MEETING THE CHALLENGE

The 2021 HFAP Quality Review

HFAP IS NOW ACHC.
Over the past 18 months, hospital materials management teams sourced against a shortage of PPE, nursing leadership reassigned staff to address illness or furloughs, normally busy ASCs cancelled cases and closed, critical access hospitals coped with patient surges, and laboratories managed new testing protocols and extraordinary volume under Emergency Use Authorizations. These, and a myriad other issues, demonstrate that no area of healthcare escaped the impact of the COVID-19 public health emergency.

HFAP programs also were affected. Survey activity was interrupted from mid-March to June during the height of state-mandated lock-downs when travel was restricted and facilities were stretched thin. During this period, we collected data from organizations with surveys pending to prioritize our approach to scheduling while minimizing burden and risk to those experiencing surges. Survey teams were assigned first to organizations with past infection control or emergency management deficiencies and closest to the end of their term of accreditation. We evaluated virtual surveys and determined that they weren’t a viable — or desired — solution for our customers. Now, we’ve caught up with the backlog this created and survey activity is back to its expected rhythm.

Not all impacts of the pandemic have been negative. Change is hard, but the drive and resourcefulness of organizations committed to meeting the needs of their communities led to innovation and rapid adoption of new ideas. For example, telehealth is a sleeping giant awakened. As providers leaned on virtual visits and remote monitoring, payers realized the benefit of improved patient access and opened the door to wider coverage of these services. Later this year, we expect to offer telehealth certification to recognize excellence in these services.

For HFAP itself, the pandemic accelerated the growth of a burgeoning idea about expanding services; an idea that resulted in the merger with Accreditation Commission for Health Care (ACHC). This change means a lot for HFAP’s customers who now can take advantage of more comprehensive education and accreditation offerings in their pursuit of quality improvement.

More change is coming. Beginning this fall, the HFAP Quality Review will take a new form, becoming separate, setting-focused editions of ACHC’s semi-annual publication, The Surveyor. It will deliver the same in-depth analysis of recent deficiencies identified by surveyors during onsite surveys and recommendations for best practice to improve compliance. Our goal is to bring focused value to customers in each accreditation program.

On a personal note, I have truly enjoyed getting to know HFAP this year as the businesses merged to become a single, high-performing organization. The passion I saw in HFAP program staff to meet the needs of customers under the most challenging circumstances was remarkable. HFAP’s small team of employees and its outstanding surveyor cadre built a 75-year legacy as the educationally-focused option for hospital, laboratory, and ambulatory surgery center accreditation. Going forward as programs of ACHC, you’ll see the same approach and commitment to quality, augmented with additional resources to support those goals of delivering an unparalleled accreditation experience. I hope that you will be proud of your association with ACHC and allow us to support your own drive for excellence.

José Domingos
President & CEO
Introduction

Welcome to the 2021 edition of the HFAP Quality Review. This document represents an analysis of deficiencies identified on 2020 surveys for HFAP hospital (acute care and critical access), ambulatory surgery center, and laboratory accreditation programs.

Using the report

The HFAP Quality Review is intended as a resource to help your organization close any existing or potential gaps between desired compliance with HFAP standards and current performance.

The Deficiency Report that you receive after an onsite survey details areas that require specific focus and a Plan of Correction. The HFAP Quality Review provides context for these deficiency citations by using aggregate data from all surveys conducted in 2020. Use it as a tool for self-assessment and to identify areas of secondary focus when the deficiencies differ from citations for your organization.

This year, in addition to identifying the standards that are repeat top deficiencies from last year, we also looked back to the last triennial survey year (or biennial year for laboratories) as a more accurate benchmark of whether organizations continue to struggle with the same requirements. Encouragingly, relatively few of the deficiencies are repeated from the preceding cycle. For those that are recurrent, there is evidence of a need for more education regarding the intent of the standard, acceptable means of achieving compliance, and/or how to implement and sustain change to improve performance. We plan to provide a range of opportunities for that learning to take place.
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Laboratory Deficiencies

Throughout 2020, clinical laboratories in all settings managed high testing volumes, demand for rapid turnaround times, and supply chain constraints related to the pandemic, in addition to the “normal” process of diagnostic testing in support of clinical, infection control, and public health decisions. Efficient and safe laboratory management is critical for maintaining accuracy of results.

Seven standards found to be deficient on more than 10% of surveys performed in 2020 are shown below. The standards that had been cited as top deficiencies in the past showed improvement in 2020. We hope our commitment to an educational accreditation experience and to enhanced resources and educational opportunities will support continuing improvement in clinical laboratory practice.

### Standards Cited

<table>
<thead>
<tr>
<th>Frequency of Citation</th>
<th>01.04.07</th>
<th>02.02.04</th>
<th>03.02.06</th>
<th>03.02.07</th>
<th>06.03.00</th>
<th>06.04.00</th>
<th>06.08.01</th>
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### Standards

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>STANDARD</th>
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<tbody>
<tr>
<td>1: General Laboratory</td>
<td>01.04.07 Eyewash/Emergency Shower Facilities</td>
</tr>
</tbody>
</table>

**Overview of the requirement:**
Approved eyewash stations/emergency showers must be provided within a 10 second travel distance from every area in which hazardous chemicals are used.

**Comment on deficiencies:**
Most deficiencies resulted from non-ANSI-approved eyewash stations.

**Frequency of citation:**
31%

**Repeat deficiency from prior year?**
No

**From 2018 surveys?**
No
**Laboratory Deficiencies**

<table>
<thead>
<tr>
<th>Examples of surveyor findings:</th>
<th>Tips for compliance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Eye wash stations did not have a single handle faucet to start the flow of water in a single motion.</td>
<td>▪ Review ANSI standard Z358.1-2014 for design, installation, and maintenance requirements.</td>
</tr>
<tr>
<td>▪ The only eye wash available was an eyewash bottle system.</td>
<td>▪ Perform weekly testing of plumbed stations.</td>
</tr>
<tr>
<td>▪ Eye wash stations were plumbed, permanent stations but lacked temperature control and a log to indicate weekly testing.</td>
<td>▪ Audit for use of corrosive chemicals.</td>
</tr>
</tbody>
</table>

**CHAPTER STANDARD**

<table>
<thead>
<tr>
<th>2: Laboratory Personnel</th>
<th>02.02.04 Testing Personnel Competency and Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>The laboratory technical supervisor/consultant is responsible for evaluating and documenting competency of staff to perform test procedures and report results. The standard identifies required elements and intervals for competency evaluations.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>This standard was cited when required elements of the evaluation were not documented as completed or when evaluations were not performed within required timeframes.</td>
</tr>
<tr>
<td><strong>Frequency of citation:</strong></td>
<td>14%</td>
</tr>
<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>Yes (19%)</td>
</tr>
<tr>
<td><strong>From 2018 surveys?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Examples of surveyor findings:</strong></td>
<td>▪ Technical staff did not have all six required competency elements evaluated for each test system in the laboratory.</td>
</tr>
<tr>
<td></td>
<td>▪ Education credentials were not available for review at the time of the survey.</td>
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<td></td>
<td>▪ Competency evaluation was not completed annually for all testing personnel.</td>
</tr>
<tr>
<td><strong>Tips for compliance:</strong></td>
<td>▪ Create a tracking document for testing personnel that lists each test system.</td>
</tr>
<tr>
<td></td>
<td>▪ Ensure that all six required elements are evaluated for each test system twice in the first year and annually thereafter for all testing personnel.</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>STANDARD</td>
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</tbody>
</table>
| 3: Provider Performed Microscopy and Waived Testing | 03.02.06 Manufacturer’s Instructions for Waived Testing  
03.02.07 Quality Control for Waived Tests |

**Overview of the requirement:** The laboratory must maintain a current copy of manufacturer’s instructions and must follow the stated instructions. The laboratory must adhere to the instructions for quality control.

**Comment on deficiencies:** This standard was cited when required elements of the evaluation were not documented as completed or when evaluations were not performed within required timeframes.

**Frequency of citation:**
- 03.02.06: 24%
- 03.02.07: 26%

**Repeat deficiency from prior year?** 
- No

**From 2018 surveys?**
- No

**Examples of surveyor findings:**

- **03.02.06**
  - The laboratory lacked procedures and/or manufacturer package inserts for the staff performing patient testing.
  - Documentation showed that glucose meter control solutions and test strips were not dated when packaging was opened nor was the new expiration date noted on the solutions and strips.
  - Temperature and humidity readings were not recorded to assure reagents were stored under proper conditions as indicated by the manufacturer.

- **03.02.07**
  - Logs revealed the laboratory was not following the Urine HCG test kit manufacturer instruction for external positive/negative quality controls or internal controls for tests performed.
  - Documentation showed that quality controls were not conducted per manufacturer-indicated schedules or according to laboratory procedures.
  - Temperature logs to monitor refrigerated materials and reagents were not maintained.

**Tips for compliance:**

- Ensure that there is a formal procedure for each test method or that the manufacturer’s package insert is available to provide a detailed procedure for each test. Manufacturer instructions are typically found as part of the package insert available with each test kit. If test kit does not come with a package insert, these instructions should be located on the manufacturer’s web site.

- Review the manufacturer’s instructions for each test to ensure that:
  - reagents are stored at the proper temperature.
  - quality control material, both internal and external, is tested at the frequency required by the manufacturer and that all controls performed are documented.
<table>
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<tr>
<th>CHAPTER</th>
<th>STANDARD</th>
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<tbody>
<tr>
<td><strong>6: Analytic Systems</strong></td>
<td><strong>06.03.00 Verification of Performance Specifications</strong></td>
</tr>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>A laboratory may not use nonwaived, unmodified, FDA-cleared test systems to report patient test results until it can demonstrate performance comparable to the specifications established by the manufacturer for accuracy, precision, and range, and verify that reference values are appropriate for the laboratory’s patient population.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>Deficiencies were cited when validations were not performed or appropriately documented.</td>
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<tr>
<td><strong>Frequency of citation:</strong></td>
<td>14%</td>
</tr>
<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>From 2018 surveys?</strong></td>
<td>No</td>
</tr>
</tbody>
</table>
| **Examples of surveyor findings:** | ▪ Reference range validations were not performed on new equipment prior to the instrument being used to report patient results.  
▪ The laboratory director had not reviewed and approved the validation for new systems prior to reporting patient test results. |
| **Tips for compliance:** | ▪ Establish a documentation system covering all test systems. Assign personnel to ensure that validation tests are completed.  
▪ Ensure that the laboratory director approves the validation studies PRIOR to the test system being used to report patient results. |

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<thead>
<tr>
<th>CHAPTER</th>
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<tr>
<td><strong>6: Analytic Systems</strong></td>
<td><strong>06.04.00 Maintenance Checks</strong></td>
</tr>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>Equipment, instrument, or test system maintenance is performed as defined by the manufacturer on at least the frequency specified by the manufacturer.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>Deficiencies were cited when maintenance was not performed or appropriately documented.</td>
</tr>
<tr>
<td><strong>Frequency of citation:</strong></td>
<td>21%</td>
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<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>No</td>
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<tr>
<td><strong>From 2018 surveys?</strong></td>
<td>Yes (16%)</td>
</tr>
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</table>
| **Examples of surveyor findings:** | ▪ Document review showed that maintenance checks on equipment or instruments were inconsistently performed.  
▪ A maintenance log was not maintained. |
### Tips for compliance:
- Create a log to document all maintenance/testing as required by the manufacturer.
- Develop a system to ensure that each maintenance log is reviewed on a regular basis, at least monthly, so that lapses in maintenance can be identified and appropriate corrective action measures taken. Be sure to document all review activities.

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<th>CHAPTER</th>
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<tbody>
<tr>
<td>6: Analytic Systems</td>
<td>06.08.01 Comparison of Test Results</td>
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</table>

**Overview of the requirement:** If the same test is performed using different methods, different instruments, and/or at multiple locations, the laboratory must compare results at least twice annually and review against written criteria for acceptable variation in test values.

**Comment on deficiencies:** Deficiencies were cited for failure to perform comparison studies.

**Frequency of citation:** 17%

**Repeat deficiency from prior year?** Yes (13%)

**From 2018 surveys?** Yes (16%)

**Examples of surveyor findings:**
- Comparison studies were not performed between automated and manual differentials twice per year.
- Comparison studies were not performed on all I-Stat meters for back up chemistries using the Chem8+ cartridge for glucose, BUN, creatinine, sodium, potassium, TCO₂, chloride.
- Studies had been completed as required for the routine chemistry tests, but there were gaps in the correlation studies for the therapeutic drugs, ETOH, ammonia, CRP, and AIC.
- A comparison study between the Quick Vue serum HCG and the Vitros 5600 was not performed every six months.

**Tips for compliance:**
- Develop a list of tests that require comparison testing.
- Develop written procedures for performing comparison studies.
- Develop a calendar/schedule to ensure that the comparison studies are completed twice each year.
ASC Deficiencies

Of the 19 top deficiencies for ASCs, the chart below shows that five stood out in terms of frequency. Three of the five centered on documentation as did many of the other top deficiencies. Standards are often closely related, even when separated in different chapters. For this reason, closely related deficiencies are shown grouped in the graph below and in the accompanying narrative. For many of these, individual corrective actions can serve to address compliance across multiple standards.

Overall, survey findings indicate that patients receive high quality care in HFAP-accredited ASCs. Improvement opportunities center on issues related to governing body responsibility for oversight of all aspects of the ASC’s operations and appropriate documentation thereof.

<table>
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<tr>
<th>CHAPTER</th>
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<tbody>
<tr>
<td>1: Governing Body and Management</td>
<td>01.01.02 Contract Services</td>
</tr>
<tr>
<td>4: Quality Assessment/Performance Improvement</td>
<td>04.00.04 Quality Program Data</td>
</tr>
</tbody>
</table>

Overview of the requirement:

These related standards represent elements of a robust quality program that provides comprehensive, data-driven evaluation of all services provided.

- The governing body holds responsibility for all services provided by the ASC, even those provided by contractors and ancillary to patient care. To ensure quality, contracted services must be included in the organization’s QAPI program.
### Overview of the requirement (continued):
- The ASC collects data related to identified indicators at the frequency defined by the QAPI program.

### Comment on deficiencies:
Deficiencies cited lack of comprehensive documentation of contracted services or failure to identify measurable quality metrics related to contracted services. Surveyors noted that data collection did not cover all patient care services and all contracted services, or data was not collected at the interval stated in the QAPI program.

### Frequency of citation:
20% (both standards)

### Repeat deficiency from prior year?
No

### From 2017 surveys?
No

### Examples of surveyor findings:
- **01.01.02**
  - The ASC did not maintain a list of all contracted services.
  - The ASC’s QAPI program did not include performance indicators related to contracted services.

- **04.00.04**
  - Services provided under contract were not included in the data collection.

### 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.
- Include quality metrics in service contracts to support accountability.
- When metrics are not met, define corrective actions and timeframe 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.

### CHAPTER 2: Administration

#### STANDARD 02.02.02 Patients Informed of Dates and Times of ASC Services

#### Overview of the requirement:
The organization must communicate to its patient population the hours of available services and what to do in the event of an emergency.

#### Comment on deficiencies:
Deficiencies resulted from missing signage.

#### Frequency of citation:
53%
Repeat deficiency from prior year? | No
---|---
From 2017 surveys? | No

**Examples of surveyor findings:**
- Building entrances lacked signage to address the standard.

**Tips for compliance:**
- This is a simple “just do it” standard. Signage and telephone messages should indicate hours of operation and provide instructions for patients in the event of an emergency such as “call 911” or “go to the nearest emergency room.”

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### CHAPTER

### STANDARD

**3: Surgical Services**

**6: Medical Staff**

**03.00.02 Surgical Procedures: Performed by Qualified Physicians**

**06.00.02 Medical Staff Granted Privileges**

**06.00.03 Medical Staff Credential Files**

**Overview of the requirement:**
These related standards require a credentialing and privileging process that supports ongoing review of medical staff credentials and licensure and a proactive process of granting and reevaluating privileges to perform specific procedures within the ASC’s scope of services.

- Policies and procedures define the process used by the governing body when determining the scope of privileges granted and included documentation thereof.

- Policies and procedures define the criteria and process for granting surgical privileges to a physician that includes legal qualification, demonstrated competence, written recommendation(s), and reporting when privileges are reduced or denied.

- A complete, current, credentials file is maintained for each member of the medical staff.

**Comment on deficiencies:**
Deficiency citations are not indicative that procedures are being performed by unqualified individuals but that the credentialing and privileging process is not adequate or did not reflect governing body review of qualifications and approval of initial and renewal privileges granted.

**Frequency of citation:**
20% (each of the three standards)

**Repeat deficiency from prior year?** | No
---|---
**From 2017 surveys?** | 26% (06.00.03 only)

**Examples of surveyor findings:**
- Document review shows that files lacked evidence that the governing body had reviewed medical staff.

- No evidence that practitioner credentials were verified prior to granting surgical privileges.

- Credentialing and privileging files contained expired information.
**Tips for compliance:**

- Review policies and procedure to ensure that the governing body follows an established process for credentialing and granting surgical privileges.
- Assign oversight of the credentialing and privileging process to an individual.
- Conduct regular audits to ensure current, accurate and complete credentialing and privileging files.

### CHAPTER 8: Medical Records

#### 08.00.03 Form and Content of the Medical Record

<table>
<thead>
<tr>
<th>Overview of the requirement:</th>
<th>The ASC must maintain an accurate and complete medical record for each patient.</th>
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<tbody>
<tr>
<td>Comment on deficiencies:</td>
<td>Deficiencies were cited when one or more required element of the medical record were missing.</td>
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<tr>
<td>Frequency of citation:</td>
<td>20%</td>
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<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
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<tr>
<td>From 2017 surveys?</td>
<td>No</td>
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</table>
| Examples of surveyor findings: | - Review of the medical records showed incomplete history and physical documentation.  
  - Informed Consents were incomplete or not signed by the appropriate medical staff. |
| Tips for compliance:          | - Review the medical record policy and forms to confirm that all requirements of the standard are included.  
  - Have a process to ensure that all signatures on the informed consent are verified prior to the procedure. |

### CHAPTER 8: Medical Records

#### 08.01.02 Record Storage

<table>
<thead>
<tr>
<th>Overview of the requirement:</th>
<th>Medical records must be secured to prevent unauthorized access and protected from physical destruction.</th>
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<tbody>
<tr>
<td>Comment on deficiencies:</td>
<td>When physical records are maintained, fire protection requirements must be met for their storage.</td>
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<tr>
<td>Frequency of citation:</td>
<td>20%</td>
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<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
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<tr>
<td>From 2017 surveys?</td>
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</table>
| Tips for compliance:          | - If the record storage area does not meet the required fire rating, records can be stored in fire resistant containers.  
  - Consider any other potential environmental threats.  
  - Develop and implement a plan addressing security of digital files. |
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<tr>
<th>CHAPTER</th>
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<tr>
<td>9: Pharmaceutical Services</td>
<td>09.00.03 Administration of Drugs: Labeling, Storage, and Disposing of Expired Medications</td>
</tr>
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</table>

**Overview of the requirement:** ASC policies provide instructions for drug storage and disposal that aligns with manufacturer’s guidelines.

**Comment on deficiencies:** Deficiencies were noted when drugs were not adequately secured from unauthorized access, when expired inventory remained accessible for use, and when syringes with drugs drawn up for use during procedures were unlabeled.

**Frequency of citation:** 20%

**Repeat deficiency from prior year?** No

**From 2017 surveys?** No

**Examples of surveyor findings:**
- Drugs were observed to be stored in unsecured cabinets.
- Expired medications were kept in storage.
- Medications for use during surgical procedures were not labeled.

**Tips for compliance:**
- Ensure staff education on medication storage, labeling and disposal.
- Perform regular inventory audits and segregate expired drugs from active stock prior to disposal.

<table>
<thead>
<tr>
<th>CHAPTER</th>
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<tbody>
<tr>
<td>12: Infection Control</td>
<td>12.00.02 Sanitary Environment</td>
</tr>
</tbody>
</table>

**Overview of the requirement:** All areas must be maintained to avoid sources and transmission of infection. Policies based on nationally-recognized infection control practice guide environmental cleanliness.

**Comment on deficiencies:** Deficiencies cited lapses in routine maintenance and housekeeping.

**Frequency of citation:** 20%

**Repeat deficiency from prior year?** Yes (23%)

**From 2017 surveys?** Yes (75%)

**Examples of surveyor findings:**
- Policy included no routine maintenance procedure assigned to the housekeeping department and no designated area for storage of dirty linen/trash (which led to overflowing trash cans, linen hampers).
- Cardboard shipping containers and clean patient care supplies were stored together.
Tips for compliance:

- Develop policies and procedures regarding cleaning.
- Educate staff on these policies.
- Conduct regular environmental surveillance rounds that include participation of the facilities manager and the infection control officer.

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<th>CHAPTER</th>
<th>STANDARD</th>
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<tbody>
<tr>
<td>12: Infection Control</td>
<td>12.01.01 Decontamination and Sterilization: Policies</td>
</tr>
</tbody>
</table>

Overview of the requirement:
ASCs have policies and procedures consistent with manufacturer’s instructions for decontamination and cleaning of surgical instruments that are reviewed and approved at least every three years, and provided to staff responsible for these processes.

Comment on deficiencies:
Most deficiencies cited reflected that while policies exist, there is inconsistent compliance with them. This indicates that staff responsible for implementing policy may be unfamiliar with it or inadequately trained on it. The standard is closely related to 12.01.02 which addresses both compliance with ASC policies and the appropriateness of processes used for decontamination and cleaning of surgical instruments.

Frequency of citation: 20%
Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:
- Based on review of sterilization policies and logs, the policy for biological testing weekly or prior to intermittent use of the sterilizer was not followed.
- Review of the sterilizer logs indicated that bacteriologic spore testing is performed monthly rather than weekly as required by policy.

Tips for compliance:
- Review timelines for policy review to ensure ongoing alignment of your policy with national guidelines and manufacturer’s updates.
- Ensure staff is familiar with policy and receives training updates with each policy review cycle.
### CHAPTER 13: Patient Admission, Assessment, and Discharge

#### STANDARD 13.00.02 Patient Pre-surgical History and Physical

**Overview of the requirement:** In 2020, the standard stated that ASCs must have a policy identifying which patients require a medical history and physical prior to surgery and define the timeframe for this examination. The manual also included the requirement that an H&P be performed for all patients no more than 30 days prior to surgery.

This added policy for identifying patients requiring a medical history and physical resulted from a relaxation of the requirement by CMS that was only partially adopted by HFAP. In 2021, HFAP fully adopted the revised CMS requirement allowing the ASC to determine, based on recognized standards of practice, which patients would be required to have an H&P prior to surgery.

**Comment on deficiencies:** Deficiencies were cited for incomplete history and physical documentation in patient medical records.

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<th>Frequency of citation:</th>
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<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
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</table>

**Examples of surveyor findings:**
- H&Ps lacked the date of exam.
- H&Ps lacked a comprehensive inventory of the body systems; the physical examinations lacked a cardiac examination, including auscultation of chest and heart sounds.

**Tips for compliance:**
- The purpose of a comprehensive medical history and physical assessment is to determine whether there is anything in the patient's overall condition that would affect the planned surgery or indicate that an ASC might not be the appropriate setting for the surgery. Consider patient population, allergies, comorbidities, etc. when developing your policy.

#### STANDARD 13.00.04 Patient Pre-surgical Assessment

**Overview of the requirement:** The patient must have a pre-surgical assessment completed immediately prior to surgery by a qualified practitioner to evaluate the patient's risk for the procedure and anesthesia.

**Comments on deficiencies:** Deficiencies were cited for incomplete assessments.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>20%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>Yes (23%)</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>Yes (38%)</td>
</tr>
</tbody>
</table>
**Examples of surveyor findings:**

- Document review revealed a failure to complete all portions of the pre-surgical assessment.
- Physicians completed the assessment after the surgical procedure.
- No anesthesiology status classification documentation was made prior to the administration of sedative agents.

**Tips for compliance:**

- Regardless of whether an H&P was completed within the 30 days preceding surgery, an assessment must be performed by a physician prior to surgery to ensure there are no changes in the patient’s condition, and to evaluate the risk of anesthesia and the patient’s overall risk for the procedure.

---

### CHAPTER 13: Patient Admission, Assessment, and Discharge

#### STANDARD 13.00.08 Discharge Order

**Overview of the requirement:**

Each patient is assessed to ensure that they have recovered sufficiently to be discharged from the facility and this is evidenced by a discharge order signed by the physician who performed the procedure.

**Comment on deficiencies:**

Deficiencies were noted when discharge orders did not meet the intent of the standard.

**Frequency of citation:** 27%

**Repeat deficiency from prior year?** No

**From 2017 surveys?** No

**Examples of surveyor findings:**

- During review of three closed medical records, none included a physician order for discharge of the patient.

- Based on review of open and closed medical records, physicians are writing discharge instructions and/or ordering medications prior to the time of entry into the ASC and before the day of surgery. The date of the discharge orders preceded the date of admission in two of two (2/2) closed medical records and six of six (6/6) open medical records.

**Tips for compliance:**

- Although using standard order sets is permissible, the physician who performed the procedure must review, sign, time, and date the discharge order following the procedure.

- Assign responsibility for management of discharge paperwork.

- Create dashboards that show compliance with documentation requirements at the team or individual level to boost accountability.
### 14.04.07 Fire-Rated Door Assemblies


**Comment on deficiencies:** Deficiencies were cited when fire doors lacked labels, automatic closure devices, or when documentation was missing regarding annual inspection.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>20%</th>
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<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
</tbody>
</table>

**Examples of surveyor findings:**
- The door to the electrical room, which was in a one-hour fire-rated wall, had a rating sticker on the door frame but the door itself lacked a fire rating and a self-closing device.
- The following five door locations in the one-hour fire-rated wall did not have fire-rated labels on the doors. All door frames were labeled as fire-rated:
  1. Door separating the pre-op area from the corridor.
  2. Door to the pre-op area from the waiting area.
  3. Door from the PACU to the lobby.
  4. Door from the lounge to the women’s lockers.
  5. Door from the lounge to the men’s lockers.
- Two doors were observed with 20-minute fire-rating labels instead of 45-minute rating labels.
- The ASC did not have documentation of an inventory of fire doors or yearly rated-door inspections.

**Tips for compliance:**
- Inventory fire doors and conduct an annual audit to ensure that doors and frames are appropriately labeled.

### 14.05.07 Automatic Transfer Switch Test

**Overview of the requirement:** Automatic transfer switches control the transfer of electrical power from one source to another, as when a generator is used. These critical units must be tested on a regular schedule with the testing documented.

**Comment on deficiencies:** Deficiencies were cited for inadequate testing.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>20%</th>
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</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
</tbody>
</table>
### Examples of surveyor findings:
- Documentation reflected that the automatic transfer switch test was conducted only annually; not at the required frequency.

### Tips for compliance:
- Develop a schedule for required equipment testing and assign responsibility for testing.

### CHAPTER STANDARD

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<tr>
<th>15: Emergency Management</th>
<th>15.01.06 Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>The Emergency Operations Plan must address emergency staffing, including management of volunteers.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>The failure to reference use of volunteers in addressing emergency staffing measures resulted in deficiency citations.</td>
</tr>
<tr>
<td><strong>Frequency of citation:</strong></td>
<td>20%</td>
</tr>
<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>Yes (31%)</td>
</tr>
<tr>
<td><strong>From 2017 surveys?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Examples of surveyor findings:</strong></td>
<td>Policy and procedure review showed that neither the volunteer management plan nor the Emergency Operations Plan addressed the use of volunteers during an emergency.</td>
</tr>
<tr>
<td><strong>Tips for compliance:</strong></td>
<td>Even if volunteers will not be used in an emergency, the EOP must state this explicitly.</td>
</tr>
<tr>
<td></td>
<td>Be sure that components required by the standards are delineated in the EOP or EOP-referenced policies.</td>
</tr>
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### CHAPTER STANDARD

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<tr>
<th>15: Emergency Management</th>
<th>15.01.07 Invoking the 1135 Waiver</th>
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</thead>
<tbody>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>A waiver under section 1135 of the Social Security Act may be issued during a public health emergency to modify certain Medicare, Medicaid or Children’s Health Insurance Program requirements to ensure adequate health care supplies and services in an emergency.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>Deficiencies resulted when ASCs did not include reference to use of an 1135 waiver in the Emergency Operations Plan.</td>
</tr>
<tr>
<td><strong>Frequency of citation:</strong></td>
<td>33%</td>
</tr>
<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>Yes (15%)</td>
</tr>
<tr>
<td><strong>From 2017 surveys?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Examples of surveyor findings:</strong></td>
<td>Review of policies and procedures did not identify a plan for invoking an 1135 waiver or for coordinating care at alternate sites.</td>
</tr>
</tbody>
</table>
**Tips for compliance:**
- When a blanket waiver is announced by CMS, review your EOP to determine how the waiver conditions are applicable to your organization.
- Compliance with blanket waiver conditions must be documented. Focus on each element required for a complete EOP.
- Be sure that components required by the standards are delineated in the EOP and EOP-referenced policies.

### CHAPTER

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<td>15: Emergency Management</td>
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<tr>
<td><strong>15.02.02 Contact Information</strong></td>
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</table>

**Overview of the requirement:**
An emergency communication plan includes complete contact information for specified individuals and organizations.

**Comment on deficiencies:**
Deficiencies resulted when the emergency communications plan was incomplete.

**Frequency of citation:**
20%

**Repeat deficiency from prior year?**
No

**From 2017 surveys?**
No

**Examples of surveyor findings:**
- The Emergency Operations Plan lacked documentation of contact information for entities involved with emergency operations.

**Tips for compliance:**
- Periodically review the contact list to ensure that contact information is complete and accurate/current.
In 2020, 39 standards were cited as deficiencies at 20% or more of the acute care hospitals (ACH) surveyed. Twenty of these were standards related to clinical or administrative functions, two were emergency management standards, and the remaining 17 were physical environment or life safety requirements. With fewer surveys conducted due to the pandemic, small numbers of citations rose to statistically significant levels.

Infection control was a significant focus in 2020, both because of significant updates to the standards in this area and because of the COVID-19 pandemic. Risk mitigation, environmental surveillance, contact isolation signage, and overall program leadership were all areas of concern.

### Acute Care Hospital Deficiencies, Clinical and Administrative Standards

**Overview of the requirement:**

HR must have policies addressing new graduate providers and those whose licensure, certification, or registration is not current based on the nature of the lapse.

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<tr>
<td>4: Human Resource Management</td>
<td>04.00.04 License Pending and Lapse or Restriction of Licensure/Certification</td>
</tr>
</tbody>
</table>
### Comment on deficiencies:
Deficiencies were cited for missing HR policies addressing lapsed, restricted, revoked, suspended, or stipulated licenses.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>20%</th>
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<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>Yes (13%)</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
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</tbody>
</table>

#### Examples of surveyor findings:
- HR licensure policies did not address the action the hospital would take in the event an employee had a restricted, lapsed, revoked, suspended, or stipulated license.
- HR records did not have current state nursing licenses for applicable employees.

#### Tips for compliance:
- Develop policy and procedure related to action that would be taken in the event of various licensing events.
- Conduct annual audits of HR policies.
- Conduct file audits for accuracy and completion.
- Identify a single source with responsibility for all licensure within the organization, including primary source verification.

### CHAPTER 4: Human Resources Management 04.00.09 Evaluation of Competence

#### Overview of the requirement:
The standard pertains to 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.

<table>
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<tr>
<th>Frequency of citation:</th>
<th>40%</th>
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<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
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</table>

#### 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 audit of job descriptions and associated competencies.
- Routinely audit HR files for accuracy and completeness.
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<th>CHAPTER</th>
<th>STANDARD</th>
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<tbody>
<tr>
<td>7: Infection Prevention and Control and Antibiotic Stewardship Programs</td>
<td>07.00.00 CONDITION OF PARTICIPATION: Infection Prevention and Control and Antibiotic Stewardship Programs 07.01.02 Infection Prevention*</td>
</tr>
</tbody>
</table>

**Overview of the requirement:**
These related requirements focus on an active, organization-wide program to proactively prevent and effectively control infection and communicable disease and to optimize the use of antibiotics.

**Comment on deficiencies:**
As the overall assessment of infection control practice for the organization, this condition is most often cited as a result of aggregate infection control deficiencies across units and/or buildings. When environment of care and housekeeping items (stained ceiling tiles, separating seams in flooring, accumulations of dust) are highlighted by the surveyor(s), it is indicative that the severity or frequency of these standard-level deficiencies has elevated the issue to an infection control concern.

Most frequently noted were deficiencies within the environment of care which are interpreted to indicate a lapse in the development of infection mitigation strategies.

**Frequency of citation:**
- 07.00.00: 20%
- 07.01.02: 32%

**Repeat deficiency from prior year?**
- 07.00.00: 12%
- 07.01.02: 55%

**From 2017 surveys?**
- 07.01.02: 15%

**Examples of surveyor findings:**

**07.00.00**
- Rusty equipment cannot be properly cleaned and sanitized. Rust was observed on the wheels of stools, IV poles, ring stands, prep tables, back tables, and a Bovie cart.
- Hospital policy failed to detail the steps required to effectively disinfect the unit.
- [In three nursing units] an excessive accumulation of dirt was observed on flat surfaces and ceiling tiles showed water damage.

**07.01.02**
- There was a significant accumulation of dust on top of the medication Pyxis in the radiology department.
- During a tour of the surgery department, the following concerns were identified: rust on the spinal table base with disruption of the paint of the base of the table; rust on various wheels of equipment.
- After opening, empty shipping boxes were left in the room on the pallets or floor.

*On June 9, 2020, Standard 07.01.02 was retitled Antibiotic Stewardship Program Leadership and rewritten with a focus on leadership of a program for clinically appropriate antibiotic use within the hospital. All standard deficiencies cited in this report came from surveys performed prior to that date when the focus was as described in the overview above.*
Examples of surveyor findings (continued):

- Floor tiles were cracked along their margins. This is an infection control concern as floor tiles that have cracks cannot be effectively cleaned and disinfected resulting in the potential for environmental cross-contamination and growth of microorganisms.
- The hospital did not conduct active surveillance via infection control rounds.

Tips for compliance:

- Raise the profile of housekeeping by aligning it with infection control.
- Conduct regular infection control surveillance rounds with rotating participation by multiple departments to promote a culture of cleanliness.
- Report findings to the relevant committee.
- Create infection control quality goals related to environmental conditions.

CHAPTER 7: 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: 36%

Repeat deficiency from prior year? No
From 2017 surveys? No

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.

**On June 9, 2020, this standard was changed from Decontamination and Sterilization which was renumbered to 07.04.01, to Risk Mitigation Measures for Infection Prevention. Most of the citations came from surveys performed after the change. However, surveyors did make the point that managing locations where high-level disinfection was conducted was in itself a risk mitigation activity.**
Examples of surveyor findings (continued):

- 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 an infection preventionist 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. These are approved by the Infection Prevention and Control function/leadership. Practice follows policy.

<table>
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<tr>
<th>CHAPTER STANDARD</th>
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<tbody>
<tr>
<td>7: Infection Prevention and Control and Antibiotic Stewardship Programs</td>
</tr>
</tbody>
</table>

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 circulated to the relevant committees.

Frequency of citation:
20%

Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:
- Based on document review, the monthly infection control surveillance reports lacked evidence that infection control surveillance had been performed.
- Based on review of the Infection Control Committee minutes and interview of the Infection Control Coordinator, environmental surveillance reports are submitted to the Safety Committee but are not reviewed by the Infection Control Committee.
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 review is performed and documented.

CHAPTER
STANDARD
7: Infection Prevention and Control and Antibiotic Stewardship Programs
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: 24%

Repeat deficiency from prior year? No
From 2017 surveys? No

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.

CHAPTER
STANDARD
8: Materials Management
08.00.01 Inventory

Overview of the requirement: An appropriate inventory of supplies is available for use and expired supplies are not used.

Comment on deficiencies: Most deficiencies occurred when expired supplies were not segregated from those for use.

Frequency of citation: 20%

Repeat deficiency from prior year? No
From 2017 surveys? No
Examples of surveyor findings:

- During the tour of the facility, the following were observed: expired lab tubes, expired boxes of A-1 Antitrypsin, boxes of outdated test reagents, and expired ultrasound gel.

- Crash cart check was not performed routinely.

Tips for compliance:

- Assign responsibility for audits to a role or individual on a defined schedule.

- Define a process to monitoring for expired supplies.

- Conduct routine audits for expired items and remove them from active use.

**CHAPTER**

**STANDARD**

<table>
<thead>
<tr>
<th>8: Materials Management</th>
<th>08.00.03 Safe Storage of Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>Supplies are appropriately stored based on their use (protected from moisture, thermal change) and other risks (rodents, vermin, theft).</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>Most citations related to maintenance of storage areas.</td>
</tr>
<tr>
<td><strong>Frequency of citation:</strong></td>
<td>40%</td>
</tr>
<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>From 2017 surveys?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Examples of surveyor findings:</strong></td>
<td>Housekeeping cleaning supplies were stored in the same room as sterile patient supplies.</td>
</tr>
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</table>

- 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 and in storerooms.

- An unmarked, unlabeled refrigerator was located immediately adjacent to the receiving dock. There was no temperature monitoring log for this refrigerator.

- During the tour of the receiving department the following were observed: pitted and cracked cement, accumulated debris in crevices surrounding the dock leveler, and rusty ceiling vents.

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.
### 10: Medical Records

#### 10.01.19 Discharge Summary Timeline

**Overview of the requirement:** A discharge summary must be completed for each patient within seven days of discharge to facilitate transitions of care.

**Comment on deficiencies:** Most citations related to failure to meet the seven-day timeframe for completion. In some cases, the summary was incomplete.

**Frequency of citation:** 40%

**Repeat deficiency from prior year?** No

**From 2017 surveys?** No

**Examples of surveyor findings:**
- Closed inpatient medical records had discharge summaries completed beyond the 7-day timeline specified by the standard.
- The attending physician had failed to sign off on the dictated discharge summary.

**Tips for compliance:**
- Audit patient records for inclusion and completion of the discharge summary within the designated time frame.
- Consider reporting compliance per physician to the medical staff office for quality tracking or use during credentialing.

### 15: 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:** 24%

**Repeat deficiency from prior year?** Yes (13%)

**From 2017 surveys?** No

**Examples of surveyor findings:**
- Patient medical beds with side rails and several points on the bed frames present a looping and 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.
Examples of surveyor findings (continued):

- 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 could 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 6 months.

- Locked psychiatric units and locked emergency department psychiatric units/rooms must be ligature risk resistant or ligature free. Other units in the facility must identify the potential ligature risks and develop safety measures to ensure patients are protected and safe.

- Provide education and training to staff and volunteers regarding assessments and mitigation efforts.

CHAPTER STANDARD

16: Nursing Services 16.01.01 Preparation and Administration of Drugs

Overview of the requirement: Drugs and biologicals are prepared and administered by those working within their scope of practice and in accordance with hospital policies and procedures.

Comment on deficiencies: Deficiencies noted where practice was at variance with scope of practice or policy.

Frequency of citation: 20%

Repeat deficiency from prior year? Yes (16%)
From 2017 surveys? Yes (10%)

Examples of surveyor findings: Based on document review of open medical records, doses of pain medications administered lacked timely reassessments.

- The hospital lacked a policy identifying time critical vs non-time critical medications and the timing for administering those medications.
### Examples of surveyor findings (continued):

- ICU medical records indicated that an RN titrated IV sedation without an order from the physician regarding RASS titration level.
- Orders for medication were not specific with the dose and the frequency of administration. By using range doses, nurses are working outside of their scope of practice.

### Tips for compliance:

- Add review of medication policies to annual staff training.
- Pain assessment/reassessment policy must be evidence-based using nationally recognized guidelines with clear processes to reassess pain and physiologic measures within specific timeframes based on the route of medication administration.

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<td><strong>16: Nursing Services</strong></td>
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#### Overview of the requirement:

Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.

#### Comment on deficiencies:

Surveyors identified instances in which policies were needed and where practice had diverged from policy.

#### Frequency of citation:

20%

#### Repeat deficiency from prior year? From 2017 surveys?

No No

#### Examples of surveyor findings:

- Staff did not document vital signs or perform an assessment according to the facility’s policy, *Minimal and Moderate Sedation*, which states “vital signs and assessments are to be taken q5 min after administration of medication and during the procedure and then q15 minutes until stable post procedure.”
- Based on open medical record review, a patient was receiving titrated IV Propofol without clarification from the ordering physician of the sedation level at which the patient should be maintained.
- Based on document review, the nursing policy, *Interdisciplinary Provision of Care*, addresses the identification and treatment of pain. There are no time frames for reassessment of the patient’s comfort level once medication has been given. This is left to the nurses’ discretion.
- Based on document review and staff interview, the facility lacked a policy that addressed risk assessment and administration of IV opioids.
Tips for compliance:

- Re-educate staff on administration of blood products and IV medications.
- Conduct periodic assessments of the administration to ensure that all staff are adhering to established policies and procedures.
- Educate staff of scope of practice.

## CHAPTER STANDARD

### 18: 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:** 20%

**Repeat deficiency from prior year?** No

**From 2017 surveys?** No

**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.

### 24: Nutritional Services 24.00.12 Emergency Preparedness Plan

**Overview of the requirement:**
The hospital’s Emergency Operations Plan (EOP) addresses how it will meet the nutritional needs of patients, visitors, and personnel in an emergency by addressing service interruptions and mandating a 3-day inventory of needed items.

**Comment on deficiencies:**
Deficiencies noted the omission of Nutrition Services from the hospital’s EOP or a lack of inventory based on calculation to meet three days of nutritional needs for the hospital.

**Frequency of citation:** 20%

**Repeat deficiency from prior year?** No

**From 2017 surveys?** No
Examples of surveyor findings:

- Based on policy review and interview, the EOP does not specifically address the role of Nutrition Services regarding alternative cooking methods, Memoranda of Understanding from vendors providing food and supplies, or a three-day menu/inventory with the calculations for amounts of supplies.

- The Nutrition EOP did not address the 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 an Emergency Preparedness Plan. Regular review of the plan should include collaboration among departments with defined responsibilities for operations in an emergency.

---

### CHAPTER

**STANDARD**

#### 24: Nutritional Services

**24.01.07 Trash Disposal**

**Overview of the requirement:**

While the Nutrition Service deals mostly with trash in the form of food waste, grease, and packaging, a patient tray may be returned with biohazardous wastes. A policy and procedure is in place for managing all types of trash and daily cleaning of trash receptacles.

**Comment on deficiencies:**

Most deficiencies resulted from missing policies to manage the range of trash generated.

**Frequency of citation:**

20%

**Repeat deficiency from prior year?**

No

**From 2017 surveys?**

No

**Examples of surveyor findings:**

- While touring the kitchen, it was observed that trash cans did not include lids as required by the hospital Dietary Policy and Procedure.

- Based on document review, the organization lacks a policy that requires daily washing of trash cans.

- Based on document review, trash disposal policies and procedures did not address the storage and disposal of grease, food waste, and bio-hazardous waste.

**Tips for compliance:**

- Review all department policies and procedures related to trash disposal and develop or expand policies as necessary to achieve compliance.
### 24: Nutritional Services 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:**
52%

**Repeat deficiency from prior year?**
No

**From 2017 surveys?**
No

**Examples of surveyor findings:**
- The casters on the movable fryer were observed to be heavily rusted and corroded indicating they should be replaced.
- The Ansul hood suppression system emergency pull station was blocked by food carts and other equipment, which would have to be moved to access 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 and expiration dates.

**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: Nutritional Services 24.01.09 Lighting, Ventilation, and Temperature Control

**Overview of the requirement:**
Ventilation, temperature, and airflow are consistent with guidelines. Lighting is adequate and bulbs are shielded from the possibility of dropping glass if broken.

**Comment on deficiencies:**
Most deficiencies resulted from equipment temperatures outside of mandated ranges.

**Frequency of citation:**
32%

**Repeat deficiency from prior year?**
No

**From 2017 surveys?**
No
Examples of surveyor findings:

- Based on document review, the temperature chart for the month of January 2020 reflected wash cycle temperatures of the dish machine as below 155 degrees 60% of the time.
- The walk-in freezer, which opens to the outside loading dock, had dripping condensation and moderate ice build-up.
- The refrigerator contained no temperature logs.
- 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.

CHAPTER 25: Pharmacy Services/ Medication Use

STANDARD 25.01.03 Security of Medications

Overview of the requirement: Medication is stored to prevent unauthorized access.

Comment on deficiencies: Deficiencies note both unattended, unlocked carts of supplies, including medications and post-use, unsecured sharps and unused portions of medications.

Frequency of citation: 20%

Repeat deficiency from prior year? Yes (13%)
From 2017 surveys? No

Examples of surveyor findings:

- While touring surgical services, the anesthesia cart in an unoccupied OR was unlocked with 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 container lids were not 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 that provides 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.
- Rounding/auditing for medication security in carts, 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 Deficiencies, Clinical and Administrative Standards

In 2020, 22 clinical and administrative standards were cited as deficiencies at 20% or more of the critical access hospitals (CAH) surveyed, with five standards standing out as most frequent. Of these five, four related to infection control. Change that resulted from CMS updates to the Condition of Participation tied to infection control and antibiotic stewardship drove some of these deficiencies. The COVID-19 public health emergency also was a contributing factor although infection prevention and control is always an important focus for surveyors as it links to patient safety and quality of care.

Educating staff on the connection between environmental conditions and infection prevention can help build a culture of cleanliness. Include discussion of handling and storage of materials, general observations of environmental conditions, and the importance of documentation.

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>4: Organizational Structure</td>
<td>04.01.01 Oversight of the QAPI Plan</td>
</tr>
</tbody>
</table>

Overview of the requirement: The governing body is responsible for an organization-wide quality program that reflects all departments and services provided.
Comment on deficiencies: The deficiency was cited because the governing body was not provided complete quality data reports for review.

Frequency of citation: 29%

Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:
- Based on document review, governing body meeting minutes do not reflect receipt and review of quality data reports indicating performance against quality indicators.

Tips for compliance:
- Schedule a regular cadence of report deadlines and route the reports through the Quality Committee for review prior to further distribution to the governing body.
- Have the governing body insert review of the quality report as a standing agenda item to ensure that review is performed and documented.

CHAPTER STANDARD
5: Staffing 05.05.03 Evaluation of Competence

Overview of the requirement: The standard pertains to 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: 29%

Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:
- Based on review of personnel records, the facility could not produce evidence 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 contain evidence that 90-day or annual evaluations competency had been completed.

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

CHAPTER STANDARD
6.03: 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 and maintenance of food preparation equipment and the physical environment in which it takes place.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>43%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
</tbody>
</table>

**Examples of surveyor findings:**

- The dry storage room had supplies blocking sprinkler heads.
- The final rinse temperature of the dishwashing machine registered 164 degrees F, not 180 degrees.
- 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:**

- Temperature 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.

---

**CHAPTER 6.05: Provision of Services: Laboratory Services**

**STANDARD 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 to see that the testing processes 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.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>29%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
</tbody>
</table>

**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 recordkeeping method is fragmented and makes it difficult to determine if employees have completed annual competency testing.
Tips for compliance:

- Re-train staff on correct labeling procedures for testing supplies when opened.
- Evaluate policies on competency testing to ensure that it is tracked for each individual employee who performs tests and for each test performed.

CHAPTER STANDARD

6.08: Provision of Services: Nursing Services

Overview of the requirement: Medical records include risk assessments performed upon admission with relevant care plans for pressure ulcers, DVT, aspiration, malnutrition, and falls. The goal is identification of patients at risk for medical complications and proactive measures to prevent these in a documented care plan.

Comment on deficiencies: Deficiencies were cited when a specified condition or a plan of care was omitted from the risk assessment.

Frequency of citation: 29%

Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:

- Two of three (2/3) open medical records reviewed lacked a Plan of Care addressing risk of skin breakdown even though the patients had been assessed as being moderate to high risk.
- One of one (1/1) ICU medical records reviewed lacked documentation of risk assessment for DVT/VTE.

Tips for compliance:

- Create risk assessments associated with each potential complication identified in the standard.
- Conduct medical record audits to ensure that risk assessments are performed and documented.
- Conduct medical record audits to ensure that care plans are implemented and updated for patients identified as being at risk.

CHAPTER STANDARD

6.10: Provision of Services: Patient Rights

Overview of the requirement: While the CAH may employ policies that restrict or limit patient visitation based on reasonable clinical indication, the hospital may not restrict visitors based on race, color, national origin, religion, gender identity, sexual orientation, or disability.

Comment on deficiencies: This standard was cited when visitation rights were not specifically included among patient rights in posted signage and patient information handouts.
<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>29%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
<tr>
<td>Examples of surveyor findings:</td>
<td>▪ Visitation rights are not included in the posted patient rights posters or in the patient rights handout that is provided to the patient.</td>
</tr>
<tr>
<td>Tips for compliance:</td>
<td>▪ Review posted patient rights and printed patient rights materials to ensure all topics are included, per regulatory requirements.</td>
</tr>
</tbody>
</table>

### CHAPTER | STANDARD
--- | ---
### 7: Medical Records | **07.00.04 Record Content Requirements**
### 8: Surgical Services | **07.02.03 Medical Record Delinquency**
 | **08.01.00 Anesthesia Risk and Evaluation**

#### Overview of the requirement:
The related standards identify elements required for a patient medical record to be considered complete, the timeframe for completion of specific elements, and the expectation of ongoing monitoring for delinquency.

#### 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.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>29% (all standards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Examples of surveyor findings:

**07.00.04**
▪ 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.

**07.02.03**
▪ The Medical Records Delinquency Metrics Report shows a rate is 5% with no associated performance goal.

▪ The Medical Records Quality Metrics Report showed results inconsistent with the medical staff rules.

**08.01.00**
▪ For anesthesia risk evaluations, charts failed to document a cardiac or pulmonary exam and post-anesthesia records failed to document cardiopulmonary status, level of consciousness, any follow up care and/or observation, or any complications occurring during the post anesthesia recovery.

▪ The anesthesia policy lacked a requirement that the pre-anesthesia evaluation include documentation of a pain assessment.
### Tips for compliance:
- See Standard 07.02.02 for expectations of the discharge summary.
- See Standard 08.00.06 for elements required in an informed consent.

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18: Infection Prevention and Control &amp; Antibiotic Stewardship</strong></td>
<td><strong>18.00.02 &amp; 18.01.02 Infection Prevention and Control Program Leadership/Antibiotic Stewardship Program Leadership</strong>&lt;br&gt;<strong>18.00.03 &amp; 18.01.01 Responsibilities of the Infection Control Professional/Antibiotic Stewardship Program Leader</strong></td>
</tr>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>Chapter 18 was a new chapter in 2020 designed to consolidate standards that had been previously located in 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.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>
| **Frequency of citation:**                                              | 18.00.02/18.01.02: 29%  
18.00.03: 43%  
18.01.01: 29%  |
| **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.

CHAPTER

18: Infection Prevention and Control & Antibiotic Stewardship

Overview of the requirement:
The standard is general, requiring comprehensive policies and procedures for preventing and controlling transmission of infection. The Required Elements include specific guidance on the inclusion of an inventory of cleaning products and their use.

Comment on deficiencies:
Surveyors cited deficiencies related to the focused requirements for cleaning products.

Frequency of citation: 29%
Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:
- The cleaning products inventory does not contain the dilution ratios for the approved cleaning products.

Tips for compliance:
- Spot check by observing practice to ensure that it matches policy and defined procedures.

CHAPTER

18.00.04 Infection Prevention and Control Policies

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 circulated to the relevant committees.

Frequency of citation: 71%
Repeat deficiency from prior year? No
From 2017 surveys? No

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 review is performed and documented.

CHAPTER

STANDARD

18: Infection Prevention and Control & Antibiotic Stewardship

18.02.07 Prevention of Central Venous Catheter Infections

Overview of the requirement: Central venous catheters, while clinically essential, pose a high risk of device-related infection. The intent of the standard is that the organization adheres to effective methods to minimize risk of central venous catheter-related bloodstream infections.

Comment on deficiencies: The Required Elements related to this standard detail three items that must be included in policy and procedure for CVCs. Deficiencies were cited when a policy omitted any of these items.

Frequency of citation: 29%

Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:  
- The prevention of central venous catheter infections policy did not include the required strategy of prompt removal of the catheter as soon as it is no longer essential.

Tips for compliance:  
- Review infection and control policies and procedures to ensure that CVCs are specifically addressed with all required elements.

CHAPTER

STANDARD

18: Infection Prevention and Control & Antibiotic Stewardship

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 by the Infection Control Committee.

Comment on deficiencies: The hospital could not produce evidence that the Infection Control Committee had approved or reviewed the Employee Health Plan for the past three years.

Frequency of citation: 29%

Repeat deficiency from prior year? No
From 2017 surveys? No

Examples of surveyor findings:  
- The Employee Health Plan was not approved by the Infection Control Committee.
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.

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18: Infection Prevention and Control &amp; Antibiotic Stewardship</strong></td>
<td><strong>18.05.04 Maintenance of Ceilings</strong></td>
</tr>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>Ceilings are maintained to prevent contaminants from falling into patient care and food service areas.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>Deficiencies noted evidence of deferred ceiling maintenance across many areas of the hospitals surveyed.</td>
</tr>
<tr>
<td><strong>Frequency of citation:</strong></td>
<td>43%</td>
</tr>
<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>From 2017 surveys?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Examples of surveyor findings:</strong></td>
<td>During the building tour, poorly seated ceiling tiles, stained ceiling tiles and perforated or cracked ceiling tiles were observed.</td>
</tr>
<tr>
<td><strong>Tips for compliance:</strong></td>
<td>Include ceilings on a checklist for environmental rounds.</td>
</tr>
<tr>
<td></td>
<td>Correct deficiencies as soon as they are noted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>18: Infection Prevention and Control &amp; Antibiotic Stewardship</strong></td>
<td><strong>18.05.05 Maintenance of Housekeeping and Laundry Equipment</strong></td>
</tr>
<tr>
<td><strong>Overview of the requirement:</strong></td>
<td>Care and cleaning of housekeeping and laundry equipment is governed by policy that addresses frequency of cleaning, approved products for use in cleaning this equipment, and storage to minimize re-contamination of equipment after cleaning.</td>
</tr>
<tr>
<td><strong>Comment on deficiencies:</strong></td>
<td>Deficiencies were cited for missing policies.</td>
</tr>
<tr>
<td><strong>Frequency of citation:</strong></td>
<td>29%</td>
</tr>
<tr>
<td><strong>Repeat deficiency from prior year?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>From 2017 surveys?</strong></td>
<td>No</td>
</tr>
<tr>
<td><strong>Examples of surveyor findings:</strong></td>
<td>The hospital could not produce a policy regarding maintenance for housekeeping and laundry equipment.</td>
</tr>
<tr>
<td><strong>Tips for compliance:</strong></td>
<td>Policies related to the maintenance of housekeeping and laundry equipment should align with currently accepted practices for healthcare facilities.</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>STANDARD</td>
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</tr>
<tr>
<td><strong>18: Infection Prevention and Control &amp; Antibiotic Stewardship</strong></td>
<td><strong>18.06.02 Clean Linen Storage</strong></td>
</tr>
</tbody>
</table>

**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 storage is observed in multiple locations in most hospitals 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:** 57%

**Repeat deficiency from prior year?** No

**From 2017 surveys?** No

**Examples of surveyor findings:**
- During a tour of the endoscopic suite, uncovered clean linen was observed in an open cabinet unit.
- In 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, Acute Care and Critical Access Hospitals

Only four individual standards were found to be frequently deficient for surveys performed in 2020 although many other emergency management standards were cited as not compliant on individual deficiency reports. Our shared recent experience with the public health emergency has vividly illustrated the need for effective emergency management planning that engages all hospital departments.

### Standards Cited

<table>
<thead>
<tr>
<th>Standards Cited</th>
<th>Frequency of Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00.04 (ACH)</td>
<td>35%</td>
</tr>
<tr>
<td>17.00.05 (CAH)</td>
<td>30%</td>
</tr>
<tr>
<td>09.01.02 (ACH)</td>
<td>25%</td>
</tr>
<tr>
<td>17.01.02 (CAH)</td>
<td>20%</td>
</tr>
</tbody>
</table>

### CHAPTER 9: Emergency Management (ACH) 09.00.04 Patient Population

**Overview of the requirement:** When creating an Emergency Operations Plan (EOP), 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:

| Repeat deficiency from prior year? | Yes (15%) |
| From 2018 surveys? | No |

### 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.

## CHAPTER

### STANDARD

<table>
<thead>
<tr>
<th>17: Emergency Management (CAH)</th>
<th>17.00.05 Services</th>
</tr>
</thead>
</table>

### Overview of the requirement:

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

### Comment on deficiencies:

Deficiencies were cited when the EOP did not identify the services that the CAH expected to continue to provide in an emergency scenario.

### Frequency of citation:

| Repeat deficiency from prior year? | No |
| From 2018 surveys? | No |

### 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.

## CHAPTER

### STANDARD

<table>
<thead>
<tr>
<th>9: Emergency Management (ACH)</th>
<th>09.01.02 &amp; 17.01.02 Nutritional Services</th>
</tr>
</thead>
</table>

### Overview of the requirement:

Under activation of the Emergency Operations Plan (EOP), 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 the requirements.
<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>20% ACH, 29% CAH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>18% ACH, 33% CAH</td>
</tr>
<tr>
<td>From 2018 surveys?</td>
<td>No</td>
</tr>
<tr>
<td><strong>Examples of surveyor findings:</strong></td>
<td></td>
</tr>
<tr>
<td>▪ The EOP did not address nutritional services.</td>
<td></td>
</tr>
<tr>
<td>▪ EOP did not address the following related to the Nutrition Department:</td>
<td></td>
</tr>
<tr>
<td>▪ Alternative cooking methods in the event of utility outage.</td>
<td></td>
</tr>
<tr>
<td>▪ Memoranda of Understanding from vendors providing food and supplies.</td>
<td></td>
</tr>
<tr>
<td>▪ A three-day menu with the calculations for amounts of needed supplies.</td>
<td></td>
</tr>
<tr>
<td><strong>Tips for compliance:</strong></td>
<td></td>
</tr>
<tr>
<td>▪ 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.</td>
<td></td>
</tr>
</tbody>
</table>
Physical Environment Deficiencies, Acute Care and Critical Access Hospitals

Hospitals are high-traffic environments that see hard use. The amount and types of use result in wear and tear, and create opportunities for shifting levels of compliance with standards for the physical environment and Life Safety Code requirements. The most challenging standards—the deficiencies most frequently cited by surveyors—tend to be the same across acute care and critical access hospitals.

The chart below and the descriptive detail that follows it cover chapters 3 Physical Environment and 14 Life Safety for critical access hospitals (CAH) and chapters 11 Physical Environment and 13 Life Safety for acute care hospitals (ACH).

<table>
<thead>
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<td>3: Physical Environment (CAH)</td>
<td>03.01.10 Eyewash stations and emergency showers</td>
</tr>
<tr>
<td>11: Physical Environment (ACH)</td>
<td>11.01.10 Eyewash stations and emergency showers</td>
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</table>

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:
40% (both standards)

<table>
<thead>
<tr>
<th>Repeat deficiency from prior year?</th>
<th>No</th>
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<tbody>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
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**Examples of surveyor findings:**
- The eyewash station was observed to be inoperable.
- The eyewash station did not meet the minimum of a 15-minute flush.
- The eyewash station did not include 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.

## CHAPTER 3: Physical Environment (CAH) 03.04.02 Fire Drills – Quarterly

**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.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
<th>29%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat deficiency from prior year?</td>
<td>No</td>
</tr>
<tr>
<td>From 2017 surveys?</td>
<td>No</td>
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</tbody>
</table>

**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 enactment.
- Develop templates for the documentation you wish to capture.
- Stagger scheduling of quarterly drills to avoid it becoming a predictable occurrence.
### 3: Physical Environment (CAH) 03.05.01 Medical Equipment and Systems – Maintenance

**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:** 29%

**Repeat deficiency from prior year?** Yes (17%)

**From 2017 surveys?** No

**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.
- New equipment must be inventoried on the maintenance plan when put into service.

### 3: Physical Environment (CAH) 03.07.03 & 11.07.03 Ventilation, Light, and Temperature Controls

**Overview of the requirement:** Lighting, temperature, humidity, and from 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 air pressure relationship issues and temperature and humidity concerns regarding the functioning of equipment and supplies.

**Frequency of citation:** 71% (CAH), 36% (ACH)

**Repeat deficiency from prior year?** Yes (33% both standards)

**From 2017 surveys?** No
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 in the ED, the clean utility room was observed to have a negative pressure relationship to the corridor when a positive relationship is required.

- The surgery decontamination hazardous materials 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.

### CHAPTER

#### STANDARD

**11: Physical Environment (ACH)**

**11.00.00 CONDITION OF PARTICIPATION: Physical Environment**

**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:** 48%

**Repeat deficiency from prior year?**
Yes (40%)

**From 2017 surveys?**
Yes (37%)
Examples of surveyor findings:

- The fire alarm panel was not connected to an automatic dialer per standard 13.02.01.
- Non-compliant air pressure relationships existed at clean storage rooms, decontamination processing.
- Smoke detectors were mounted less than three feet from the air diffusers and more than twelve inches below the deck above.
- No evidence of performance of the two-year smoke detector sensitivity test per standard 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 were not labeled with biohazard labels.
- No evidence of an annual inspection for emergency lighting in the kitchen or generator room.
- Cardboard and trash compactor key switch were observed to be 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.
Life Safety Deficiencies, Acute Care and Critical Access Hospitals

The chart below and the descriptive detail that follows it cover chapters 13 Life Safety for acute care hospitals (ACH) and 14 Life Safety for critical access hospitals (CAH). A total of 15 life safety standards were frequent deficiencies for acute care hospitals; 13 life safety standards were frequently cited at critical access hospitals. They are presented in groups corresponding to the chapter sections.

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<tr>
<td>Section 00: General Requirements</td>
<td>13.00.05 Facility Demographic Report (ACH)</td>
</tr>
<tr>
<td>Overview of the requirement:</td>
<td>The Facility Demographic Report (FDR) serves as a guide for determining how the organization achieves and maintains compliance with the NFPA Life Safety Code. The intention of the standard is that the FDR is reviewed on at least an annual basis for each facility identified as a healthcare occupancy or an ambulatory healthcare occupancy, for accuracy of the information.</td>
</tr>
<tr>
<td>Comment on deficiencies:</td>
<td>Deficiencies were cited for missing, inaccurate or incomplete Facility Demographic Reports.</td>
</tr>
</tbody>
</table>
**Frequency of citation:** 20%

**Examples of surveyor findings:**
- The organization did not provide a current FDR.
- The organization had errors on the FDR.
- During the document review session, the organization did not identify an access-control locking system to the main entrance to the surgery department.

**Tips for compliance:**
- Assign the responsibility to maintain an accurate FDR to a Facilities Manager.
- Implement a quarterly audit of the FDR to ensure accuracy and completion.

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<tr>
<td>Section 01: Means of Egress</td>
<td>13.01.01 &amp; 14.01.01 Doors 13.01.02 Door Locks (ACH)</td>
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</table>

**Overview of the requirement:** Means of egress standards address provision of a safe, protected means of travel from any point in the building to the exterior during emergency situations, especially fire and smoke incidents. These related standards focus on requirements for doors within the egress pathway.

**Comment on deficiencies:** Deficiencies were cited for non-latching doors that would fail to protect a corridor in case of a smoke or fire incident and egress doors with non-compliant locking systems.

**Frequency of citation:**
- 13.01.01: 32%
- 14.01.01: 32%
- 13.01.02: 29%

**Examples of surveyor findings:**
- Exit access corridor doors did not positively latch or lacked latching hardware.
- Doors could not be opened to a full 90-degrees due to a blockage.
- Doors were observed to be wedged open while the fire alarm hold-open circuit was being installed.
- When testing the doors, they would not release when holding down the panic hardware.
- Doors were locked with a mechanism that did not meet the requirements of any of the locking systems allowed by the Life Safety Code.
- Doors did not operate within 15 seconds after activation and did not have the 15-second delayed egress signage installed.
Tips for compliance:

- Assign routine checks of all doors and means of egress to the Facilities Manager to ensure compliance.
- Conduct general staff education on requirements and rotate inclusion in environmental surveillance rounds. Focus on the impact of convenience vs. life safety compliance, e.g., propping doors open or blocking full door swing opening with equipment.

<table>
<thead>
<tr>
<th>CHAPTER</th>
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</table>
| **Section 02: Fire Alarms** | **13.02.01 & 14.02.01 Fire Alarm System – Installation and Maintenance**  
**13.02.02 & 14.02.02 Fire Alarm System – Testing** |

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

Comment on deficiencies:
Deficiencies reflect poorly located smoke detectors and missed elements of testing (or documentation).

Frequency of citation:
13.02.01 (ACH): 48%
14.02.01 (CAH): 29%
13.02.02 (ACH): 44%
14.02.02 (CAH): 29%

Examples of surveyor findings:

**13.02.01/14.02.01**

- Smoke detectors were observed to be installed less than 36” from a return or supply air diffuser at the following locations: soiled utility room, pre-op nurse station, stairwell landing, electrical 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 event of fire.
- There was no evidence that the Fire Alarm Control Panel batteries’ load voltage tests had been performed for one month.

**13.02.02/14.02.02**

- 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.

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<td>Section 03: Fire Suppression</td>
<td>13.03.01 &amp; 14.03.01 Water-based Fire Protection System – Installation and Maintenance</td>
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<tr>
<td>Systems</td>
<td>13.03.02 &amp; 14.03.02 Water-based fire protection system – Testing and inspection</td>
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<tr>
<td></td>
<td>13.03.03 Water-based fire protection system – Control valves, piping, and hangers</td>
</tr>
<tr>
<td></td>
<td>13.03.09 Portable fire extinguishers – Installation, inspection, and maintenance</td>
</tr>
</tbody>
</table>

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 (ACH): 48%
- 14.03.01 (CAH): 23%
- 13.03.02 (ACH): 28%
- 14.03.02 (CAH): 40%
- 13.03.03 (ACH): 40%
- 13.03.09 (ACH): 28%

Examples of surveyor findings:

- The Emergency Department ambulance canopy was not provided with fire sprinkler coverage.
- 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 any 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.
- Sprinkler head in the environmental services closet was observed to be covered in dust.
Examples of surveyor findings (continued):

13.03.02
- Organization did not present evidence that the control valves had been inspected monthly for the past twelve 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.

13.03.03
- Low-voltage cables were observed hanging on the sprinkler pipe.
- A section of HVAC ductwork was observed to be supported by the water-based sprinkler piping above the ceiling.

13.03.09
- Portable fire extinguishers were observed to be missing annual and monthly inspection tags. The tamper device on one discharge trigger that prevents the pin from being removed without evidence was broken off.
- Travel distance to an accessible fire extinguisher for an office suite was greater than 75'.
- Access to the fire extinguisher was blocked by a chair.
- A fire extinguisher was missing monthly inspections.

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.
- Maintain an inventory of all equipment components and include inspection on regular rounding of the physical environment.
- Inspect piping, including above the level of ceiling tiles, to be sure it is free of other materials.

CHAPTER STANDARD

Section 04: Fire Safety Systems 13.04.01 & 14.04.01 Fire Rated Barriers
13.04.07 & 14.04.07 Fire Rated Door Assemblies
14.04.08 Hazardous Areas
13.04.09 & 14.04.09 Ceilings

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.

<table>
<thead>
<tr>
<th>Frequency of citation:</th>
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<tbody>
<tr>
<td>13.04.01 (ACH): 32%</td>
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<tr>
<td>14.04.01 (CAH): 43%</td>
</tr>
<tr>
<td>13.04.07 (ACH): 40%</td>
</tr>
<tr>
<td>14.04.07 (CAH): 57%</td>
</tr>
<tr>
<td>14.04.08 (CAH): 29%</td>
</tr>
<tr>
<td>13.04.09 (ACH): 48%</td>
</tr>
<tr>
<td>13.04.09 (CAH): 43%</td>
</tr>
</tbody>
</table>

**Examples of surveyor findings:**

13.04.01/14.04.01
- 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 1” 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.
- Two large, unprotected penetrations of approximately 2’x3’ 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 were observed to not have rating labels.
- A door was observed to be noted as a 90-minute door and 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.

14.04.08
- The environmental services office was listed as a hazardous area on the life safety drawings. It was observed that the environmental services office was not constructed to be protected with one-hour fire-rated barriers that enclose the room.
- The environmental services office was being used for storage of combustible supplies. This office was not listed as a hazardous area nor was it rated appropriately.

13.04.09/14.04.09
- Ceilings were observed to have gaps greater than $\frac{1}{8}”$.
- Areas were observed to have missing ceiling tiles.
- An over-cut was observed around the escutcheon trim.
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).

CHAPTER

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<td><strong>Section 05: Building Services</strong></td>
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<td>14.05.02 Elevator Recall</td>
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<tr>
<td>13.05.04 &amp; 14.05.04 Generator Inspection</td>
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<tr>
<td>13.05.09 &amp; 13.05.09 Utility Systems</td>
</tr>
<tr>
<td>13.05.10 Medical Gas Systems: Maintenance</td>
</tr>
</tbody>
</table>

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:

- 14.05.02 (CAH): 29%
- 13.05.04 (ACH): 24%
- 14.05.04 (CAH): 43%
- 14.05.05 (CAH): 29%
- 13.05.09 (ACH): 28%
- 14.05.09 (CAH): 29%
- 13.05.10 (ACH): 24%

Examples of surveyor findings:

14.05.02
- During document review, evidence of required monthly elevator recall testing could not be provided.

13.05.04/14.05.04
- The generator was observed to lack a remote shut-off switch located outside the room that housed the generator.
- During the document review session, the following deficiencies were observed:
  - A fuel quality sample sent to the testing laboratory in February 2020 had not returned testing results at the time of survey.
  - Conductance testing was not performed or documented for the generator batteries.
  - No evidence that electrolyte specific gravity tests had not been performed weekly for the past 12 months.
  - No current annual fuel testing documentation.
Examples of surveyor findings (continued):

14.05.05
- Monthly load tests on generators did not consistently meet the nameplate rating.
- No evidence was provided that testing was performed based on the manufacturer’s recommended prime mover’s exhaust gas temperature.
- No evidence of an annual test providing validation that required loads are met.

13.05.09/14.05.09
- Circuit directory schedules on electrical control panels did not label all circuits as to what function they served.
- A low-voltage junction box was missing the cover plate.

13.05.10
- E- and H-size medical gas tanks were not secured or retained with chains.
- The medical gas storage room did not have ventilation installed 12" above the floor.
- The central medical gas alarm monitoring station was located in a room that does not have constant monitoring.
- Oxygen cylinders were not labeled FULL/EMPTY.
- Empty and full oxygen cylinder storage racks were not labeled for proper segregation of full and not-full cylinders.

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.
Notes