02.03.01/EP9

The Joint Commission
Requirements for Improvement

Program: Hospital

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.02.01	3	Low Limited	The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.	1). Observed in Tracer Visit at [redacted] site . Cap on eye wash station was noted to be open which would allow debris to collect in the chamber.	§482.41(a)	Standard
EC.02.02.01	5	Moderate Pattern	The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.	1). Observed in Building Tour at [redacted] site . In the [redacted] generator room where the specific gravity of the generator batteries is tested there was no eyewash station available for use.	§482.41(a)	Standard
				2). Observed in Building Tour at [redacted] site . on the [redacted] had bottled bleach and bleach wipes, there was no eyewash located within the room.	§482.41(a)	Standard
				3). Observed in Tracer Activities at [redacted] site . During individual tracer activity on the [redacted] unit it was noted that the eyewash station had obstruction to access. Specifically, the station was behind a door that had key pad access. This finding was discussed with unit leadership who accompanied the surveyor.		
EC.02.03.01	9	Moderate Limited	The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, and how to evacuate to areas of refuge. Staff and licensed independent practitioners are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting authorities. A copy of the plan is readily available with the telephone operator or security.	1). Observed in Document Review at [redacted] site . The provided fire response plan did not include the roles of [redacted].	§482.15(d)(1)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.			
EC.02.03.05	3	Moderate Widespread	Every 12 months, the hospital tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.	1). Observed in Document Review at [redacted] site . 6 smoke detectors not tested per the annual testing documentation provided for December 2018	§482.41(d)(2)	Standard
EC.02.03.05	4	Moderate Widespread	Every 12 months, the hospital tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.	1). Observed in Document Review at [redacted] site . 147 speaker strobe not tested per the annual testing documentation provided for December 2018	§482.41(d)(2)	Standard
EC.02.03.05	15	Low Limited	At least monthly, the hospital inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.	1). Observed in Building Tour at [redacted] site . Fire extinguisher in [redacted] construction area had no checks in April, May, July, and September 2019	§482.41(d)(2)	Standard
EC.02.03.05	27	Low Limited	Elevators with firefighters' emergency operations are tested monthly. The test completion dates and results are documented. (For full text, refer to NFPA 101-2012: 9.4.3; 9.4.6)	1). Observed in Document Review at [redacted] site . The monthly elevator fire services testing was not conducted in January 2019	§482.41(d)(2)	Standard
EC.02.04.03	3	Low Widespread	The hospital inspects, tests, and maintains non-high -risk equipment identified on the medical equipment inventory. These activities are documented. Note: Scheduled maintenance activities for non-high -risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program.	1). Observed in Document Review at [redacted] site . The biomedical non high risk equipment PMs for the first 10 months of 2019 did not meet the 100% completion rate.	§482.41(d)(2)	Standard
EC.02.05.01	9	Low	The hospital labels utility system controls to facilitate	1). Observed in Building Tour at [redacted]	§482.41(a)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
		Limited	partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.	[redacted] site . There was an in accurate panel schedule for the life safety panel the fire alarm panel was located in.		
EC.02.05.01	15	High Limited	In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).	1). Observed in Building Tour at [redacted] site . In the [redacted] the [redacted] were positive to the [redacted] area. This was corrected before the surveyor departed the facility.	§482.42	Condition
EC.02.05.01	16	Moderate Limited	In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. Note: Examples of non–critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments.	1). Observed in Building Tour at [redacted] site . The soiled utility room in the [redacted] was found positive to the corridor.	§482.41(d)(4)	Standard
EC.02.05.05	4	Moderate Limited	The hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.	1). Observed in Building Tour at [redacted] site . In the fire damper testing documentation provided during survey dated 10/10/2019 FD Damper [redacted] failed the test there was no documentation showing that it had been repaired or that an ILSM had been done.	§482.41(d)(2)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate. Note 3: Scheduled maintenance activities for high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.			
EC.02.05.05	5	Low Widespread	The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate. Note 2: Scheduled maintenance activities for infection control utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.	1). Observed in Document Review [redacted] site . The preventative maintenance for nonhigh risk utility systems was not at the required 100% the documents provided show that only 85% of non critical PM's were completed.	§482.41(d)(2)	Standard
EC.02.05.05	8	Low Limited	The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning (HVAC). (For full text, refer to NFPA 99-2012: Chapters 6 and 9) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3.	1). Observed in Building Tour at [redacted] site . The ice machine in the [redacted] room was not plugged in or connected to a GFI outlet or breaker.	§482.41(d)(2)	Standard
EC.02.05.09	11	Low Limited	The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less	1). Observed in Tracer Activities at [redacted] site . During tracer activities on the [redacted], it was noted that the medical gas shutoff valves were blocked by a counter top which held a computer and other equipment. This observation was discussed with unit leadership who accompanied the surveyor.	§482.41(d)(2)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. (For full text, refer to NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11)			
EC.02.06.01	1	Moderate Widespread	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	1). Observed in Building Tour at [redacted] site . There was a stained ceiling tile in the 1st floor near the [redacted] elevators.	§482.41(a)	Standard
				2). Observed in Building Tour at [redacted] site . In [redacted] storage area there were 6 carts with no lower shelf liners.	§482.41(a)	Standard
				3). Observed in Building Tour at [redacted] site . In the [redacted] unit there is a sheetrock barrier that was not sealed or painted, having tears and exposed drywall gypsum.	§482.41(a)	Standard
				4). Observed in Building Tour at [redacted] site . In the [redacted] unit there was a recent sewer leak that stained ceiling tiles, the stained ceiling tiles were still in place after one week.	§482.41(a)	Standard
EC.02.06.05	2	High Limited	When planning for demolition, construction, renovation, or general maintenance, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services. Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.	1). Observed in Building Tour at [redacted] site . During the building tour of the [redacted] floor [redacted], there was a construction barrier installed due to a sewage leak from above, leak occurred over a week ago. There was no mitigation or cleaning of the area. During the [redacted] session I spoke with the [redacted] staff who stated that they had no knowledge of the sewage leak and that there was no ICRA in place.	§482.42	Condition
HR.01.01.01	2	Low Limited	The hospital verifies and documents the following: - Credentials of care providers using the primary source when licensure, certification, or registration is	1). Observed in Competency Session at [redacted]		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.	[redacted] site . During the competence session, the nursing license for the [redacted] was not verified at the primary source by the organization prior to hiring. The license was verified upon discovery and prior to the end of the survey.		
IC.02.01.01	1	Low Pattern	The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. (See also MM.09.01.01, EP 5)	1). Observed in Tracer Activities at [redacted] site . During tracer activities in the [redacted], it was noted that multiple staff members were wearing necklaces and watches which were not confined within their scrub attire. These included: a [redacted] This was not in alignment with the hospital's policy: Periop/CVC Surgical Attire, effective 10/29/19.	§482.42	Condition
				2). Observed in Tracer Activities at [redacted] site . The organization stated that they followed AORN guidelines. During tracer activities in the [redacted] it was observed that the cell phone used for interpretive services was not subjected to low level decontamination prior to being brought into the [redacted] room.	§482.42	Condition
IC.02.02.01	1	Low Pattern	The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical	1). Observed in Tracer Activities at [redacted] site . During tracer	§482.42	Condition

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			equipment, devices, and supplies. * Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions. Footnote *: For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3.	activities in the [redacted], the three [redacted] were visited. It was noted that in three out of the three rooms there were metal cabinets with rust along their bases. The presence of rust interfered with the ability to clean the cabinets. These observations were confirmed by leadership who accompanied the surveyor.		
IC.02.02.01	2	High Widespread	The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4) Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes. Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3 (Sterilization and Disinfection in Healthcare Settings).	1). Observed in Tracer Activities at [redacted] site . During tracer activities in the [redacted] department staff it was observed that the log book contained documentation of weekly testing of the washer-disinfectors and staff reported that weekly testing was the current process. AAMI ST79, which this HCO follows, specifies in section 13.2 that washer-disinfectors be tested every day that they are used. This was confirmed with the [redacted].	§482.51	Condition
				2). Observed in Tracer Activities at [redacted] site . During tracer activities in the [redacted] a small hemostat was observed to be labeled with marking tape that was cracked, revealing a crevice in which material could accumulate and prevent effective sterilization. This was confirmed with the [redacted].	§482.51	Condition
				3). Observed in Tracer Activities at [redacted]	§482.42	Condition

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				[redacted] site . During tracer activities in the [redacted] staff described the reprocessing method for humidification chambers. It was observed that these chambers were being utilized on multiple patients and that the manufacturer's instructions for use specified that the chambers either be high level disinfected or sterilized between patients (for a maximum of 100 reprocessing cycles), however staff were not employing HLD or sterilization or counting cycles. Rather, the chambers were being washed in hot water and detergent and then used on subsequent patients. This was confirmed with the [redacted] and after discussion of the matter, staff opted to discard the used chambers and utilize all future chambers as single-patient items until a compliant reprocessing procedure is in place.		
				4). Observed in Individual Tracer at [redacted] site . While reviewing the cleaning of the manometers in the [redacted], it was noted that while the QC of the test strips is being done, there is no log of the positive and negative tests.. The lot and date of expiration was recorded for each scope. Confirmed with [redacted].	§482.51(b)	Standard
				5). Observed in Individual Tracer at [redacted] site . During tracer activities in the [redacted] staff it was observed that only weekly testing of the washer-disinfectors efficiency was being done, and staff reported that weekly testing was the current process. AAMI ST79, which this HCO follows, specifies that washer-disinfectors be tested every day that they are used.	§482.51(b)	Standard
				6). Observed in Individual Tracer at [redacted] site . While conducting tracer in the [redacted], it was noted that the ultrasonic was only tested for	§482.51(b)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				efficiency weekly. AAMI, which this organization follows, requires that ultrasonics be tested daily when in use. Confirmed with [redacted].		
LD.01.03.01	12	High Widespread	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a governing body that assumes full legal responsibility for the operation of the hospital.	1). Observed in Tracer Activities at [redacted] site . The governing body/leadership did not ensure that the following Conditions of Participation were met, determined by direct observation, documentation, and staff interviews. The Conditions of Participation include: 481.13 - Patient Rights, 482.41 - Physical Environment, 482.42 - Infection Control, and 482.51 - Surgical Services.	§482.12	Condition
LD.04.01.05	4	Moderate Limited	Staff are held accountable for their responsibilities.	1). Observed in Document Review at [redacted] site . There were at least three elements of performance (EPs) under standard EC 02.03.05 fire alarm testing that were not met.		
LS.01.02.01	14	Moderate Limited	The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital's interim life safety measure (ILSM) policy. Note: Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.	1). Observed in Building Tour at [redacted] site . In the fire damper testing documentation provided during survey dated 10/10/2019 FD Damper [redacted] failed the test there was no documentation showing that it had been repaired or that an ILSM had been done.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission		
LS.02.01.10	1	Low Widespread	Buildings meet requirements for construction type and height. In Types I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. All new buildings contain approved automatic sprinkler systems. Existing buildings contain approved automatic sprinkler systems as required by the	1). Observed in Building Tour at [redacted] site . The spray on fire proofing was missing from multiple areas of a structural beam in the [redacted] The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved	§482.41(b)(1)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			construction type. (For full text, refer to NFPA 101-2012: 18/19.1.6; 18.3.5.1; 19.3.5.3; 18/19.3.5.4; 18/19.3.5.5; 18.3.5.6)	and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)		
LS.02.01.10	14	Low Widespread	The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)	1). Observed in Building Tour at [redacted] site . Outside the entrance to [redacted] in the data closet there was a 4 inch conduit that was not sealed.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§482.41(b)(1)(i)	Standard
				2). Observed in Building Tour at [redacted] site . In the [redacted] floor ceiling next to door [redacted] there was a blow out patch located in the 2hour fire barrier.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)	§482.41(b)(1)(i)	Standard
LS.02.01.34	9	Low Widespread	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)	1). Observed in Building Tour at [redacted] site . Next to door [redacted] there were two large gaps over 1 inch each in the drop ceiling.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission		
LS.02.01.35	4	Low Widespread	Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2)	1). Observed in Building Tour at [redacted] site . In the [redacted] construction area there were data wires and electrical conduit being supported by the sprinkler pipes.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be	§482.41(b)(1)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)		
				2). Observed in Building Tour at [redacted] site . In the [redacted] construction area there were data wires and electrical extension cords being supported by the sprinkler pipes.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)	§482.41(b)(1)(i)	Standard
LS.02.01.35	5	Low Widespread	Sprinkler heads are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)	1). Observed in Building Tour at [redacted] site . In [redacted] there were two sprinkler heads missing the Escutcheons plates.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)	§482.41(b)(1)(i)	Standard
				2). Observed in [redacted] site . In [redacted] decontamination there were two sprinkler heads missing the Escutcheons plates.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)	§482.41(b)(1)(i)	Standard
				3). Observed in Building Tour at [redacted] site . In the [redacted] there were 15	§482.41(b)(1)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				sprinkler heads adjacent to the grill and fryer cooking area that were covered in grease, dust and debris. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)		
LS.02.01.35	10	Low Widespread	The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed either in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 18/19.3.5.12; 9.7.4.1; NFPA 10-2010: 6.2.1.1; 6.1.3.3.1; 6.1.3.4; 6.1.3.8)	1). Observed in Building Tour at [redacted] site . The fire extinguisher located adjacent to door [redacted] was installed above the maximum height of 60 inches.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)	§482.41(b)(1)(i)	Standard
				2). Observed in Building Tour at [redacted] site . The fire extinguisher located adjacent to door [redacted] was installed above the maximum height of 60 inches.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Conduct education promoting awareness of deficiencies(EP-13)	§482.41(b)(1)(i)	Standard
MM.05.01.01	4	Low Limited	All medication orders are reviewed for the following: - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values - Therapeutic duplication	1). Observed in Individual Tracer at [redacted] site . During tracer activities in the [redacted], the medication record of a patient was reviewed. Two medications (Zyrtec and Allegra) were ordered for the same indication without differentiating instructions. The nurse who was interviewed stated that she would use her judgement regarding which one to choose. This finding was discussed with [redacted] who		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			- Other contraindications	accompanied the surveyor.		
MM.05.01.01	11	Low Limited	After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.	1). Observed in [redacted] site . During tracer activities in the [redacted], a medication order for hydration was reviewed. "NSS 999 ml/hour IV continuous for 1 hour. One liter NSS over 3 hours, prn hypotension." The nurse who was interviewed stated that she had run the infusion in over one hour on [redacted] and [redacted]. There was documentation that the nurse had contacted the physician to change the order but it had not been changed. There was no evidence of pharmacy review of lack of clarity regarding the period of time for infusion.		
MM.05.01.07	2	Low Pattern	Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.	1). Observed in Tracer Activities at [redacted] site . During tracer activity in the [redacted], the medication room was visited. It was noted that the Silent Knight pill crusher was dirty as evidenced by dark residue in the crevices. This finding was confirmed with [redacted] leadership who accompanied the surveyor.	§482.23(c)	Standard
				2). Observed in Tracer Activities at [redacted] site . During tracer activity on [redacted], the medication room was visited. It was noted that the Silent Knight pill crusher was dirty as evidenced by dark residue in the crevices. This finding was confirmed with [redacted] leadership who accompanied the surveyor.	§482.23(c)	Standard
MM.06.01.01	3	Moderate Pattern	Before administration, the individual administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3) - Verifies that the medication has not expired	1). Observed in Individual Tracer at [redacted] site . During individual tracer activity in the [redacted], prn medications were reviewed. "Atropine 0.4mg/ml q 15 min. prn early cholinergic syndrome" had been ordered. The medication had been administered on 11/13 at 1217. There was no documentation of any	§482.23(c)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			- Verifies that no contraindications exist - Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route - Discusses any unresolved concerns about the medication with the patient's licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient's care, treatment, and services	symptoms which would support giving the medication. The nurse who was interviewed stated that this was a routine practice, to give the medication as a prophylaxis prior to treatment. This finding was discussed with [redacted] leadership.		
				2). Observed in Individual Tracer at [redacted] site . During individual tracer activity, prn medications were reviewed. On 11/13 at 1730 the patient had been administered Tylenol for pain documented as level 4. The Tylenol order was for mild pain which was defined by hospital policy as 1-3.	§482.23(c)	Standard
				3). Observed in Individual Tracer at [redacted] site . During individual tracer activity in the [redacted], a record was reviewed. AT 11:45 there was an order for a lactated ringers bolus to be given. As of time of record review, at 2:45pm, there was no documentation that the bolus had been administered. The nurse who was interviewed stated that she should have notified the provider that she had held the bolus based on her clinical judgement. Discussion with the nurse and leadership included that there was a need to obtain a provider order to hold or discontinue the bolus.	§482.23(c)	Standard
NPSG.01.01.01	1	Low Pattern	Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 7 and 10; NPSG.01.03.01, EP 1)	1). Observed in Tracer Activities at [redacted] site . On the [redacted] unit a [redacted] was observed to have delivered a lunch tray without using any patient identifier. Hospital policy - Patient Identification, revised 9/7/16, required that "staff will use the appropriate two patient identifiers... prior to... 4. delivering a dietary meal..." This observation was validated by leadership who		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				accompanied the surveyor.		
NPSG.15.01.01	1	High Widespread	For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital. Note: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).	1). Observed in Building Tour at [redacted] site . While conducting the building tour in the [redacted] unit, there were chairs in the patient rooms that pose a ligature risk to the patients.	§482.13(c)(2)	Standard
				2). Observed in Building Tour at [redacted] site . While conducting the building tour in the [redacted] unit, there were radiator heaters have open grates in the patient rooms that pose a ligature risk to the patients.	§482.13(c)(2)	Standard
				3). Observed in Building Tour at [redacted] site . While conducting the building tour in the [redacted] unit, there were many areas that were out of view of the nurses station and staff where patients	§482.13(c)(2)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				could access the above ceiling area. the ceiling was not clipped to prevent access.		
NPSG.15.01.01	3	High Widespread	Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.	1). Observed in Individual Tracer at [redacted] site . During the patient tracer conducted on the [redacted] unit, the patient was admitted with depression and screened during triage in the ED. There was no documentation of a suicide assessment in the medical record. The [redacted] stated that the psychiatric evaluation conducted by the licensed social worker and the psychiatrist was considered to be the suicide assessment. There was no documentation that the psychiatric evaluation was evidence-based or that it contained information regarding plan, intent, behaviors, risk factors, or protective factors.	§482.13(c)(2)	Standard
NPSG.15.01.01	5	High Widespread	Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for patients at risk for suicide - Guidelines for reassessment - Monitoring patients who are at high risk for suicide	1). Observed in Individual Tracer at [redacted] site . During the patient tracer conducted on [redacted], the patient was admitted with suicidal ideation and was screened as high risk. An assessment confirmed risk. However, the nurse caring for the patient was not certain of when a reassessment was required and the organizational policy did not state when reassessment should occur. The nurse did conduct an reassessment based on her judgement that it was needed.	§482.13(c)(2)	Standard
PC.01.03.01	1	Low Pattern	The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also PC.01.02.13, EP 2)	1). Observed in Individual Tracer at [redacted] site . During the patient tracer conducted in [redacted], the patients had specific needs, i.e. sepsis, developmental delays, nutrition, and cardiac, that were being actively treated, however, these were not included in the plan of care.	§482.23(b)(4)	Standard
				2). Observed in Individual Tracer at [redacted] site . During the patient	§482.23(b)(4)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				tracer conducted on [redacted], the patient had additional conditions that were being treated that were not included in the plan of care.		
PC.02.01.03	7	Low Pattern	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).	1). Observed in Individual Tracer at [redacted] site . During individual tracer activity, orders for incentive spirometry (IS) were reviewed. The order was for IS q 4 hours, starting at 1943 on 11/11. Documentation did not support that this order was followed. The treatments were documented next on 11/12 at 1115, then at 1800 and midnight. This was discussed with leadership who accompanied the surveyor.		
				2). Observed in Individual Tracer at [redacted] site . During individual tracer activity, an order for SCDs was placed on admission on 11/12. They were to be maintained "until discontinued". There was no documentation that they had been applied on 11/12. There was documentation that the patient had refused them during day shift on 11/13. On the evening shift, there was no documentation that the SCDs had been applied or that the patient had refused them. This was reviewed with the [redacted] who navigated the record and with leadership who accompanied the surveyor.		
PC.02.01.11	2	Moderate Limited	Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)	1). Observed in Tracer Activities at [redacted] site . During tracer activities in the [redacted], the contents of the emergency delivery bag were reviewed. It was noted that the end tidal, CO2 detector had expired on 12/21/18.		
PC.02.02.03	6	Moderate Pattern	The hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.	1). Observed in Tracer Visit at [redacted] site . During tracer activities in the [redacted], a staff member was asked to demonstrate her process for cleaning Dr. Brown's specialty feeding bottles. She did not follow		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				manufacturer's instructions for use (IFU) as evidenced by her failure to use a brush to clean the nipples. "The bottle, nipple, collar and internal parts should be disassembled and thoroughly cleaned... after each use with a dishwashing detergent and brush to eliminate all debris." In two out of two logs of sterilization bags which were reviewed, staff had not tracked the number of times these bottles had been sterilized. Hence staff had not ensured that the sterilization bags' use had been limited to the 20 cleaning cycles as required by the IFU. "Each steam sterilization bag can be used for a total of 20 times." These observations were discussed with leadership who accompanied the surveyor.		
PC.02.02.03	11	Low Pattern	The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.	1). Observed in Tracer Activities at [redacted] site . During tracer activities on the [redacted] unit, it was noted that there was out of date food in the nourishment refrigerator. Multiple packets of butter had an expiration date of 11/11/19. These were removed while the surveyor was on site.		
				2). Observed in Tracer Activities at [redacted] site . During tracer activities on the [redacted] unit it was noted that the nourishment refrigerator had not been maintained as evidenced by sticky and dusty shelves. This observation was confirmed by unit leadership who accompanied the surveyor.		
				3). Observed in Tracer Activities at [redacted] site . During individual tracer activity in the [redacted], the nourishment refrigerator was inspected. It was noted to be dirty as evidenced by dusty and sticky shelves. This finding was discussed with leadership who accompanied the surveyor.		
PC.03.05.11	1	Moderate	A physician, clinical psychologist, or other licensed	1). Observed in Individual Tracer at [redacted]	§482.13(e)(12)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
		Limited	independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance. Note 2: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).	[redacted] site . While reviewing the chart of a patient who was in restrains due to active danger of harm to themselves, it was noted that the patient was taken out of 4 point restraints to wrists only. The patient then began [redacted]. A verbal order to resume 4 point restraints was obtained from a different provider. No face to face evaluation was documented in the chart after the resumption of 4 point restraints. Confirmed with [redacted].	(A)	

The Joint Commission

Appendix

Conditions of Participation Text

Program: Hospital

CoP	Tag	CoP Standard text
§482.13 Condition of Participation: Patient's Rights	A-0115	§482.13 Condition of Participation: Patient's Rights A hospital must protect and promote each patient's rights.
§482.13(c)(2) Standard: Privacy and Safety	A-0144	(2) The patient has the right to receive care in a safe setting.
§482.13(e)(12)(i)(A) Standard: Restraint or seclusion	A-0178	(A) Physician or other licensed independent practitioner; or
§482.23 Condition of Participation: Nursing Services	A-0385	§482.23 Condition of Participation: Nursing Services The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.
§482.23(b)(4) Standard: Staffing and Delivery of Care	A-0396	(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.
§482.23(c) Standard: Preparation and Administration of Drugs	A-0405	(c) Standard: Preparation and administration of drugs.
§482.41 Condition of Participation: Physical Environment	A-0700	§482.41 Condition of Participation: Physical Environment The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.
§482.41(a) Standard: Buildings	A-0701	§482.41(a) Standard: Buildings The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
§482.41(b)(1)(i) Standard: Life Safety from Fire	A-0710	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.
§482.41(d)(2) Standard: Facilities	A-0724	(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
§482.41(d)(4) Standard: Facilities	A-0726	(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.

The Joint Commission

CoP	Tag	CoP Standard text
§482.42 Condition of Participation: Infection Control	A-0747	§482.42 Condition of Participation: Infection Control The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.
§482.51 Condition of Participation: Surgical Services	A-0940	§482.51 Condition of Participation: Surgical Services If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.
§482.51(b) Standard: Delivery of Service	A-0951	§482.51(b) Standard: Delivery of Service Surgical services must be consistent with needs and resources. Policies governing surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.
§482.12 Condition of Participation: Governing Body	A-0043	§482.12 Condition of Participation: Governing Body There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.
§482.15 Establishment of the Emergency Program (EP)	E-0001	§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:
§482.15(d)(1)(i) Emergency Prep Training Program	E-0037	(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.

The Joint Commission

Appendix

Standard and EP Text

Program: Hospital

Standard	EP	Standard Text	EP Text
EC.02.02.01	3	The hospital manages risks related to hazardous materials and waste.	The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.
EC.02.02.01	5	The hospital manages risks related to hazardous materials and waste.	The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.
EC.02.03.01	9	The hospital manages fire risks.	The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, and how to evacuate to areas of refuge. Staff and licensed independent practitioners are periodically instructed on and kept informed of their duties under the plan, including cooperation with firefighting authorities. A copy of the plan is readily available with the telephone operator or security. Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.
EC.02.03.05	3	The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Every 12 months, the hospital tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.
EC.02.03.05	4	The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Every 12 months, the hospital tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.
EC.02.03.05	15	The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least monthly, the hospital inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check

Standard	EP	Standard Text	EP Text
			for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.
EC.02.03.05	27	The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Elevators with firefighters' emergency operations are tested monthly. The test completion dates and results are documented. (For full text, refer to NFPA 101-2012: 9.4.3; 9.4.6)
EC.02.04.03	3	The hospital inspects, tests, and maintains medical equipment.	The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented. Note: Scheduled maintenance activities for non-high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital's AEM program.
EC.02.05.01	9	The hospital manages risks associated with its utility systems.	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.
EC.02.05.01	15	The hospital manages risks associated with its utility systems.	In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).
EC.02.05.01	16	The hospital manages risks associated with its utility systems.	In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. Note: Examples of non–critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments.

Standard	EP	Standard Text	EP Text
EC.02.05.05	4	The hospital inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.	The hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate. Note 3: Scheduled maintenance activities for high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.
EC.02.05.05	5	The hospital inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.	The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented. Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers' recommendations must have a 100% completion rate. Note 2: Scheduled maintenance activities for infection control utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.
EC.02.05.05	8	The hospital inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.	The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning (HVAC). (For full text, refer to NFPA 99-2012: Chapters 6 and 9) Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3.
EC.02.05.09	11	The hospital inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.	The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in

Standard	EP	Standard Text	EP Text
			emergency. (For full text, refer to NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11)
EC.02.06.01	1	The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
EC.02.06.05	2	The hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.	When planning for demolition, construction, renovation, or general maintenance, the hospital conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services. Note: See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.
HR.01.01.01	2	The hospital defines and verifies staff qualifications.	The hospital verifies and documents the following: - Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.
IC.02.01.01	1	The hospital implements its infection prevention and control plan.	The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. (See also MM.09.01.01, EP 5)
IC.02.02.01	1	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies. * Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions. Footnote *: For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the

Standard	EP	Standard Text	EP Text
			website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3.
IC.02.02.01	2	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4) Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes. Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3 (Sterilization and Disinfection in Healthcare Settings).
LD.01.03.01	12	The governing body is ultimately accountable for the safety and quality of care, treatment, and services.	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a governing body that assumes full legal responsibility for the operation of the hospital.
LD.04.01.05	4	The hospital effectively manages its programs, services, sites, or departments.	Staff are held accountable for their responsibilities.
LS.01.02.01	14	The hospital protects occupants during periods when the Life Safety Code is not met or during periods of construction.	The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital's interim life safety measure (ILSM) policy. Note: Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.
LS.02.01.10	1	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.	Buildings meet requirements for construction type and height. In Types I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. All new buildings contain approved automatic sprinkler systems. Existing buildings contain approved automatic sprinkler systems as required by the construction type. (For full text, refer to NFPA 101-2012: 18/19.1.6; 18.3.5.1; 19.3.5.3; 18/19.3.5.4; 18/19.3.5.5; 18.3.5.6)
LS.02.01.10	14	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.	The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.

Standard	EP	Standard Text	EP Text
			Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)
LS.02.01.34	9	The hospital provides and maintains fire alarm systems.	The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)
LS.02.01.35	4	The hospital provides and maintains systems for extinguishing fires.	Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2)
LS.02.01.35	5	The hospital provides and maintains systems for extinguishing fires.	Sprinkler heads are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)
LS.02.01.35	10	The hospital provides and maintains systems for extinguishing fires.	The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed either in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 18/19.3.5.12; 9.7.4.1; NFPA 10-2010: 6.2.1.1; 6.1.3.3.1; 6.1.3.4; 6.1.3.8)
MM.05.01.01	4	A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.	All medication orders are reviewed for the following: - Patient allergies or potential sensitivities - Existing or potential interactions between the medication ordered and food and medications the patient is currently taking - The appropriateness of the medication, dose, frequency, and route of administration - Current or potential impact as indicated by laboratory values - Therapeutic duplication - Other contraindications
MM.05.01.01	11	A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.	After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.
MM.05.01.07	2	The hospital safely prepares medications.	Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.
MM.06.01.01	3	The hospital safely administers medications.	Before administration, the individual administering the medication does the following: - Verifies that the medication selected matches the medication order and product label - Visually inspects the medication for particulates, discoloration, or other loss of integrity (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3) - Verifies that the medication has not expired - Verifies that no contraindications exist

Standard	EP	Standard Text	EP Text
			- Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route - Discusses any unresolved concerns about the medication with the patient's licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient's care, treatment, and services
NPSG.01.01.01	1	Use at least two patient identifiers when providing care, treatment, and services.	Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 7 and 10; NPSG.01.03.01, EP 1)
NPSG.15.01.01	1	Reduce the risk for suicide. Note: EPs 2–7 apply only to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospitals.	For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital. Note: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).
NPSG.15.01.01	3	Reduce the risk for suicide. Note: EPs 2–7 apply only to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospitals.	Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.
NPSG.15.01.01	5	Reduce the risk for suicide.	Follow written policies and procedures addressing the care of patients

Standard	EP	Standard Text	EP Text
		Note: EPs 2–7 apply only to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospitals.	identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for patients at risk for suicide - Guidelines for reassessment - Monitoring patients who are at high risk for suicide
PC.01.03.01	1	The hospital plans the patient's care.	The hospital plans the patient's care, treatment, and services based on needs identified by the patient's assessment, reassessment, and results of diagnostic testing. (See also PC.01.02.13, EP 2)
PC.02.01.03	7	The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital provides care, treatment, and services using the most recent patient order(s).
PC.02.01.11	2	Resuscitation services are available throughout the hospital.	Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)
PC.02.02.03	6	The hospital makes food and nutrition products available to its patients.	The hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.
PC.02.02.03	11	The hospital makes food and nutrition products available to its patients.	The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.
PC.03.05.11	1	The hospital evaluates and reevaluates the patient who is restrained or secluded.	A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3. Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance. Note 2: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

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Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

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Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

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Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.