FALL/WINTER 2021

Quality Review Edition

THE SURVEYOR

ACUTE CARE HOSPITAL CRITICAL ACCESS HOSPITAL

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MISSION STATEMENT

Accreditation Commission for Health Care (ACHC) is dedicated to delivering the best possible experience and to partnering with organizations and healthcare professionals that seek accreditation and related services.

CORNER VIEW

In the fall of 2020, ACHC merged with the parent company of the first U.S. healthcare accreditation program, HFAP. The merger added CMS-deemed accreditation for facility-based care including acute care hospitals, ambulatory surgery centers, clinical laboratories, critical access hospitals; non-deemed accreditation for office-based surgery; and certification for stroke care, wound care, joint replacement, and lithotripsy to ACHC's existing portfolio of community-based accreditation and education programs.

Part of the assimilation process has been to audit our distinct resources in order to bring the very best from each separate entity to our new, unified company. You are reading one result of that exercise. **The Surveyor** is an ACHC legacy publication, but the Fall/Winter edition now parallels what was previously HFAP's annual **Quality Review**. That publication examined the most frequently cited deficiencies for each accreditation program to give organizations a tool for benchmarking and improving their performance.

> **While healthcare is constantly evolving, we are currently emerging from a time of unusually rapid change.**

In years past, ACHC identified frequent deficiencies by program and made them available annually as a "top ten" list. Now, using **The Surveyor** to share the data gives us a vehicle to add value by deepening the analysis. This is presented in separate editions for closely affiliated programs. You can access any of them on our website (achc.org) under Resources and Education/Publications.

As you review the edition or editions most relevant to your setting, you will read examples of actual survey findings. These serve to clarify the specific aspects of the standard that were found to be non-compliant. Following the sample citations, you'll find tips for compliance.

While healthcare is constantly evolving, we are currently emerging from a time of unusually rapid change. Some of the deficiencies cited in the following pages can be traced directly to the impact of COVID-19. Many organizations made significant adjustments to continue to meet the needs of their patient/client populations: adopting new technology for remote visits and patient monitoring; sourcing against PPE shortages; reassigning staff to manage furloughs and quarantines. These are all examples of unanticipated change that required quick action that may have shifted focus away from some areas of required compliance.

Organizations that previously received the HFAP **Quality Review** used it in conjunction with their Deficiency Report (ACHC's Summary of Findings) to compare their performance against peer organizations and to proactively address issues frequently seen in other organizations. Used this way, the data becomes part of the process of continuous quality improvement and on-going survey readiness. We want to help you avoid a series of ramp up activities as your survey approaches by making ACHC Standards part of your overall quality strategy.

As always, ACHC is here as a partner in meeting your accreditation and education needs. Your feedback on this publication and on any aspect of our programs is welcomed and invited.

José Domingos
President & CEO

TOP DEFICIENCIES

Acute Care Hospital Clinical and Administrative Deficiencies 6
Critical Access Hospital Clinical and Administrative Deficiencies 16
Emergency Management Deficiencies (all hospitals) 24
Physical Environment Deficiencies (all hospitals) 29
Life Safety Deficiencies (all hospitals) 35

ACHC's Acute Care Hospital Accreditation Program and Critical Access Hospital Accreditation Program offer "deemed status" for Medicare-certified facilities or "accreditation only" for those that are reviewed for CMS by the state agency or do not bill Medicare for services.

FROM THE PROGRAM DIRECTOR

For the past five years, we have provided an annual review of the "top deficiencies" across hospitals based on surveys conducted. While the appearance of individual standards has varied, there has been a level of consistency with regard to the general topics that pose challenges for hospitals.

Trending Deficiencies

Organizations look to ACHC (and to HFAP prior to our merger) for leadership in establishing and evaluating quality. Identifying frequently-cited deficiencies provides a data-driven review of survey results across a defined period of time. It gives ACHC-accredited hospitals a roadmap for improvement and it helps guide our efforts to provide relevant, actionable education.

The data in this report reflect deficiencies cited on surveys performed between June 1, 2020, and May 31, 2021.

We were curious about what the ongoing COVID-19 public health emergency (PHE) might reveal over this period. Virtually every hospital experienced a direct impact — and for many, this continues — creating new and significant stress on resources and processes. In some instances, there is a direct correlation between this impact and the deficiencies cited.

Two examples will require an increased level of attention for many organizations, especially as an extraordinary situation evolves to a "new normal."

1. Citations related to storage of supplies.
   Materials are stored throughout the hospital and supplies have seen more frequent turnover and movement with increased utilization of inpatient services. Standardized practices to maintain safe storage are essential.
2. Failure to approve required policies, procedures, plans, and related documents.
   This may be the result of a decrease in the frequency of meetings or a switch to remote meetings. However, the expectation for compliance remains.

Fewer repeat deficiencies

Most of the findings in this report are not repeat deficiencies. As previously noted, we design education based on these annual results so it is encouraging to see the value of this ongoing process play out. Another positive observation includes the low volume of deficiencies related to Emergency Management. Pre-COVID, there was significant emphasis on Emergency Management. Under the PHE, planning came to reality and it is great to see hospitals maintaining compliance with this chapter.

More and more, hospital see improved survey results as they go through the accreditation process multiple times. Each cycle allows for a deeper dive for the ACHC Surveyor and a recalibration opportunity for the hospital. Generally speaking, we find that organizations that embrace the concept of accreditation as a framework for continuous quality improvement do improve over time.

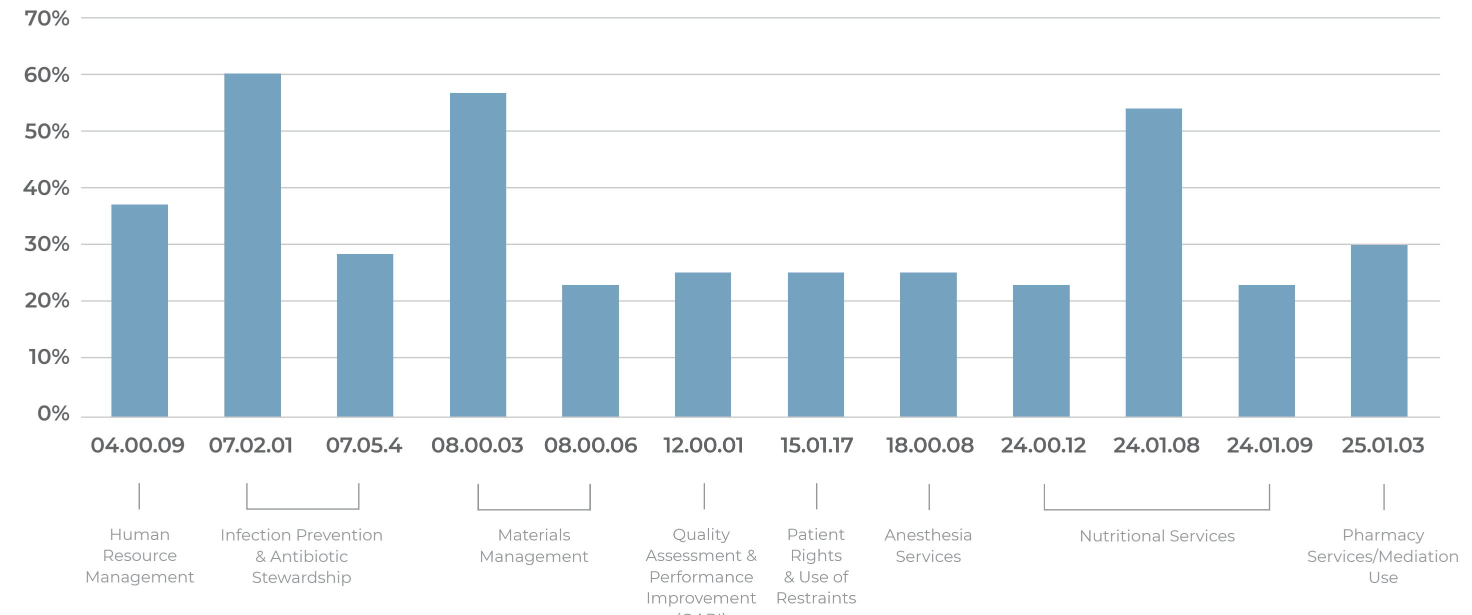
Our focus is always on the individual organization and how it meets the standards in a practical, sustainable way. This personal approach is appreciated by hospitals and systems of all sizes and organizational structures, and we are proud of our exceptional customer retention rate.

The ACHC Acute Care and Critical Access Hospital teams continue to look for ways to use customer feedback to improve our process, specifically with training and consistency among Surveyors and standards interpretation. In the coming year, we plan to build on the momentum that the program has created by improving internal performance and building increased value in the programs that we offer. I speak for the entire team when I say that your feedback is welcomed and valued.

Deanna Scatena

Deanna Scatena, RN
Associate Program Director

ACUTE CARE HOSPITAL CLINICAL AND ADMINISTRATIVE DEFICIENCIES



ACUTE CARE HOSPITAL

HUMAN RESOURCE MANAGEMENT

04.00.09 Evaluation of Competence

Overview of the requirement

The standard requires ongoing assessment of staff competency.

Comment on deficiencies

This deficiency is cited when HR files are not complete and accurate relative to annual staff competency and training.

Frequency of citation: 37%

Examples of Surveyor findings

- HR files did not contain probationary employee evaluations completed within 90 days, per hospital policy.
- Job specific competencies were not defined for all positions.
- Employee files lacked documentation of competency evaluation.

Tips for compliance

- Conduct periodic audits of job descriptions and associated competencies.
- Routinely audit HR files for accuracy and completeness.

INFECTION PREVENTION AND CONTROL AND ANTIBIOTIC STEWARDSHIP PROGRAMS

07.02.01 Risk Mitigation Measures for Infection Prevention

Overview of the requirement

Hospitals have documented policies and procedures for preventing and controlling the transmission of infection within the facility and between the facility and other settings.

Comment on deficiencies

The standard is most often cited when equipment is not maintained thereby increasing risk of transmitting infection.

Frequency of citation: 60%

Examples of Surveyor findings

- While touring Surgical Services, the following infection control issues were observed: rust on wheels and on IV poles, prep tables, trash cans; paint chips in various locations, air supply vents and air return grilles with a heavy static dust covering them, and stained ceiling tiles.

- Based on interview, the infection control practitioners failed to identify and monitor locations where high-level disinfection was being conducted to verify the required standards were being met.
- Based on a tour of the facilities, the following deficiencies were observed: clean scrubs on the floor, next to the clean linen cart in the clean utility room; clean supplies and PPE including face-shields were stored in the soiled utility room; corrugated cardboard boxes in the delivery area; monitor in the corner of the OR had heavy layer of static dust.

Tips for compliance

- Conduct regular infection control surveillance rounds with rotating participation by multiple departments to promote a culture of cleanliness.
- Create infection control quality goals related to environmental conditions.
- Ensure infection preventionist(s) conducts/participates in active surveillance rounding. "Walking rounds" are conducted to assess conformance with standard precautions and aseptic principles. Throughout the hospital, observe the sanitary condition of the environment of care, noting the cleanliness of patient rooms, floors, horizontal surfaces, patient equipment, air inlets, mechanical rooms, food service activities, treatment and procedure areas, surgical areas, central supply, storage areas, etc.
- Policies and procedures are in place defining housekeeping services, linen service compliance, and the hospital's maintenance of environment. Ensure that these are approved by the Infection Prevention and Control function/leadership.

07.05.04 Maintenance of Ceilings

Overview of the requirement

Ceilings are maintained to prevent contaminants from falling into patient care and food service areas.

Comment on deficiencies

Deficiencies noted evidence of deferred ceiling maintenance across many areas of the hospitals surveyed.

Frequency of citation: 28%

Examples of Surveyor findings

- During the building tour, the following was observed: stained ceiling tiles; ceiling grids taped to the ceiling tiles with clear plastic tape.
- In the ER, the grille in the ceiling of the x-ray room had a heavy build-up of dust.
- In the med/surg department, four of seven ceiling tiles in an empty patient room had gaps where the tiles were not correctly seated.
- In the hallway by staff showers, water damage was noted on two ceiling tiles.

Tips for compliance

- Include ceilings on a checklist for environmental rounds.
- Correct deficiencies as soon as they are noted.

MATERIALS MANAGEMENT

08.00.03 Safe Storage of Supplies

Overview of the requirement

Supplies are appropriately stored based on their use (protected from moisture, thermal change) and other risks (rodents, vermin, theft).

Comment on deficiencies

Most citations related to maintenance of storage areas.

Frequency of citation: 58%

Examples of Surveyor findings

- Housekeeping cleaning supplies were stored in the same room as sterile patient supplies.
- During the tour of the hospital, corrugated cardboard was observed as follows: walkers were packaged and stored with corrugated cardboard dividers in the clean storeroom; cardboard shipping containers co-mingled with open containers of clean supplies in the main laboratory and laboratory storage area; storerooms.
- An unmarked, unlabeled refrigerator was located immediately adjacent to the receiving dock. There was no temperature monitoring log for this refrigerator.

Tips for compliance

- Develop a process for the management of corrugated shipping containers and clean supplies.
- Routinely inspect supply carts, cabinets, and storeroom(s).
- Store supplies off floor surfaces by at least four inches.
- Group/segregate supplies by type.
- Do not store hazardous chemicals with food products, medical supplies, or medications.
- Supplies requiring special temperature ranges are identified and stored accordingly.

08.00.06 Materials Management

Overview of the requirement

Hospitals must have policies and procedures implemented to effectively manage product recalls.

Comment on deficiencies

Deficiencies resulted from incomplete and inconsistent documentation and corrective actions.

Frequency of citation: 23%

Examples of Surveyor findings

- Safety Committee meeting minutes did not include adequate information (number of recall alerts, recall alerts still open/pending, special problems)to ensure that recalls were handled effectively.

- Policies lacked required elements.
- Process of product recall notification only consisted of verbal communication.
- Procedures lacked a documented process to validate that all recalled products have been removed from inventory.

Tips for compliance

- Review policies and procedures on product recalls to ensure that policies are comprehensive and effective.
- Re-educate staff on the process for product recall notification, verification, and monitoring, including best practices on documentation.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

12.00.01 Data Collection and Analysis: Program Scope

Overview of the requirement

The hospital must have a program showing measurable improvement and evidence of improving health outcomes. The QAPI program is focused on identifying high-risk opportunities and taking action to reduce errors.

Comment on deficiencies

Deficiencies resulted from ineffective data collection and inconsistencies in quality data reporting.

Frequency of citation: 26%

Examples of Surveyor findings

- No evidence that the governing body had reviewed the annual Quality Plan.
- No evidence of data collection and monitoring for effectiveness and safety related to contracted services.
- Departments had annual quality plans but lacked an overview of how and why the metrics were developed.
- Quality indicators were not reported to the Quality Committee and Board.

Tips for compliance

- Re-educate the governing body, the Quality Committee, and all staff on the importance of an effective QAPI program.
- Conduct review of the current QAPI program and identify areas for improvement.

PATIENT RIGHTS AND USE OF RESTRAINTS

15.01.17 Privacy and Safety: Safe Setting

Overview of the requirement

Patients receive care in an environment that protects physical and emotional health and safety. The required elements of the standard include a focus on risk mitigation for patient self-harm.

Comment on deficiencies

Deficiency findings focused on missed environmental safety risks and lack of staff training on how to assess patients for risk of self-harm.

Frequency of citation: 26%

Examples of Surveyor findings

- Patient medical beds with side rails and several looping points on the bed frames present a ligature potential for patient self-harm.
- Patient bathrooms have gooseneck and lever handle faucets that present a looping and ligature potential for patient self-harm; toilets with exposed plumbing pipes without a safety cover also have potential for patient harm.
- Psychiatric unit policy for the hospital requires the day room to be either under continuous observation with staff present or locked so that no one can enter. During the tour of the unit, a wandering patient was observed exiting the day room. The room was neither secured nor under continuous observation. The entrance to the room lacked a door to secure the room. The room had tables and chairs that were not bolted; the moveable furniture could serve as a weapon or a ligature risk; a dropped ceiling was observed which can be a ligature risk.
- The organization failed to protect a minor patient who presented to the Emergency Department following an alleged suicidal attempt.

Tips for compliance

- Establish policies and procedures to assess and identify patients at risk of harm to self or others throughout the organization.
- Develop an environmental risk assessment tool to identify potential ligature risks.
- Conduct environmental risk assessment every six months.
- Locked psychiatric units and locked emergency department psychiatric units/rooms must be ligature resistant or ligature free. Other units in the facility must identify the potential ligature risks and develop measures to mitigate existing risk to patients.
- Provide education and training to staff and volunteers regarding assessments and mitigation efforts.

ANESTHESIA SERVICES

18.00.08 Equipment Safety

Overview of the requirement

Anesthetizing equipment is appropriately maintained.

Comment on deficiencies

This standard crosses the realms of equipment management, medical records, and anesthesia services. Deficiencies in each of these areas contributed to citations for this standard.

Frequency of citation: 26%

Examples of Surveyor findings

- Based on document review, surgical records did not include the anesthesia machine number.
- Based on observation, it was found that none of the anesthesia machines has been labeled with an identification number.

Tips for compliance

- Inventory and assign ID tags to all equipment.
- Calendar maintenance per manufacturer's instructions.
- Include identification of equipment used as part of all surgical records.

NUTRITIONAL SERVICES

24.00.12 Emergency Preparedness Plan

Overview of the requirement

The hospital's Emergency Operations Plan addresses how it will meet the nutritional needs of patients, visitors, and personnel in an emergency by addressing service interruptions and mandating a three-day inventory of needed items.

Comment on deficiencies

Deficiencies noted the omission of Nutrition Services from the hospital's Emergency Operations Plan or a lack of inventory based on calculation to meet three days of nutritional needs for the hospital.

Frequency of citation: 23%

Examples of Surveyor findings

- Based on policy review and interview, the Emergency Preparedness Plan does not specifically address the role of Nutrition Services regarding alternative cooking methods, Memoranda of Understanding from vendors providing food and supplies, and a three-day menu/inventory with the calculations for amounts of supplies needed.
- Based on review of the Emergency Operations Plan (EOP) for nutrition, it was observed that the EOP did not address loss of generator fuel or failure of equipment, pumps, and refrigeration or cooking appliances.
- The supply list had not been reviewed semi-annually with the inventory checked and updated.

Tips for compliance

- Nutrition Services has a specific role within the Emergency Preparedness Plan. Regular review of the plan should include collaboration among departments with defined responsibilities for operations in an emergency.

24.01.08 Physical Environment

Overview of the requirement

The intent of the standard is to ensuring proper labeling, storage, and risk mitigation measures for infection control within food services.

Comment on deficiencies

This high-frequency deficiency was mostly cited because of inadequate storage, labeling, or maintenance within the department.

Frequency of citation: 53%

Examples of Surveyor findings

- The casters on the movable fryer were observed to be heavily rusted and corroded indicating they should be replaced.
- The emergency pull station for the Ansul hood fire suppression system was blocked by food carts and other equipment, which impeded access to the pull station.
- Accumulated debris in floor seam separations, rusted ceiling vents, and chipped paint and exposed metal on the floor mixer were observed.
- The tops of several appliances (refrigerators) were visibly dirty.
- During the departmental tour of Nutrition Services, food supplies were observed to be unlabeled, lacking an indication of the contents, open date, and expiration date.

Tips for compliance

- Re-educate staff on the labeling of food supplies.
- Engage the nutritional/food services director in general environmental rounds to build a culture of cleanliness.
- Ensure that the kitchen areas are included in overall inspection of the physical environment, supplies, and equipment for cleanliness and compliance with regulations.

24.01.09 Lighting, Ventilation, and Temperature Control

Overview of the requirement

Ventilation, temperature, and airflow are consistent with nationally accepted guidelines. Lighting is adequate and bulbs are shielded from the possibility of dropping glass if broken.

Comment on deficiencies

Most deficiencies resulted from temperatures outside of mandated ranges.

Frequency of citation: 23%

Examples of Surveyor findings

- Based on document review, the temperature chart for the month of January 2021 reflected dish machine wash cycle temperatures as below 155°F 60% of the time.
- The walk-in freezer, which opens to the outside loading dock, had dripping condensation and moderate ice build-up.
- There were no temperature logs for the refrigerator.
- Refrigerators and the dishwashing machine had recorded temperatures outside the acceptable ranges and no action had been initiated to rectify these temperature variances.

Tips for compliance

- Temperature recording processes should be evaluated to maintain proper temperatures. Take corrective action immediately when necessary.
- Conduct routine inspection of the food preparation area to maintain cleanliness and infection control.

PHARMACY SERVICES/MEDICATION USE

25.01.03 Security of Medications

Overview of the requirement

Medication is stored to prevent unauthorized access.

Comment on deficiencies

Deficiencies note unattended, unlocked carts of supplies, including medications; unsecured, used sharps; and unused portions of medications.

Frequency of citation: 30%

Examples of Surveyor findings

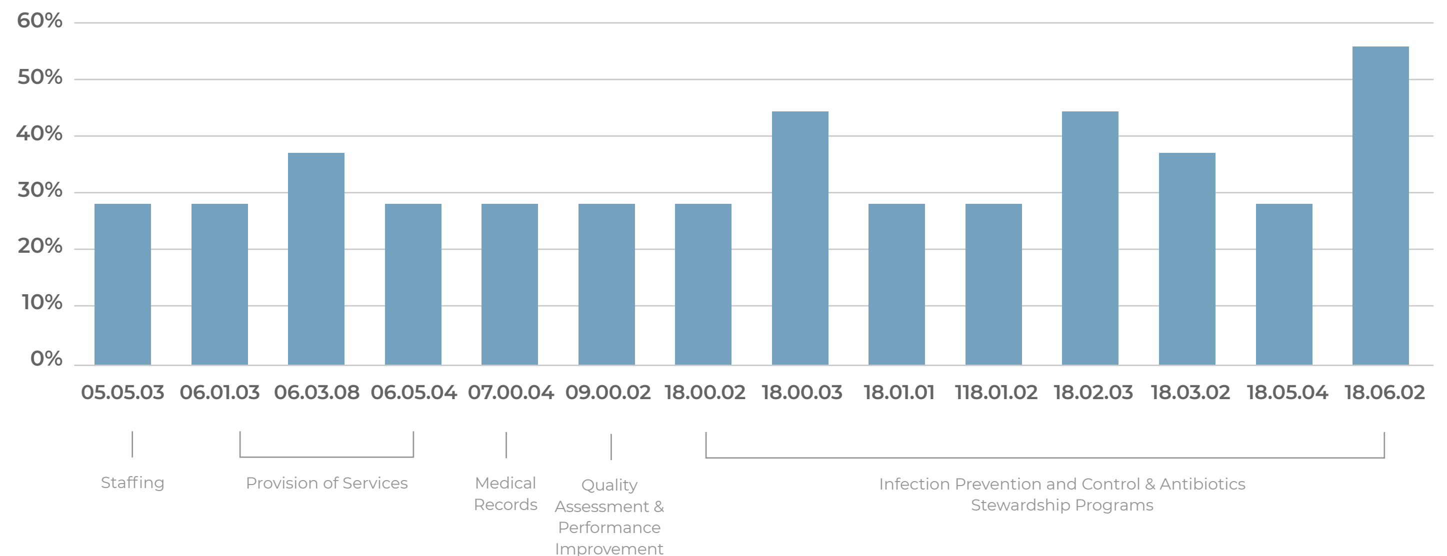
- While touring surgical services, an unlocked anesthesia cart was observed in an unoccupied OR containing two drawers of non-secured anesthesia medications including Propofol.
- Open sharps containers were observed to contain unused portions of medications following surgical procedures; this included syringes of unused Propofol.
- Sharps containers had lids but neither of the container lids was closed.
- The mobile crash cart, which contains medications, is not secured when the unit is closed.
- Code carts were stored in cubby holes in the hallway away from a nursing station preventing continuous observation and outside of a locked area. Standards require that due to mobility, mobile carts containing drugs must be locked in a secure area when not in use.

Tips for compliance

- Environmental surveillance could include observation of secured medications.
- Establish rounding/auditing for medication security in carts, and appropriate disposal of medications and sharps.
- Hospitals must balance the need to access medications quickly with the need to secure them from unauthorized individuals. Establish policies to place carts with drugs and biologicals in a locked room or a secured area.

CRITICAL ACCESS HOSPITAL

CRITICAL ACCESS HOSPITAL CLINICAL AND ADMINISTRATIVE DEFICIENCIES



STAFFING

05.05.03 Evaluation of Competence

Overview of the requirement

The standard addresses ongoing assessment of staff competency.

Comment on deficiencies

This deficiency is cited when HR files are not complete and accurate relative to annual staff competency and training.

Frequency of citation: 27%

Examples of Surveyor findings

- Based on review of personnel records, there was no documentation that the nurses had the training to care for pediatric patients.
- Based on the HR file review, it was observed that contract employee files did not include evidence that an initial 90-day or ongoing annual competency evaluation had been completed.

Tips for compliance

- Conduct periodic audit of job descriptions and associated competencies.
- Routinely audit HR files for accuracy and completeness.

THE PREPARATION & ADMINISTRATION OF MEDICATIONS

06.01.03 Security

Overview of the requirement

Drugs and biologicals are stored as per state and federal laws. CAH policies and procedures must address access to pharmacy/drug storage areas.

Comment on deficiencies

Deficiencies for this standard do not necessarily reflect inadequate policies and procedures. Rather, the implementation needs to be reviewed and staff to be re-educated on policy.

Frequency of citation: 27%

Examples of Surveyor findings

- Respiratory therapy medications are not secured appropriately.
- Nebulizers are bulk distributed to respiratory therapy from the pharmacy without itemized control.
- Unlocked anesthesia boxes contain unused drugs that were not appropriately disposed of after each surgical case.
- Medication is stored in an unlocked, unattended exam room.

Tips for compliance

- Review the storage and security protocol for drugs and biologicals with staff.

PROVISION OF SERVICES: NUTRITIONAL SERVICES

06.03.08 Policy Requirements: Food Preparation and Storage

Overview of the requirement

Food products are maintained to ensure an acceptable level of safety and quality.

Comment on deficiencies

Citations focused on temperature monitoring, the maintenance of food preparation equipment, and the physical environment in which it takes place.

Frequency of citation: 36%

Examples of Surveyor findings

- The dry storage room had supplies blocking sprinkler heads.
- The gas shut off valve was not labeled and kitchen staff were unsure of its location.
- The walk-in freezer had static dust on its fan guards and ice accumulation on the ceiling near the condenser.
- Corrugated cardboard shipping containers were observed to occupy 40-50% of the shelf space.
- Temperature logs were not maintained consistently.

Tips for compliance

- Acceptable temperature ranges are defined and logs are maintained to promote immediate action when temperatures go out of range.
- Conduct routine surveillance rounds of the food preparation area to maintain appropriate conditions for storage of supplies.

PROVISION OF SERVICES: LABORATORY SERVICES

06.05.04 Point of Care Testing

Overview of the requirement

Regardless of where testing is performed and who performs it, the laboratory manager is responsible for testing processes which meet all requirements for competency, quality control, and monitoring.

Comment on deficiencies

Deficiencies cited lack of labeling on testing supplies when opened and laboratories not tracking competency testing.

Frequency of citation: 27%

Examples of Surveyor findings

- It was observed that staff failed to write the expiration date on two vials of AccuChek Inform II solution after it was opened.
- Based on document review and review of the point of care testing records, the laboratory is tracking competency testing by office location rather than for each individual who performs tests. The current record keeping method is fragmented and makes it difficult to determine if employees had completed annual competency testing.

Tips for compliance

- Re-train staff to correctly label testing supplies upon opening.
- Evaluate policies on competency testing to ensure that it is tracked for each individual employee who performs tests and for each test performed.

MEDICAL RECORDS

07.00.04 Record Content Requirements

Overview of the requirement

The standard identifies elements required for a patient medical record to be considered complete, including consent forms, progress notes, discharge summary, and follow-up care.

Comment on deficiencies

Deficiencies cited incomplete records with discharge summaries, surgical informed consents, anesthesia risk assessments, and post-anesthesia evaluations most frequently noted as missing.

Frequency of citation: 27%

Examples of Surveyor findings

- Based on review of closed inpatient medical records older than seven days post-discharge, discharge summaries were missing.
- Open medical records of patients who had undergone surgical procedures requiring anesthesia had incomplete informed consents for anesthesia.

Tips for compliance

- Review the policies for medical records with staff and re-educate on best practices for documentation.
- Conduct regular audits of medical records for completeness and accuracy.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

09.00.02 QAPI

Overview of the requirement

The CAH's QAPI program must be organization-wide, involving all services including those provided by contractors.

Comment on deficiencies

Surveyors noted that data collected did not include all services provided.

Frequency of citation: 27%

Examples of Surveyor findings

- The annual QAPI plan lacked quality indicators for contracted services.
- Based on review of QAPI committee minutes and quality reports, the QAPI program did not include all departments and services.

Tips for compliance

- Document all contracted services and perform regular audits to maintain accuracy and completeness.
- Establish and communicate expectations for performance through identification of metrics and regular reporting. When metrics are not met, define corrective actions and time frame for remeasurement.
- Establish a schedule for patient care and contracted services to be reviewed and for data to be collected.
- Educate the staff on the QAPI plan and data collection interval indicated.

INFECTION PREVENTION & ANTIBIOTIC STEWARDSHIP

18.00.02 & 18.01.02 Infection Prevention and Control Program Leadership /Antibiotic Stewardship Program Leadership

18.00.03 Responsibilities of the Infection Control Professional

18.01.01 Responsibilities of the Antibiotic Stewardship Program Leader

Overview of the requirements

Chapter 18 was a new chapter in 2020 designed to consolidate standards that had been previously split across chapters related to specific services. The new chapter gives additional prominence to the importance of infection prevention and antibiotic stewardship. The standards below are closely related in addressing a focus on program leadership and responsibilities.

Comment on deficiencies

Surveyors noted that some facilities had not designated program leaders and in cases where there was a designation, the written job descriptions did not include the range of responsibilities defined by the standard to lead infection control or antibiotic stewardship.

Frequency of citation: 18.00.02 & 18.01.02: 27% | **18.00.03:** 45% | **18.01.01:** 27%

Examples of Surveyor findings

18.00.02 & 18.01.02:

- Based on document review, the hospital has not designated in writing an individual or group of individuals as its infection preventionist(s)/infection control officer(s).
- Based on document review, the hospital has not designated in writing an individual or group of individuals as its antibiotic stewardship leader(s).

18.00.03:

- The job description for the infection prevention professional did not include the responsibilities defined by the standard.
- Based on interview, the organization lacked evidence of education for users of all sterile products regarding the importance of evaluating hinged or ratcheted instruments to ensure they did not become closed or locked during the sterilization processes and to reject these instruments upon discovery. The infection prevention professional is responsible for the education and training of all personnel and the development, implementation, and adherence to infection prevention policies and procedures.

18.01.01:

- The job description for the antibiotic stewardship program leader did not include the responsibilities defined by the standard.

Tips for compliance

- Assign leadership to these programs.
- Review job descriptions for compliance with the requirements.
- Review infection prevention and control policies to ensure a comprehensive program that includes staff education and training.
- Review antibiotic stewardship program policies to establish a comprehensive program that includes staff education and training.

18.02.03 Environmental Surveillance

Overview of the requirement

Reports of environmental surveillance activities are reported by the infection control leader to various committees.

Comment on deficiencies

Deficiencies were noted when reports were not appropriately circulated.

Frequency of citation: 45%

Examples of Surveyor findings

- Based on document review, the facility conducts regular 'walking rounds' but the surveillance reports are not submitted to the Infection Control Committee for review.

Tips for compliance

- Schedule a regular cadence of report deadlines and route the reports through the Infection Control Committee for review prior to further distribution to the required list.
- Have each relevant committee insert review of the report as a standing agenda item to ensure that its review is performed and documented.

18.03.02 Employee Health Policies

Overview of the requirement

The Infection Control Committee is responsible for establishing and evaluating employee health policies. This is accomplished through at least quarterly review of health reports and annual approval of the Employee Health Plan.

Comment on deficiencies

Deficiencies were cited when there was no documentation that the Infection Control Committee had approved or reviewed the Employee Health Plan.

Frequency of citation: 36%

Examples of Surveyor findings

- Employee Health Plan was not approved by the Infection Control Committee for the past three years.

Tips for compliance

- Orient the Infection Control Committee and Human Resources to the relationship between the employee health plan and infection prevention.
- Audit the hospital's Employee Health Plan to ensure that the plan is approved by the Infection Control Committee and that the annual approval is documented.
- Ensure that reports are maintained and distributed for review at least quarterly with relevant OSHA forms completed.

18.05.04 Maintenance of Ceilings

Overview of the requirement

Ceilings are maintained to prevent contaminants from falling into patient care and food service areas.

Comment on deficiencies

Deficiencies noted evidence of deferred ceiling maintenance across many areas of the hospitals surveyed.

Frequency of citation: 27%

Examples of Surveyor findings

- During the building tour, poorly seated ceiling tiles, stained ceiling tiles, and perforated or cracked ceiling tiles were observed.

Tips for compliance

- Include ceilings on a checklist for environmental rounds.
- Correct deficiencies as soon as they are noted.

18.06.02 Clean Linen Storage

Overview of the requirement

Soiled and clean linen are segregated and clean linen is stored and transported to prevent inadvertent contamination from airborne or surface sources.

Comment on deficiencies

Generally, linen is stored in multiple locations for convenient access. Each location must comply with the requirements of the standard. Deficiencies were cited for each instance of non-compliance.

Frequency of citation: 55%

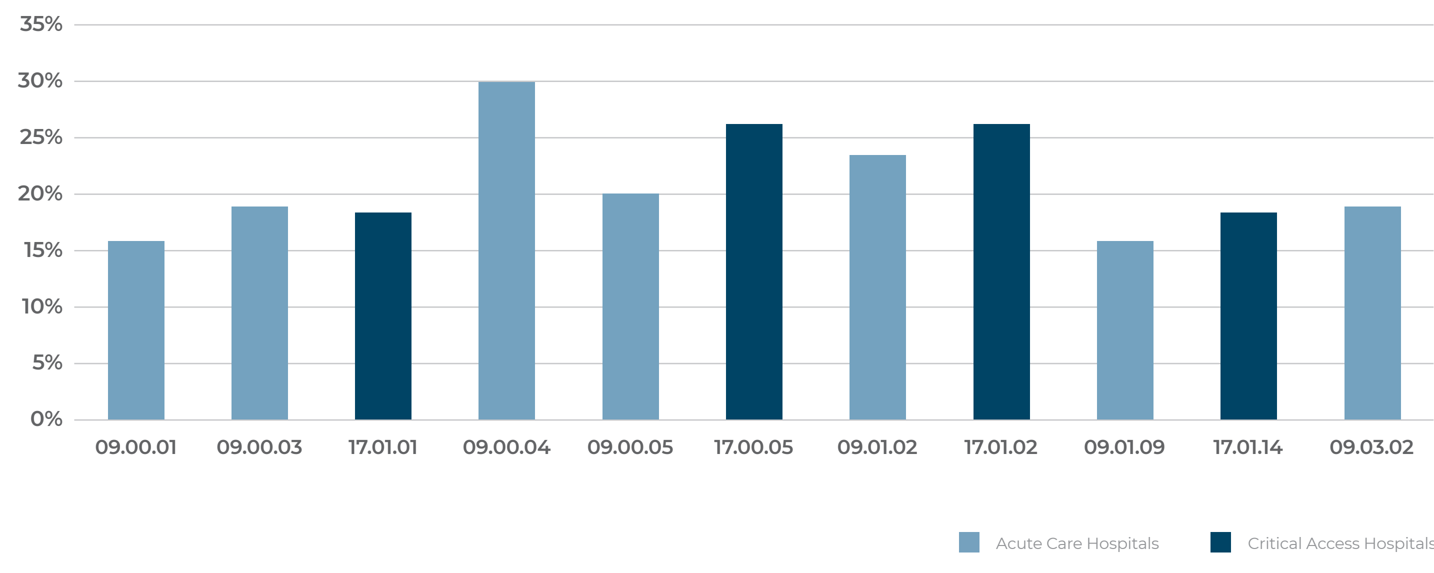
Examples of Surveyor findings

- During a tour of the endoscopic suite, uncovered clean linen was observed in an open cabinet unit.
- In the environmental service's clean linen room, an accumulation of dust and debris was observed on the floor under the clean linen.
- In the medical-surgical unit linen storage closet, the bottom shelf on the clean linen rack lacked a solid surface.
- The linen cart in the clean storage area was unzipped and patient gowns were lying on top of the cart.
- The linen cart was not zippered and the cover for the linen cart had tears in it.

Tips for compliance

- Provide training to emphasize the relationship between appropriate storage and transportation of linens and infection control.
- Conduct routine inspections of all clean linen storage areas to ensure that infection control measures are followed.

EMERGENCY MANAGEMENT DEFICIENCIES



09.00.01: Condition of Participation: Emergency Preparedness (ACH)
09.00.03: Emergency Operations Plan (ACH)
17.01.01: Policies and Procedures (CAH)

Overview of the requirements

The hospital's emergency preparedness program must include planning, procedures, communication, training, and testing.

The Emergency Operations Plan (EOP) must be developed and available to all staff for crisis preparation and response.

Comment on deficiencies

- Deficiencies were cited due to missing elements in the hospital's emergency preparedness program.
- In some cases, the EOP was not integrated into the hospital-wide QAPI program.

Frequency of citation: 09.00.01: 16% | **09.00.03:** 19% | **17.01.01:** 18%

Examples of Surveyor findings

- The EOP did not address precautions for specific groups in the event of an incident or evacuation.
- Long term continuity protocol was not developed.
- Policies were not reviewed annually.
- No system of medical documentation that preserves patient information, confidentiality, and availability of record was defined.
- Patient populations at risk were not specifically identified and specific mitigation efforts were not identified for each at-risk patient population.
- The plan did not specifically and definitively address the type of services the hospital has the ability to provide in an emergency.
- The EOP was not integrated into the hospital QAPI program and no performance measures were monitored.
- The EOP was not reviewed and approved every two years.
- The EOP was not shared with community partners.

Tips for compliance

- Review the current Emergency Preparedness program for all required elements. Ensure that a comprehensive policy exists.
- Review the hospital QAPI program for inclusion of the EOP and confirm that performance measures are implemented.
- Review the standard requirements with the emergency management oversight committee, particularly related to informing community partners of the EOP and reviewing the plan every two years.

EMERGENCY MANAGEMENT DEFICIENCIES

09.00.04 Patient Population (ACH)

Overview of the requirement

When creating an Emergency Operations Plan, the hospital specifically addresses patient (and other) populations within the organization that may need special accommodation in the event of an emergency, e.g., those with communications deficits or mobility issues.

Comment on deficiencies

Compliance with this standard involves two components: identification of "at-risk" individuals and a plan to address their needs under a variety of emergency scenarios.

Frequency of citation: 30%

Examples of Surveyor findings

- The EOP did not include information regarding patient populations and at-risk populations.
- EOP did not identify the significant number of orthopedic post-operative patients treated in the hospital.
- Document review showed that the EOP identified patient populations at risk within the hospital, but it lacked specific methods to address and mitigate these risks.

Tips for compliance

- Cross reference the EOP against each hospital department to ensure that the range of "at-risk" patients is addressed in the plan.

09.00.05 Services (ACH)
17.00.05 Services (CAH)

Overview of the requirement

Within an Emergency Operations Plan, hospitals must identify what services can be provided including staff roles and equipment available for use.

Comment on deficiencies

Deficiencies were cited when validations were not performed or appropriately documented.

Frequency of citation: 09.00.05: 21% | **17.00.05:** 27%

Examples of Surveyor findings

- Based on review of the document, the EOP did not describe the services the hospital would continue to provide in the event the EOP is activated.

Tips for compliance

- For a range of emergency scenarios, consider the services that can be maintained without interruption and delineate those within the EOP.

09.01.02 Nutritional Services (ACH)
17.01.02 Nutritional Services (CAH)

Overview of the requirement

Under activation of the Emergency Operations Plan, the hospital must be prepared to meet nutritional needs of patients, staff, and visitors for up to three days.

Comment on deficiencies

Most deficiencies resulted from missed requirements within the EOP or lack of knowledge within the nutrition department regarding emergency equipment.

Frequency of citation: 09.01.02: 23% | **17.01.02:** 27%

Examples of Surveyor findings

- The EOP did not address nutritional services.
- EOP did not address the following related to the nutrition department:
  - Alternative cooking methods in the event of utility outage.
  - Memoranda of Understanding from vendors providing food and supplies.
  - A three-day menu with the calculations for amounts of needed supplies.

Tips for compliance

- Provide a detailed and quantitative outline of menus, supplies, required inventory, and means of preparation under emergency circumstances. Show the assumptions for occupancy and the math used to determine quantities required.

09.01.09 Volunteers (ACH)

Overview of the requirement

The Emergency Operations Plan must address emergency staffing, including management of volunteers.

Comment on deficiencies

The failure to reference use of volunteers in addressing emergency staffing measures resulted in deficiency citations.

Frequency of citation: 16%

Examples of Surveyor findings

- Policy and procedure review showed that neither the volunteer management plan nor the Emergency Operations Plan addressed the use of volunteers during an emergency.

Tips for compliance

- If volunteers will not be used in an emergency, the EOP must state this explicitly.
- Be sure that components required by the standard are delineated in the EOP or

EMERGENCY MANAGEMENT DEFICIENCIES

EOP-referenced policies.

17.01.14 Incident Command Center (CAH)

Overview of the requirement

The emergency management policy must include the location of the CAH's incident command center for directing and controlling response operations.

Comment on deficiencies

The standard was cited when the command center diagram did not include equipment needed for incident response.

Frequency of citation: 18%

Examples of Surveyor findings

- The plan diagram did not provide for equipment needed in the incident command center, including designation of equipment, placement of furniture and equipment, and locations of emergency power.

Tips for compliance

- Review the Incident Command Center plan and ensure that all components are addressed.

09.03.02 Emergency Exercises (ACH)

Overview of the requirement

The hospital must develop and maintain a testing program (exercises) that is based on the Emergency Operations Plan and implemented to build competencies in staff.

Comment on deficiencies

Deficiencies resulted when hospitals did not conduct at least two exercises per calendar year.

Frequency of citation: 19%

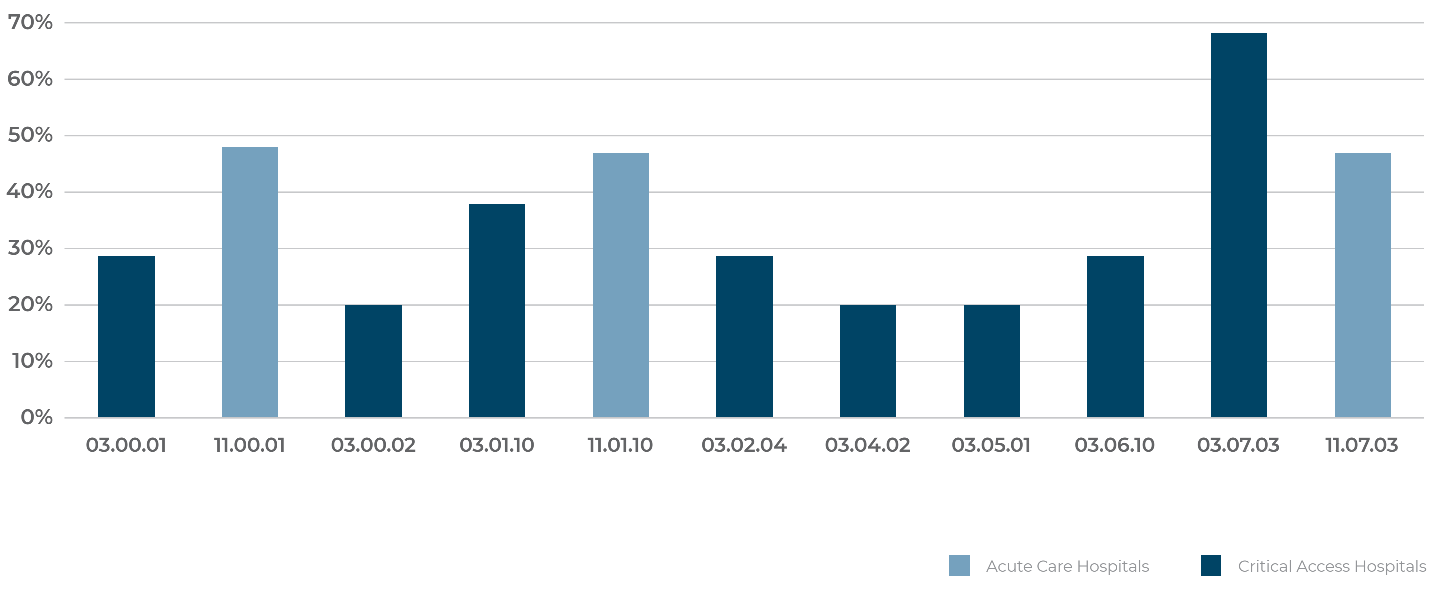
Examples of Surveyor findings

- No documentation was available to validate that any of the off-site facilities had participated in emergency exercises in the past 12 months.
- Only one emergency drill was documented in the past year.

Tips for compliance

- Review the hospital's testing program and the policy with the oversight committee.
- Ensure that two exercises are conducted every calendar year.

PHYSICAL ENVIRONMENT DEFICIENCIES



PHYSICAL ENVIRONMENT

03.00.01 Condition of Participation: Physical Environment (CAH)

11.00.01 Condition of Participation: Physical Environment (ACH)

Overview of the requirement

This Condition-level requirement focuses on assessment of construction and maintenance throughout the entire organization to meet the diagnostic and treatment needs of the community served.

Comment on deficiencies

As the overall assessment of the physical environments of the hospital, this Condition is most often cited as a result of aggregate deficiencies across multiple standards.

Frequency of citation: 03.00.01: 27% | **11.00.01:** 47%

Examples of Surveyor findings

- The fire alarm panel was not connected to an automatic dialer. See also 13.02.01.
- Non-compliant air pressure relationships existed at clean storage rooms and sterile processing.
- Smoke detectors were mounted less than three feet from the air diffusers and more than 12 inches below the deck above.
- No evidence that the two-year smoke detector sensitivity test was performed. See also 13.02.02.
- The main electrical room was being used for storage.
- No evidence that monthly inspections were conducted for the kitchen hood Ansul system.
- Airborne infection isolation room exhaust fans did not have bio-hazard labels affixed.
- No evidence of an annual inspection for emergency lighting in the kitchen or generator room.
- The trash compactor key switch was left in the "on" position, allowing the compactor to be operated by unauthorized personnel.
- Soiled utility rooms were unlocked.

Tips for compliance

- Conduct regular environmental surveillance rounds with rotating participation by multiple departments to promote awareness of the issues and encourage reporting by staff throughout the organization.
- Develop a robust, quality-reporting plan for ongoing review of the physical environment with defined goals and benchmarking, results reporting, defined corrective action, and follow-up protocols.

03.00.02 Required Plans and Performance Standards (CAH)

Overview of the requirement

The hospital's written plans and performance improvement standards must include six required management topics that are tracked through an established process.

Comment on deficiencies

Deficiencies resulted from incomplete performance improvement plans that do not address all six topics.

Frequency of citation: 18%

Examples of Surveyor findings

- Not all six topics had a written performance improvement plan:
  - Security and Hazardous Materials and Waste were observed to be missing performance improvement goals or objectives.
- Performance goals were tracked, but goals were not specified in the management plans.

Tips for compliance

- Review the written plans for performance improvement and verify that all six topics are included and monitored.

03.01.10 Eyewash Stations and Emergency Showers (CAH)

11.01.10 Eyewash Stations and Emergency Showers (ACH)

Overview of the requirement

Approved eyewash stations/emergency showers must be provided in every area in which a person may be exposed to hazardous corrosive materials.

Comment on deficiencies

Most deficiencies resulted from eyewash stations that did not meet ANSI standards.

Frequency of citation: 03.01.10: 36% | **11.01.10:** 44%

Examples of Surveyor findings

- The eyewash station was observed to be inoperable.
- The eyewash station did not have a minimum 15-minute flush.
- The eyewash station did not have the correct mixing valves in the system.
- Access to the eyewash was blocked by equipment.
- The facility does not have documentation to confirm the maintenance and testing processes for the eyewash stations/emergency showers.

Tips for compliance

- Review ANSI standard Z358.1-2014 for design, installation, and maintenance requirements.
- Perform weekly testing of plumbed stations.
- Audit for use of corrosive chemicals.

03.02.04 Security Sensitive Areas (CAH)

Overview of the requirement

The hospital must identify areas that are believed to be security sensitive and implement control systems to protect the areas.

Comment on deficiencies

Deficiencies were cited when there was no list of security sensitive areas or the policy implementation was ineffective.

Frequency of citation: 27%

Examples of Surveyor findings

- The security sensitive area policy did not list specific locations or the measures to be implemented to protect these areas.
- Syringes and needles were observed to be unmonitored in areas where they could be easily accessed by visitors and non-licensed individuals.

Tips for compliance

- Develop a list of all security sensitive areas and verify that the list and the control systems are documented in writing.
- Review the list (or policy if that is the solution chosen) with staff to ensure effective implementation.

03.04.02 Fire Drills – Quarterly (CAH)

Overview of the requirement

Fire drills simulating an emergency fire condition must be conducted and documented on all shifts at least quarterly.

Comment on deficiencies

Deficiencies were cited for lack of documentation reflecting one drill per shift per quarter.

Frequency of citation: 18%

Examples of Surveyor findings

- Facility logs revealed that drills were not conducted for some shifts or for some quarters.
- It was observed that a clear pattern of fire drill times had been established.

Tips for compliance

- Fire drills must simulate emergency fire conditions. Documentation should reflect actual response to the exercise.
- Stagger quarterly drill scheduling to avoid it becoming a predictable occurrence.
- Develop templates for the documentation you wish to capture.

03.05.01 Medical Equipment & Systems – Maintenance (CAH)

Overview of the requirement

Preventive maintenance and testing are performed on all medical equipment per a defined schedule or an Alternative Equipment Management (AEM) program.

Comment on deficiencies

Surveyors cited this standard when a comprehensive list of equipment and testing logs were not available or complete.

Frequency of citation: 18%

Examples of Surveyor findings

- Crash carts were not checked regularly.
- Preventive maintenance (PM) date stickers were not affixed to the equipment.
- Staff interviews revealed inconsistent knowledge of the policies and procedures for equipment maintenance.

Tips for compliance

- Create a comprehensive inventory of relevant equipment and calendar the scheduled maintenance/testing.
- Establish an ID for each piece of equipment.

03.06.10 Plant Equipment Inventory (CAH)

Overview of the requirement

The hospital must maintain a written inventory of all plant equipment in use.

Comment on deficiencies

Deficiencies resulted from incomplete inventories.

Frequency of citation: 27%

Examples of Surveyor findings

- The plant equipment inventory did not include an acceptance date or identification of the department considered to own the equipment.
- Inventory did not include the manufacturer, model number, serial number, or the date the equipment was placed in service.

Tips for compliance

- Assign responsibility to the facilities manager for development of a comprehensive list of all plant equipment in use.

PHYSICAL ENVIRONMENT

ACUTE CARE HOSPITAL CRITICAL ACCESS HOSPITAL

03.07.03 Ventilation, Light, and Temperature Controls (CAH)

11.07.03 Ventilation, Light, and Temperature Controls (ACH)

Overview of the requirement

Lighting, temperature, humidity, and air pressure relationships are monitored against defined parameters to inhibit microbial growth, reduce risk of infection, control odor, and promote patient comfort.

Comment on deficiencies

Most deficiencies resulted from issues with air pressure relationships or temperature and humidity concerns regarding the functioning of equipment and supplies.

Frequency of citation: 03.01.10: 64% | 11.01.10: 47%

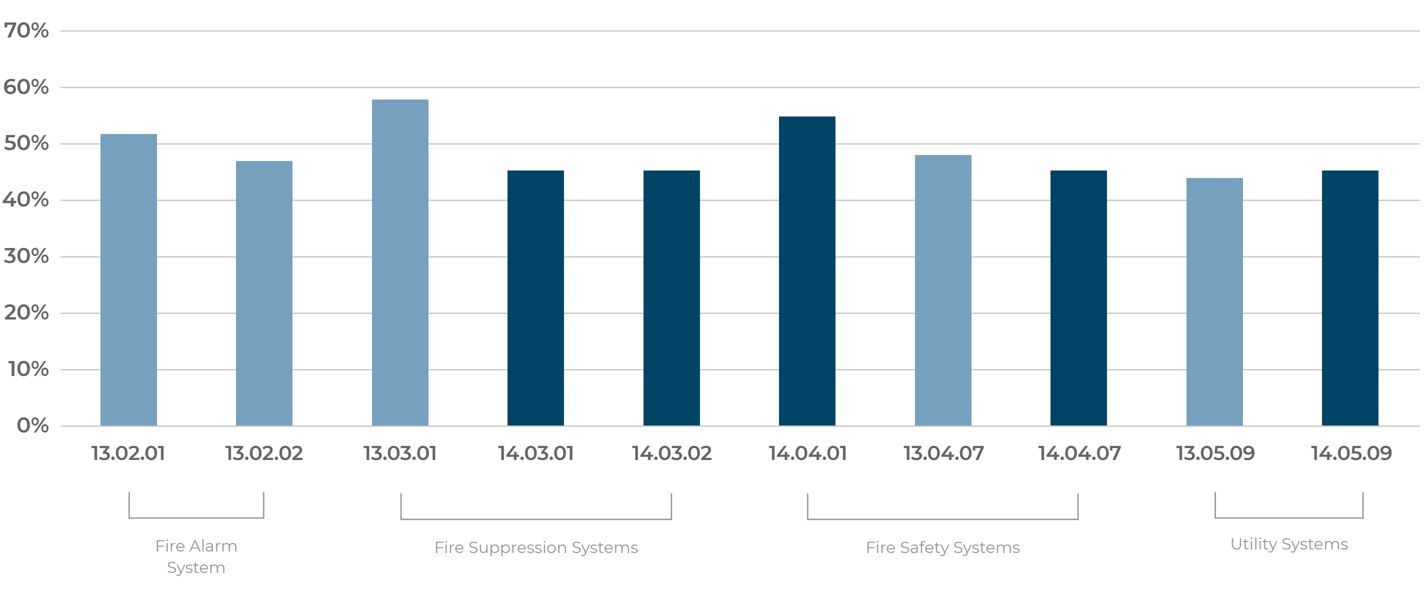
Examples of Surveyor findings

- Prolystica Enzymatic Detergent was being stored in the mechanical space behind the sterilizer unit. Evidence of this space being a temperature-controlled environment could not be provided.
- During document review, it was observed that the temperature and humidity policy allowed for a humidity range of 20%-60% in the operating rooms but without an assessment that the sterile supplies and electromechanical equipment will function as designed in that humidity range.
- The facility could not provide evidence of air pressure relationship testing.
- During the building tour, the clean utility room in the ED was observed to have a negative pressure relationship to the corridor. A positive relationship is required.
- The surgery hazardous materials decontamination storage room was observed as positive to the corridor where a negative pressure relationship is required.

Tips for compliance

- Policy and procedures include verification of conditions. They should also include steps to be taken when conditions fall outside of defined ranges.
- Verification testing and corrective action must be documented.

LIFE SAFETY DEFICIENCIES



Acute Care Hospitals   Critical Access Hospitals

FIRE ALARM SYSTEM

13.02.01 Fire Alarm System – Installation and Maintenance (ACH)

13.02.02 Fire Alarm System – Testing (ACH)

Overview of the requirement

Fire alarm systems must be installed and maintained in accordance with NFPA code with basic and secondary system components tested at specified intervals.

Comment on deficiencies

Deficiencies reflect poorly located smoke detectors and missed elements of system testing (or documentation).

Frequency of citation: 13.02.01: 51% | **13.02.02:** 47%

Examples of Surveyor findings

- Smoke detectors were observed to be installed fewer than 36 inches from a return or supply air diffuser at the following locations: soiled utility room, pre-op nurse station, stairwell landing, electrical room.
- Smoke detectors were observed to be installed more than 12 inches from the deck above at the following locations: electrical room, shell space, IDF room.
- During the facility tour, it was observed that access to a fire alarm manual pull station was blocked by a file cabinet.
- A smoke detector was observed hanging from its wiring.
- A room was not equipped with a fire alarm annunciation audio-visual device.
- The alarm panel was not connected to a digital alarm communication transmitter to notify the fire department in the event of fire.
- There was no evidence that the fire alarm control panel batteries' load voltage tests had been performed for one month.
- There was no evidence that the two-year smoke detector sensitivity test had been performed.
- Semi-annual inspection of tamper switches for the control valves was not conducted.
- Magnetic locks that hold doors in the locked position were not tested annually.

Tips for compliance

- Review smoke detector locations relative to other features as per NFPA requirements.
- Evaluate the testing requirements under NFPA and these standards to verify that the documentation will portray and recreate testing activities. Testing documentation is proof and evidence of how the activity was performed and whether it would pass or fail testing.

FIRE SUPPRESSION SYSTEMS

13.03.01 Water-based Fire Protection System – Installation and Maintenance (ACH)

14.03.01 Water-based Fire Protection System – Installation and Maintenance (CAH)

14.03.02 Water-based Fire Protection System – Testing and Inspection (CAH)

Overview of the requirement

The expectation is that each element of a fire suppression system is installed, tested, and maintained to function effectively when needed.

Comment on deficiencies

Citations focused on elements installed outside prescribed parameters, incomplete testing documentation, and inappropriate use of system elements — either accidental or for convenience.

Frequency of citation: 13.03.01: 58% | **14.03.01:** 45% | **14.03.02:** 45%

Examples of Surveyor findings

13.03.01/14.03.01

- The Emergency Department ambulance canopy was not provided with fire sprinkler coverage under the canopy.
- A light fixture was within 2" of a sprinkler, which will obstruct the flow of water from the sprinkler.
- The central storage area was observed to be storing combustibles and had missing ceilings without sprinkler heads installed.
- The following rooms were observed to be without fire suppression system coverage: walk-in refrigerators and freezer in the kitchen, soiled storage room, IT main server and BMET room.
- Fire sprinkler escutcheons were observed to be missing and one sprinkler head dispersion plate was broken off the sprinkler head.
- A sprinkler head in the environmental services closet was observed to be covered in dust.

14.03.02

- Organization did not present evidence that the control valves had been inspected monthly for the past 12 months.
- Annual inspection of the sprinkler piping and hangers was not completed.
- Quarterly and annual main drain tests were not completed.
- Document review showed that no inventory was maintained with types or dates of installation available for quick-response or standard response sprinkler heads. Date of installation determines testing and replacement intervals for sprinkler heads.

LIFE SAFETY

Tips for compliance

- Focus on specific expectations for location of equipment. Often, sprinkler heads are installed and later, signage and/or furnishings are added that compromise the ability of the sprinklers to function as intended.

14.04.01 Fire Rated Barriers (CAH)
13.04.07 Fire-Rated Door Assemblies (ACH)
14.04.07 Fire-Rated Door Assemblies (CAH)

Overview of the requirement

Fire safety systems reflect standards for building construction and maintenance designed to impede the ability of smoke or fire to travel through the structure.

Comment on deficiencies

Most deficiencies result from maintenance (or lack thereof). When a fire safety deficiency is observed, whether a single example or in multiple locations, each observation will be cited.

Frequency of citation: 14.04.01: 55% | **13.04.07:** 49% | **14.04.07:** 45%

Examples of Surveyor findings

14.04.01

- An unprotected penetration for a one-inch electrical conduit was observed in the one-hour fire-rated barrier above the ceiling.
- Two-hour fire barrier was observed to have three one-inch open holes with no protection and two patches of drywall-over-drywall applied to the surface so that the applied gypsum board repair was not in-plane with the original wall construction.
- A two large, unprotected penetrations of approximately 2' X 3' for duct work from exhaust fans were observed in the two-hour fire barrier.

13.04.07/14.04.07

- Doors in the two-hour fire-rated barriers did not have rating labels.
- A door noted as a 90-minute door was not listed when reviewing the annual fire door testing log.
- Doors did not have an automatic closer on the door and did not latch.

Tips for compliance

- Promote the practice of reporting maintenance issues promptly throughout the organization.
- Identify a list of approved fire-stopping materials and wall repair designs and use these exclusively and consistently throughout the facility.
- Review the physical state of rated assemblies. Rated doors are high-use items and their state of compliance may not be consistent from one annual inspection to the next.
- Before repurposing spaces for storage of combustible materials, check the protection level based on fire-rated barriers or review criteria in chapter 43 NFPA 101 (2012).

BUILDING SERVICES

13.05.09 Utility Systems (ACH)
14.05.09 Utility Systems (CAH)

Overview of the requirement

These standards reflect requirements for systems other than fire suppression.

Comment on deficiencies

When a system deficiency is observed, whether a single example or in multiple locations, each observation will be cited.

Frequency of citation: 13.05.09: 44% | **14.05.09:** 45%

Examples of Surveyor findings

- Circuit directory schedules on electrical control panels did not include all circuits as to what function they served.
- A low-voltage junction box was missing the cover plate.

Tips for compliance

- Conduct regular facility rounding to verify compliance and immediately correct deficiencies.
- Verify that medical gas testing documentation will portray inspections appropriately. Since testing cannot be witnessed by surveyors, the documentation is evidence of how you performed an activity and the results.

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