



Critical Access Hospital

NEW Survey Tools Guide (STG)

September 2026

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Summary of Changes

Note: Updates from the last published version of the Survey Process Guide are identified by underlined and ~~striketrough~~ text throughout this document.

Changes effective September 1, 2026

- This new survey tools guide is a companion to the Critical Access Hospital's *Survey Process Guide* and contains the same survey tools Joint Commission accredited organizations are already familiar with.
- Updated EP references in the Kitchen Tracer Survey Guide
- Added Construction Survey Tool
- Added Hyperbaric Tour Tool
- Updated Document Review Tool
- Updated Building Tour Guide Tool
- Updated Ambulatory and Business Occupancy Building Tour Guide Tool
- Removed all K-Tag tool references from required survey processes
- Updated National Performance Goals Module with a revised note at NPG.01.01.01, EP 3, pertaining to baby naming conventions

Contents

CAH Medical Records Documentation Requirements (C Tags).....	4
CAH Psychiatric and Rehabilitation Distinct Part Units (DPUs) Medical Records Documentation Requirements (A Tags and 412.27, 412.29).....	9
Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool.....	22
Fire Drill Matrix	75
Critical Access Hospital Physical Environment Document List & Review Tool	76
Health Care Occupancy LSC and HCFC Evaluation Tool.....	98
Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital.....	156
HAP/CAH SPG 2026 – Building Tour Guidance Document.....	164
HAP/CAH Construction Building Tour Tool	167
HAP/CAH Hyperbaric Facility Building Tour Tool.....	168
HAP/CAH Business Occupancy Building Tour Guidance	170
HAP/CAH Infection Prevention and Control Program Assessment Tool	176
Imaging Document Review Guide	193
Performance Improvement Evaluation Tool.....	196
Emergency Management (EM) Discussion Tool.....	209
Emergency Management (EM) Documentation Review Tool – HAP/CAH	213
Program Specific Tracer – Suicide Prevention, including Ligature and Other Safety Risks Assessment	217
Workplace Violence Evaluation Tool	221
Excellent Health Outcomes for All Evaluation Tool (HAP/CAH).....	225
Antibiotic Stewardship Evaluation Tool (HAP/CAH)	230
Critical Access Hospital National Performance Goals Evaluation Module	236
Medical Staff-Related Standards Compliance Evaluation Guides	276
OPTIONAL Primary Care Medical Home (PCMH) Certification Evaluation Guide (Hospital and Critical Access Hospital)	291

CAH Medical Records Documentation Requirements (C Tags)

Medical Records Review	
The denominator needs to be no fewer than 20 inpatient records (minimum of 5 of the 20 records should be swing bed patient records) for all unshaded items, provided that number is adequate to determine compliance. Additionally, select a sample of outpatients in order to determine compliance in outpatient and emergency services.	
Reference	Admission and Registration
485.614(h)(1-4)	➤ Patient informed of visitation rights ; records contain documentation that the required notice was provided
485.614(b)(3)	➤ Advanced directives – record contains documentation that notice of the hospital’s advance directives policy was provided at the time of admission or registration; document in a prominent part of the patient’s medical record whether or not the patient has executed an advance directive; if yes, a copy of the patient’s advance directive is in the medical record.
485.614(b)(4)	➤ Patient asked (unless incapacitated) about notifying family and physician about inpatient admission; if the patient was incapacitated at the time of admission record documents what steps were taken to identify a family member or representative and the patient’s physician.
485.638(b)(3)	➤ The patient's written consent is required for release of information not required by law.
Reference	Care Documentation
485.635(b)(1)(i)	➤ The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician’s office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department.

	○ These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.
485.638(a)(2)	➤ The records are legible, complete, accurately documented , readily accessible, and systematically organized.
485.638(a)(4)(iv)	➤ Dated signatures of the doctor of medicine or osteopathy or other health care professional.
Reference	Intervention Documentation
485.638(a)(4)(i)	➤ Identification and social data, evidence of properly executed informed consent forms , pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient ;
485.638(a)(4)(ii)	➤ Reports of physical exams, diagnostic and laboratory test results, and consultative findings
485.638(a)(4)(iii)	➤ All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications , and other pertinent information necessary to monitor the patient's progress , such as temperature graphics, progress notes describing the patient's response to treatment ; and
485.639(b)(1)	➤ A qualified practitioner . . . must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed .
485.639(b)(2)	➤ A qualified practitioner . . . must examine each patient before surgery to evaluate the risk of anesthesia .
485.639(b)(3)	➤ Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner . . .

485.635(a)(3)(vi)	➤ Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices. All patient diets, including therapeutic diets, must be ordered by the practitioner responsible for the care of the patients or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff in accordance with State law governing dietitians and nutrition professionals and that the requirement of § 483.25(i) of this chapter is met with respect to inpatients receiving post CAH SNF care.
485.614(e)(4)	➤ Restraint and seclusion: The CAH must have written policies and procedures regarding the use of restraint and seclusion that are consistent with current standards of practice .
485.614(g)(3)(i) and (ii)	➤ Medical record includes the date and time death associated with use of restraint or seclusion was reported to CMS or recorded in the internal log or other system
Reference	Discharge Planning, Evaluation, Post Hospital Needs
485.635(d)(4)	A nursing care plan must be developed and kept current for each inpatient.
485.635(e)	Physical therapy, occupational therapy, and speech-language therapy pathology services furnished at the CAH, if provided, are provided by staff qualified under State law, and consistent with the requirements for therapy services in §409.17 . . . which specifies the following rehabilitation services plan of care requirements : • – Establishment of the plan: “The plan must be established before treatment begins by one of the following: (1) A physician; (2) A nurse practitioner, a clinical nurse specialist or a physician assistant; (3) The physical therapist furnishing the physical therapy services; (4) A speech-language pathologist furnishing the speech-language pathology services; (5) An occupational therapist furnishing the occupational therapy services.” – Content of the plan: “The plan: (1) Prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual; and (2) Indicates the diagnosis and anticipated goals.”

	– Changes in the plan: “Any changes in the plan are implemented in accordance with the provider’s policies and procedures.”
485.639(d)	➤ All patients are discharged in the company of a responsible adult , except those exempted by the practitioner who performed the surgical procedure .
485.642(a)	(a) Standard: Discharge planning process. The CAH's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.
485.642(a)(1)	Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-CAH care will be made before discharge and to avoid unnecessary delays in discharge.
485.642(a)(2)	A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-CAH services, including, but not limited to, hospice care services, post-CAH extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.
485.642(a)(3)	The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).
485.642(a)(4)	Upon the request of a patient's physician, the CAH must arrange for the development and initial implementation of a discharge plan for the patient.
485.642(a)(5)	Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.
485.642(a)(6)	The CAH's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes .
485.642(a)(7)	The CAH must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those

	patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs. (This is NOT in the medical record, see OQPI)
485.642(a)(8)	The CAH must assist patients, their families, or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to, HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The CAH must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.
485.642(b)	The CAH must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

CAH Psychiatric and Rehabilitation Distinct Part Units (DPUs) Medical Records Documentation Requirements (A Tags and 412.27, 412.29)

Introduction to Medical Record Reviews	
- Review a sample of active and closed medical records for completeness and accuracy in accordance with Federal and State laws and regulations and hospital policy. - The sample should be 10 percent of the average daily census and be no less than 30 records. - Within the sample, select at least one patient from each nursing unit (e.g., med/surg, ICU, OB, pediatrics, specialty units, etc.). In addition to the inpatient sample, select a sample of outpatients in order to determine compliance in outpatient departments, services, and locations. The sample size may be expanded as needed to assess the hospital's compliance with the CoPs. Request patient care policies and other supporting documents prior to reviewing medical records. This worksheet will assist surveyors in determining an organization's compliance with medical record documentation requirements and provide the opportunity to see trends in performance as well as track progress on performing the required quantity of review.	
485.647 Condition of participation: psychiatric and rehabilitation distinct part units.	(a) Conditions. (1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of part 412 of this chapter for excluded psychiatric units. (2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§ 412.29 and § 412.30 of part 412 of this chapter related specifically to rehabilitation units.
Reference	Admission and Registration

482.13(a)(1)	➤ Records of Medicare beneficiaries contain a signed and dated standardized notice, “An Important Message from Medicare” (IM) provided to inpatients within 2 days of the admission. For patients whose discharge occurred more than 2 days after the initial IM notice was issued, determine whether the hospital provided another copy of the IM to the patient prior to discharge in a timely manner.
482.13(b)(3)	➤ Advanced directives – record contains documentation that notice of the hospital’s advance directives policy was provided at the time of admission or registration; document in a prominent part of the patient’s medical record whether or not the patient has executed an advance directive; if yes, a copy of the patient’s advance directive is in the medical record.
482.13(b)(4)	➤ Patient asked (unless incapacitated) about notifying family and physician about inpatient admission; if the patient was incapacitated at the time of admission record documents what steps were taken to identify a family member or representative and the patient’s physician.
482.13(h)(1)	➤ Patient informed of visitation rights ; records contain documentation that the required notice was provided
Reference	Care Documentation
	Justification for Admission:
482.24(c)(4)(ii)	➤ Admitting diagnosis
482.24(c)	➤ Medical record information justifies admission and continued hospitalization , supports the diagnosis, and describes patient’s progress and response to medications, services (interventions, care, treatments).
482.24(c)(1)	➤ Medical record entries are legible, complete, dated, timed & authenticated -consistent with policy/procedure

482.24(c)(3)(iv)	➤ Pre-printed or electronic standing orders , order sets, and protocols are dated, timed, and authenticated promptly in the medical record
482.24(c)(4)(iv)	➤ Documentation of complications, healthcare associated infections (HAI's) and unfavorable reactions to drugs and anesthesia
482.24(c)(4)(i)(A)	Admission Note or H&P: ➤ A medical history and physical examination completed and documented no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and except as provided under paragraph (c)(4)(i)(C) of this section. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. ➤ An updated examination of the patient, including any changes in the patient's condition, when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (c)(4)(i)(C) of this section. Documentation of the updated examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. ➤ An assessment of the patient (in lieu of the requirements of paragraphs (c)(4)(i)(A) and (B) of this section) completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at §482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.
482.24(c)(4)(i)(B)	
482.24(c)(4)(i)(C)	

482.51(b)(1)(i)	Surgical or procedure requiring anesthesia services H&P ➤ Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies: A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.
482.51(b)(1)(ii)	➤ Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies: An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration, and except as provided under paragraph (b)(1)(iii) of this section.
482.51(b)(1)(iii)	➤ Prior to surgery or a procedure requiring anesthesia services and except in the case of emergencies: An assessment of the patient must be completed and documented after registration (in lieu of the requirements of paragraphs (b)(1)(i) and (ii) of this section) when the patient is receiving specific outpatient surgical or procedural services and when the medical staff has chosen to develop and maintain a policy that identifies, in accordance with the requirements at § 482.22(c)(5)(v), specific patients as not requiring a comprehensive medical history and physical examination, or any update to it, prior to specific outpatient surgical or procedural services.

482.24(c)(4)(v)	Informed Consent: ➤ Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, require written patient consent. (The medical record must contain a document recording the patient's informed consent for those procedures and treatments that have been specified as requiring informed consent). A properly executed informed consent form contains the following minimum elements: Name of the hospital..., Name of the specific procedure..., Name of the responsible practitioner..., Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient..., Signature of the patient..., Date and time the informed consent form is signed by the patient... ○ If there is applicable State law governing the content of the informed consent form, then the hospital's form must comply with those requirements.
482.51(b)(2)	➤ A properly executed informed consent form for the operation must be in the patient's chart before surgery, except in emergencies.
482.24(c)(4)(vi)	Monitoring of Care: ➤ The medical record must contain: all practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition ○ Orders radiologic services ○ Radiologist signs reports of interpretation ○ Orders for patient diets ○ Nuclear med interpretation of tests signed and dated ○ Respiratory care orders ➤ All orders, including verbal orders, are dated, timed, and authenticated. The receiver of a verbal order must date, time, and sign the verbal order in accordance with hospital policy
482.26(b)(4)	
482.26(d)(1)	
482.28(b)(2)	
482.53(d)(2)	
482.57(b)(4)	
482.24(c)(2)	

482.28(b)(1), (b)(2)	➤ Nutritional needs – monitoring the dietary intake and nutritional status of patients identified as having special nutritional needs; diet orders prescribed by the practitioner, a qualified dietician, or qualified nutrition professional.
Reference	Intervention Documentation
482.52(b)(1)	Anesthesia: ➤ Pre-anesthesia eval within 48 hours prior to surgery or anesthesia ➤ Intraoperative anesthesia record or report ➤ Post anesthesia eval no later than 48 hours after surgery or anesthesia
482.52(b)(2)	
482.52(b)(3)	
482.51(b)(6)	Procedure: ➤ An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon
482.24(c)(4)(iii)	Consults: ➤ Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
482.23(c)(1)(i) &(ii)	Medication: ➤ Review a sample of patient health records to determine: ○ if medication administration conformed to an authorized practitioner’s order (that is, there is an order from an authorized practitioner, or an applicable standing order, and that the correct medication was administered to the right patient at the right dose via the correct route) and if the timing of administration complied with the hospital’s policies and procedures.

482.23(c)(2)	○ All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel.....
482.23(c)(3)	○ Orders for drugs and biologicals are documented and signed by any practitioner who is authorized.... Influenza and pneumococcal vaccines may be administered per physician-approved hospital policy after an assessment of contraindications...
482.23(c)(4)	➤ Review a sample of medical records of patients who received blood transfusions or IV medications. ○ Are blood transfusions and IV medications administered in accordance with state law and approved medical staff policies and procedures? ○ Are blood transfusions and IV medications administered by personnel who are working within their scope of practice in accordance with state law and approved medical staff policies?
482.23(c)(6)(i)(E)	Medication Self Administration ➤ Documentation of self-administration of hospital issued medication as reported by patient ➤ Documentation of self-administration of medication brought in by patient as reported by patient
482.23(c)(6)(ii)(E)	
	Blood Products: ➤ Documentation of notification of or attempts to notify patient of potentially infectious blood. ➤ If hospital unable to locate patient, it documents in the medical record the extenuating circumstances that caused notification to exceed 12 weeks.
482.27 (b)(6)(iii)	
482.27(b)(7)(ii)	
	Restraints: ➤ Orders for restraint or seclusion used for the management of violent or self-destructive behavior may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older;
482.13(e)(8)(i)	

	(B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1 hour for children under 9 years of age;
482.13(e)(16)(i-v)	➤ Documentation of the following when restraints or seclusion is used: (i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior; (ii) A description of the patient's behavior and the intervention used; (iii) Alternatives or other less restrictive interventions attempted (as applicable); (iv) The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; (v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention
482.13(e)(12) 482.13 (e)(12)(i)	➤ Face-to-face evaluation within 1 hour after the initiation of restraint or seclusion is used for the management of violent or self-destructive behavior by a— (A) Physician or other licensed practitioner (B) Registered nurse who has been trained in accordance with the requirements in 482.13(f)
482.12(e)(12)(ii)	➤ Documentation of the face-to-face evaluation includes the following: (A) The patient's immediate situation; (B) The patient's reaction to the intervention; (C) The patient's medical and behavioral condition; and (D) The need to continue or terminate the restraint or seclusion.
482.13(e)(14)	➤ Documentation of consultation with the attending physician or other LP when the 1-hour face-to-face evaluation was conducted by a trained RN (as soon as possible in accordance with hospital policy)
482.13(g)(3)(i) and (ii)	➤ Medical record includes the date and time death associated with use of restraint or seclusion was reported to CMS or recorded in the internal log or other system
Reference	Discharge Planning, Evaluation, Post Hospital Needs
	Care Plans (nursing or interdisciplinary)

482.13(b)(1)	➤ Confirm that there is evidence that the patient or their representative was included or proactively involved in the development and implementation of their plan of care.
482.23(b)(4)	➤ For each plan reviewed, verify the following with respect to the nursing care component: • Was the plan initiated as soon as possible after admission for each patient? • Does the plan describe and reflect patient goals as part of the patient's nursing care assessment and, as appropriate, physiological and psychosocial factors and patient discharge planning? • Is the plan consistent with the medical care plan of the practitioner responsible for the care of the patient? • Is there evidence of reassessment of the patient's nursing care needs and response to nursing interventions and, as applicable, revisions to the plan? • Was the plan implemented in a timely manner?
	Case Manager and/or Social Work Notes
482.43(a)(1)	➤ Discharge planning in early stage of hospitalization to ensure appropriate arrangements for post-hospital care will be made before discharge
482.43(a)(2)	➤ Discharge planning evaluation – eval of pt needing post-hospital services and determination of the availability of services
482.43(a)(3) & (a)(5)	➤ Discharge planning evaluation and plan – by, or under the supervision of a RN, social worker, or other qualified personnel; the discharge planning evaluation results are included in the medical record
482.43(a)(3)	➤ Discharge planning evaluation results discussion – with the patient or representative and communication documented in the medical record
482.43(a)(6)	➤ Reassess discharge plan

482.43(d)(1)(i) &(iii)	➤ Document in the record that the list of HHAs, SNFs, IRFs, or LTCHs was presented to the patient or to the patient's representative. (Note: disclosable financial interests if they exist must be stated on the list provided to the patient)
482.43(d)(1)(ii)	➤ Patients enrolled in managed care organizations made aware of the need to verify which providers or suppliers are in network
482.43(b)	➤ Necessary medical information is forwarded to next provider(s) of care
482.24(c)(4)(vii)	➤ Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care. (including final diagnosis)
482.24(c)(4)(viii)	➤ Final diagnosis with completion of medical records within 30 days following discharge.
485.647 Condition of participation: psychiatric and rehabilitation distinct part units.	(a) Conditions. (1) If a CAH provides inpatient psychiatric services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payment systems, and the additional requirements of § 412.27 of part 412 of this chapter for excluded psychiatric units.
412.25 Excluded hospital units: Common requirements.	(a)(2) Have written admission criteria that are applied uniformly to both Medicare and non-Medicare patients.
412.27(a)	Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification.

412.27(c)(1)	Development of assessment/diagnostic data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.
412.27(c)(1)(i)	The identification data must include the inpatient's legal status.
412.27(c)(1)(ii)	A provisional or admitting diagnosis must be made on every inpatient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.
412.27(c)(1)(iii)	The reasons for admission must be clearly documented as stated by the inpatient or others significantly involved, or both.
412.27(c)(1)(iv)	The social service records, including reports of interviews with inpatients, family members, and others must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.
412.27(c)(1)(v)	When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.
412.27(c)(2)	Psychiatric evaluation. Each inpatient must receive a psychiatric evaluation that must—
412.27(c)(2)(i)	Be completed within 60 hours of admission;
412.27(c)(2)(ii)	Include a medical history;
412.27(c)(2)(iii)	Contain a record of mental status;
412.27(c)(2)(iv)	Note the onset of illness and the circumstances leading to admission;
412.27(c)(2)(v)	Describe attitudes and behavior;
412.27(c)(2)(vi)	Estimate intellectual functioning, memory functioning, and orientation; and
412.27(c)(2)(vii)	Include an inventory of the inpatient's assets in descriptive, not interpretative fashion
412.27(c)(3)(i)	Each inpatient must have an individual comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the

	treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out; and
412.27(c)(3)(ii)	The treatment received by the inpatient must be documented in such a way as to assure that all active therapeutic efforts are included.
412.27(c)(4)	Recording progress. Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the inpatient, a nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the inpatient but must be recorded at least weekly for the first two months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the inpatient's progress in accordance with the original or revised treatment plan.
412.27(c)(5)	Discharge planning and discharge summary. <i>The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the inpatient's hospitalization in the unit and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient's condition on discharge.</i>
412.27(d)(5)	Social services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures. Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.
485.647 Condition of participation: psychiatric and rehabilitation distinct part units.	(a) Conditions. (2) If a CAH provides inpatient rehabilitation services in a distinct part unit, the services furnished by the distinct part unit must comply with the hospital requirements specified in subparts A, B, C, and D of part 482 of this subchapter, the common requirements of § 412.25(a)(2) through (f) of part 412 of this chapter for hospital units excluded from the prospective payments systems, and the additional requirements of §§ 412.29 and § 412.30 of part 412 of this chapter related specifically to rehabilitation units.
412.29(d)	Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 of this chapter, during the Public Health Emergency, as defined in § 400.200 of this chapter, have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital

	program. This procedure must ensure that the preadmission screening for each Medicare Part A fee-for-Service patient is reviewed and approved by a rehabilitation physician prior to the patient's admission to the IRF.
412.29(e)	Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 , during the Public Health Emergency, as defined in § 400.200 of this chapter , have in effect a procedure to ensure that patients receive close medical supervision, as evidenced by at least 3 face-to-face visits per week by a licensed physician with specialized training and experience in inpatient rehabilitation to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process except that during the Public Health Emergency, as defined in § 400.200 of this chapter , for the COVID-19 pandemic such visits may be conducted using telehealth services (as defined in section 1834(m)(4)(F) of the Act). Beginning with the second week, as defined in § 412.622 , of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law.
412.29(h)	Except for care furnished to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge, as defined in § 412.622 of this chapter , during the Public Health Emergency, as defined in § 400.200 of this chapter , have a plan of treatment for each inpatient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient.

Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool

The **Ambulatory Health Care Occupancy LSC and HCFC Evaluation Tool** reflects the Centers for Medicare & Medicaid Services (CMS) K-tags which represent the detailed NFPA 101 Life Safety Code and NFPA 99 Health Care Facilities Code requirements that are evaluated for compliance to determine if hospitals and critical access hospitals meet the Conditions of Participation. Hospitals and critical access hospitals and surveyors must refer to the tool for the content of Code requirements as these details no longer appear in individual elements of performance under the new, streamlined Joint Commission Physical Environment (PE) standards.

The tool will assist both organizations and surveyors in identifying the hospital and critical access hospital Conditions of Participation (CoPs) and the Physical Environment requirements that relate to the K-tags. Refer to the hospital and critical access hospital crosswalks for more detailed information related to the Physical Environment CoP requirements and Joint Commission Physical Environment standards relationships.

K-tag	Code Requirement	CoP	JC EP	Comments
SECTION 1 – GENERAL REQUIREMENTS				
K100	General Requirements – Other Any LSC Section 20.1 and 21.1 General Requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01 The hospital/CAH addresses life safety from fire. EP 3 The hospital/CAH meets the applicable provisions of the Life Safety Code (NFPA 101: 2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).	
K111	Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 21 Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 20.1.1.4.3, 21.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01 The hospital/CAH addresses building safety and facility management. EP 1 The hospital/CAH meets the applicable provisions and proceeds in accordance with the Health Care Facilities	

K-tag	Code Requirement	CoP	JC EP	Comments
	Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 20.1.1.4.2 or 21.1.1.4.2. 20.1.1.4.2, 21.1.1.4.2, 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. 20.1.1.4.1, 21.1.1.4.1.1, 4.6.5, 4.6.7, 43.1.2.3 (43.8)		Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2,	
K131	Multiple Occupancies – Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: • The occupancy is not intended to serve ambulatory healthcare occupants for treatment or customary access • They are separated from the ambulatory health care occupancy by a 1-hour fire resistance rating Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: • Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab • Doors are constructed of not less than 1-3/4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments									
	inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. - Doors are self-closing and are kept in the closed position, exceptwhen in use. - Windows in the barriers are of fixed fire window assemblies per8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44												
K161	Building Construction Type and Height Building construction type and stories meet Table 20.1.6.1 or Table 21.1.6.1, respectively. <table><tr><td></td><td>Construction Type</td><td></td></tr><tr><td>1</td><td>I (442), I (332), II (222), II (111), III (211), IV (2HH), V (111)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr><tr><td>2</td><td>II (000), III (200), V (000)</td><td>One story non-sprinklered Any number of stories sprinklered</td></tr></table> Any level below the level of exit discharge shall be separated by Type II (111), Type III (211), or Type V (111) construction unless both of the following are met: - Such levels are under the control of the ambulatory healthcare occupancy. - Hazardous spaces are protected per section 8.7.		Construction Type		1	I (442), I (332), II (222), II (111), III (211), IV (2HH), V (111)	Any number of stories non-sprinklered or sprinklered	2	II (000), III (200), V (000)	One story non-sprinklered Any number of stories sprinklered	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
	Construction Type												
1	I (442), I (332), II (222), II (111), III (211), IV (2HH), V (111)	Any number of stories non-sprinklered or sprinklered											
2	II (000), III (200), V (000)	One story non-sprinklered Any number of stories sprinklered											

K-tag	Code Requirement	CoP	JC EP	Comments
	<i>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 20.3.5 or 21.3.5, respectively)</i> <i>Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.</i> 20.1.6.1, 20.1.6.2, 21.1.6.1, 21.1.6.2			
K163	Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 20.1.6.3, 20.1.6.4, 21.1.6.3, 21.1.6.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
SECTION 2 – MEANS OF EGRESS REQUIREMENTS				
K200	Means of Egress Requirements – Other Any LSC Section 20.2 and 21.2 Means of Egress requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K211	Means of Egress – General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1			
K222	Egress Doors Special locking arrangements are in accordance with section 7.2.1.6 ☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayedegress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 20.2.2.2, 21.2.2.2, 7.2.1.6.1 through 7.2.1.6.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
K223	Doors with Self-Closing Devices Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire facility, and all stair enclosure doors upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K231	Means of Egress Capacity The capacity of required means of egress is in accordance with 7.3. 20.2.3.1, 21.2.3.1, 38.2.3, 39.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K232	Aisle, Corridor or Ramp Width The clear width of any corridor or passageway required for egress shall be not less than 44 inches wide. Where a corridor is 6 feet wide, projections of not more than 6 inches from the corridor wall above the handrail height are permitted for alcohol-based hand rub dispensers. 20.2.3.2, 20.2.3.3, 21.2.3.2, 21.2.3.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K233	Clear Width of Exit and Exit Access Doors 2012 EXISTING Doors in the means of egress from diagnostic or treatment areas, such as x-ray, surgical, or physical therapy, shall provide a clear width of not less than	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	32 inches, unless the doors are existing 34 inch wide doors. 21.2.3.4 2012 NEW Doors in the means of egress from diagnostic or treatment areas, such as x-ray, surgical, or physical therapy, shall provide a clear width of not less than 32 inches. 20.2.3.4			
K241	Number of Exits – Story and Compartment 2012 EXISTING Single means of egress is allowed from a mezzanine or balcony if one of the following exist: 1. Common path of travel is under 100 feet if in a sprinklered building. 2. Common path of travel 75 feet if in a non-sprinklered building. 3. Common path of travel is not limited if occupant load is under 30. Not less than 2 exits, as described in 38.2.2, are remotely located for each fire section or patient care area of the building and are accessible from each smoke compartment. Patient care suites larger than 2500 square feet have 2 exits remotely located from each other. Egress from smoke compartments, if installed, shall be permitted through adjacent compartments provided the egress does not return through the compartment of fire origin. 21.2.3.1 through 21.2.3.5, 7.4.1.1, 7.4.1.3 through 7.4.1.6	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	2012 NEW Meets the requirements of section 7.4. Not less than 2 exits, as described in 38.2.2, are remotely located for each fire section or patient care area of the building and are accessible from each smoke compartment. Patient care suites larger than 2500 square feet have 2 exits remotely located from each other. Egress from smoke compartments, if installed, shall be permitted through adjacent compartments provided the egress does not return through the compartment of fire origin. 20.2.4.1 through 20.2.4.5, 7.4			
K251	Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead end corridors shall not exceed 50 feet. Common path of travel is no more 75 feet, and no more than 100 feet sprinklered story. Common path of travel is not limited in singletenant space with an occupant load not exceeding 30 persons. 21.2.5, 39.2.5.2 2012 NEW Dead-end corridors are no more than 50 feet in sprinklered buildings, and no more than 20 feet in non-sprinklered buildings. Common path of travel is no more 75 feet, and no more than 100 feet in sprinklered buildings or single tenant space with an occupant load not exceeding 30 persons. 20.2.5, 38.2.5.2, 38.2.5.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
K261	Travel Distance to Exits Travel distance between any point in a room and an exit is 150 feet or 200 feet in sprinklered buildings. 20.2.6, 21.2.6	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K271	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 07-38. 20.2.7, 21.2.7, 38.2.7, 39.2.7, 7.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K281	Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 20.2.8, 21.2.8, 7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K291	Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9	HAP 482.41(a)(1) HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d) EP 3 applies to CAH but is not linked to a CAH	PE.03.01.01, EP 3 PE.04.01.01, EP 1 PE.04.01.03, EP 1 The hospital/CAH has emergency power and lighting in, at a minimum, the following areas:	

K-tag	Code Requirement	CoP	JC EP	Comments
		CoP (Above and beyond requirement)	• Operating rooms • Recovery rooms • Intensive care • Emergency rooms • Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	
K292	Life Support Means of Egress Where general anesthesia or life-support equipment is used, each ambulatory health care facility shall be provided with an essential electric system in accordance with NFPA 99. (N/A if life support equipment is for emergency purposes only.) 20.2.9.2, 21.2.9.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K293	Exit Signage Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 20.2.10, 21.2.10, 7.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
SECTION 3 - PROTECTION				
K300	Protection – Other Any LSC Section 20.3 and 21.3 Protection requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	standard citation, should be included in the finding.			
K311	Vertical Openings – Enclosure 2012 EXISTING Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Unenclosed openings which do not serve as a required means of egress are permitted. 3. Exit access stairs may be unenclosed if they meet the following conditions: Two stories or less a. Building is protected throughout by a supervised sprinkler system per 9.7.1.1(1). b. Total travel distance to outside does not exceed 100 feet. Three stories or less a. Occupant load per story does not exceed 15 people. b. Building is sprinkler protected throughout per 9.7.1.1(1). c. Building contains an automatic smoke detection system per 9.6. d. Activation of the sprinkler system or smoke detection system notifies all	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	occupants of the building. e. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 21.3.1, 39.3.1.1, 39.3.1.2 2012 NEW Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Exit access stairs may be unenclosed if they meet the 2 conditions: a. Building is sprinkler protected throughout. b. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 20.3.1, 38.3.1.1, 38.3.1.2			
K321	Hazardous Areas – Enclosure Hazardous areas must meet one of the following: ☐ Contain 1-hour rated enclosure when non-sprinklered ☐ Sprinkler-protected with smoke resistive separation ☐ Severe hazard locations contain sprinkler	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7			
K322	Laboratories Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, <i>Standard on Fire Protection for Laboratories Using Chemicals</i>. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 20.3.2.2, 21.3.2.2 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K323	Anesthetizing Locations Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical- surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12-inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 20.3.2.3, 21.3.2.3, NFPA 99 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3.4, 6.4.2.2.4.2			
K324	Cooking Facilities Commercial cooking equipment shall be installed per NFPA 96 unless used for food warming or limited cooking. 20.3.2.4, 20.3.2.5, 21.3.2.4, 21.3.2.5, 9.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Any automatic fire-extinguishing system in the kitchen every 6 months Note: For automatic kitchen fire-extinguishing systems, see NFPA 96-2011: 11.2.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K325	Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: • Corridor is at least 6 feet wide. • Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. • Dispensers shall have a minimum of four foot horizontal spacing. • Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. • Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. • Dispensers are not installed within 1 inch of an ignition source. • If floor is carpeted, the building is fully sprinkler protected.. • ABHR does not exceed 95 percent alcohol. • Operation of the dispenser shall comply with Section 20.3.2.6(11) or 21.3.2.6(11). • ABHR is protected against inappropriate access.	HAP 482.41(b)(7) CAH 485.623(c)(5)	PE.03.01.01 The hospital/CAH addresses life safety from fire. EP 7 When the hospital/CAH installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.	

K-tag	Code Requirement	CoP	JC EP	Comments
	20.3.2.6, 21.3.2.6, 8.7.3.1, CFR 416.44			
K331	Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes in exits and exit access corridors shall have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. All other areas may be class C rated material. Indicate flame spread rating(s) walls. _____ 20.3.3, 21.3.3, 38.3.3, 39.3.3, 10.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K332	Interior Floor Finish 2012 NEW (N/A for 2012 EXISTING) Interior floor finish in exit enclosures must meet 10.2 and be Class I or Class II. All other areas must meet 10.2.7.1 or 10.2.7.2. Indicate rating(s) for floors ____ 20.3.3, 21.3.3, 38.3.3, 39.3.3, 10.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K341	Fire Alarm System – Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, <i>National Electric Code</i>, and NFPA 72, <i>National Fire Alarm Code</i> to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	power extenders, and supervising station transmitting equipment. Fire alarm system wiring, or other transmission paths are monitored for integrity. 20.3.4.2.1, 21.3.4.1, 9.6			
K342	Fire Alarm System – Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 ft travel distance is not exceeded. 20.3.4.2, 21.3.4.2, 9.6.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K343	Fire Alarm – Notification 2012 EXISTING A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished automatically per 9.6.4. Smoke detection devices or systems equipped with reconfirmation features shall not be required to automatically notify the fire department, unless the alarm condition is reconfirmed within 120 seconds (2 minutes) 21.3.4.3 through 21.3.4.3.2.2, 9.6.3, 9.6.4 2012 NEW A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	automatically per 9.6.4. 20.3.4.3 through 20.3.4.3.2.1, 9.6.3, 9.6.4			
K344	Fire Alarm – Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 20.3.4.4, 21.3.4.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K345	Fire Alarm System – Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, <i>National Electric Code</i> , and NFPA 72, <i>National Fire Alarm and Signaling Code</i> . Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory - Visual and audible fire alarms (including speakers and door-releasing devices on the inventory) - Fire alarm equipment on the inventory for notifying off-site responders - Automatic smoke-detection shutdown devices for air-handling equipment Note: For additional guidance on duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors; visual and audible fire alarms; and fire alarm	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	equipment, see NFPA 72-2010: Table 14.4.5; 17.14.			
K346	Fire Alarm – Out of Service Fire alarms that are out of service for 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.9.6.1.6	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K351	Sprinkler System – Installation Sprinkler systems (if installed) are installed per NFPA 13. Where more than two sprinklers are installed in a single area for protection, waterflow devices shall be provided to sound the building fire alarm system or to notify a constantly attended location such as a PBX, security office, or emergency room. 20.3.5.1, 20.3.5.2, 21.3.5.1, 21.3.5.2, 9.7.1.2, 9.7, NFPA 13	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K353	Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, <i>Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems</i> . Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Supervisory signal devices on the inventory, quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices; semiannually for valve supervisory switches; and annually for other supervisory initiating devices Note: For supervisory signal devices, water storage tanks and associated water storage equipment do not require testing. For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5. The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - For automatic sprinkler systems, main drains at system low point or at all system risers - For automatic sprinkler systems, fire pumps under flow(fire pump supervisory signals for “pump running” and “pump power loss”) Note: For automatic sprinkler systems, main drains, and system risers, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. Note 3: For automatic sprinkler system fire pumps, see NFPA 25-2011: 8.3.3; 8.3.3.4. The hospital maintains fire safety equipment and fire safety building features by testing the following based	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	on the identified timeframes: - Vane-type and pressure-type water flow devices every 6 months - For automatic sprinkler systems, electric motor-driven fire pumps monthly and diesel engine-driven fire pumps every week under no-flow conditions - Hydrostatic and water flow for standpipe systems every 5 years - Automatic fire extinguishing systems (carbon dioxide systems every 12 months, halon systems every 6 months, other special systems per NFPA standards and manufacturer's recommendations) - Hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter Note 1: For vane-type and pressure-type water flow devices, mechanical water flow devices (including but not limited to water motor gongs) should be tested quarterly. (For full text, refer to NFPA 25-2011: Table 5.1.1.2). For additional guidance also see NFPA 72-2010: Table 14.4.5. Note 2: For hydrostatic tests on standpipe occupant hoses, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6 The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - For automatic sprinkler systems, all fire department water supply connections every quarter Note: For automatic sprinkler systems, see NFPA 25-2011: 13.7; Table 13.1.1.2.			

K-tag	Code Requirement	CoP	JC EP	Comments
K354	Sprinkler System – Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 9.7.5, 15.5.2 (NFPA 25)	HAP 482.41(b)(8)(i) HAP 482.41(b)(8)(ii) CAH 485.623(c)(6)(i) CAH 485.623(c)(6)(ii)	PE.03.01.01 The hospital/CAH addresses life safety from fire. EP 8 When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or establishes a fire watch until the system is back in service.	
K355	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, <i>Standard for Portable Fire Extinguishers</i>. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Portable fire extinguishers at least monthly (this includes recharging every 12 months) Note 3: For portable fire extinguishers, there are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. For	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.			
K362	Corridors – Construction of Walls 2012 NEW (Indicate N/A for 2012 EXISTING) Where access to exits is provided by corridors, such corridors shall be separated from use areas by a minimum 1-hour fire barrier constructed per section 8.3, unless one of the following exists: 1. Where exits are available from an open floor area 2. Where the entire space is a single tenant 3. Where the building is protected throughout by an approved automatic sprinkler system installed per 9.7.1.1(1) If the walls have a fire resistance rating, give the rating. _____ 20.3.6.1, 38.3.6.1, 38.3.6.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K364	Corridor - Openings 2012 NEW (Indicate N/A for 2012 EXISTING) Miscellaneous openings, such as mail slots, pharmacy/laboratory/cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection provided that they meet both of the following: 1) The aggregate opening does not exceed 20 square inches. 2) The opening is installed at or below half the distance from the floor to the ceiling. If the room is protected throughout by an automatic	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	sprinkler system. The aggregate opening shall not exceed 80 square inches. 20.3.6.2.1, 20.3.6.2.2			
K371	Subdivision of Building Spaces – Smoke Compartments Smoke compartments do not exceed 25,000 square feet in size. Every story shall be divided into not less than 2 smoke compartments unless one of the following conditions occur: ☐ Facility is less than 5,000 square feet protected by an approved smoke detection system. ☐ Facility is less than 10,000 square feet protected by an approved, supervised sprinkler system per 9.7. ☐ Adjoining occupancy is used as a smoke compartment if all of the following are met: a. Separating wall is 1 hour fire resistive rated. b. Doors in the 1 hour rated wall at 1-3/4 inches thick. c. Doors in the 1 hour rated wall are self-closing. d. Windows in the 1 hour rated wall are fixed fire window assemblies per 8.3. e. The ambulatory health care facility is less than 22,500 square feet. f. Access from the ambulatory health care facility is unrestricted to another occupancy. 20.3.7.2, 21.3.7.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
K372	Subdivision of Building Spaces – Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 21.3.7.5, 21.3.7.6, 8.5 2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 20.3.7.5, 20.3.7.6, 8.5	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Fire and smoke dampers 1 year after installation and at least every 6 years thereafter to verify they fully close Note: For operation of fire and smoke dampers, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5.	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K374	Subdivision of Building Spaces – Smoke Barrier Doors 2012 EXISTING Smoke barrier doors shall be a minimum of 1-3/4 inches thick, solid-bonded wood core or equivalent	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	with self-closing or automatic-closing devices in accordance with 21.2.2.4. Latching hardware is not required. Doors are not required to swing in the direction of egress travel. 21.3.7.9, 21.3.7.10 2012 NEW Smoke barrier doors shall be a minimum of 1-3/4 inches thick, solid-bonded wood core or equivalent with self-closing or automatic-closing devices in accordance with 21.2.2.4. Latching hardware is not required. Doors are required to swing in the direction of egress travel. Rabbits, bevels, or astragals are at meeting edges, and stops are at the head and sides of door frames. Center mullions are prohibited in smoke barrier door openings. 20.3.7.9, 20.3.7.10, 20.3.7.13, 20.3.7.14			
K379	Smoke Barrier Door Glazing 2012 NEW (Indicate N/A for 2012 EXISTING) Cross-corridor swinging doors or cross corridor horizontal-sliding doors, contain a vision panel consisting of fire-rated glazing in approved frames in each door. Vision panels in any other door in the smoke barrier, if provided, shall be fire-rated glazing in approved frames. 20.3.7.11, 20.3.7.12, 21.3.7.7, 8.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
SECTION 4 – SPECIAL PROVISIONS				
K400	Special Provisions – Other Any LSC Section 20.4 and 21.4 Special Provisions requirements that are not addressed by the provided K-tags but are deficient. This information, along with the	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	applicable Life Safety Code or NFPA standard citation, should be included in the finding.			
K421	High-Rise Buildings 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.1.1(1), or an engineered life safety system complying with 39.4.2.1(2). 21.4, 39.4.2 2012 NEW High-rise buildings comply with section 11.8. 20.4, 38.4.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
SECTION 5 – BUILDING SERVICES				
K500	Building Services – Other Any LSC Section 20.5 and 21.5 Building Services requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K511	Utilities – Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, <i>National Fuel Gas Code</i> , electrical wiring and equipment complies with NFPA 70, <i>National Electric Code</i> . Existing installations can continue in service provided no hazard to life. 20.5.1, 21.5.1, 9.1.1, 9.1.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K521	HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 20.5.2.1, 21.5.2.1, 9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K522	HVAC – Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 20.5.2.2, 20.5.2.2.1, 21.5.2.2, 21.5.2.2.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K523	HVAC – Suspended Unit Heaters Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the area. • Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 20.5.2.2.2, 21.5.2.2.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
K531	Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 21.5.3, 9.4.2, 9.4.3 2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, <i>Safety Code for Elevators and Escalators</i>, including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke	HAP 482.41(b)(1)(i) HAP 482.41(d)(2) CAH 485.623(c)(1)(i) CAH 485.623(b)(1)	PE.03.01.01, EP 3 PE.04.01.01, EP 2	

K-tag	Code Requirement	CoP	JC EP	Comments
	detectors.) 20.5.3, 9.4.2, 9.4.3			
K532	Escalators, Dumbwaiters, and Moving Walks Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 20.5.3, 21.5.3, 9.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K541	Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING Rubbish chutes are installed per section 9.5: ☐ Walls, partitions, and inlet openings meet the requirements of 8.3. ☐ Doors of chutes open to a room designed exclusively for accessing the chute opening. ☐ Room used for accessing the chute opening(s) are separated from other spaces per 8.7. ☐ Chutes shall be permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and the room is not used for storage.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	OR Existing installations having properly enclosed and maintained chute openings shall be permitted to have inlets open to a corridor or normally occupied space. 21.5.4, 9.5, NFPA 82 2012 NEW Rubbish chutes are installed per section 9.5: ☐ Walls, partitions, and inlet openings meet the requirements of 8.3. ☐ Doors of chutes open to a room designed exclusively for accessing the chute opening. ☐ Room used for accessing the chute opening(s) are separated from other spaces per 8.7. ☐ Chutes shall be permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and the room is not used for storage. ☐ Maintenance and installation are per NFPA 82. 20.5.4, 9.5, NFPA 82			
SECTION 7 – OPERATING FEATURES				
K700	Operating Features – Other Any LSC Section 20.7 and 21.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K711	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 20/21.7.2.1.2 and provides for all of the fire safety plan components per 20/21.7.2.2. 20.7.1.1 through 20.7.1.3, 20.7.1.8 through 20.7.2.3.3 21.7.1.1 through 20.7.1.3, 21.7.1.8 through 20.7.2.3.3			
K712	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 20.7.1.4 through 20.7.1.7, 21.7.1.4 through 21.7.1.7 ***Varying conditions means: Fire drills vary by at least one hour for each shift from quarter to quarter through four consecutive quarters	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K741	Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 20.7.4, 21.7.4			
K751	Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies at showers and baths. 20.7.5.1 through 20.7.5.3, 21.7.5.1 through 21.7.5.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K752	Upholstered Furniture and Mattresses Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 20.7.5.2, 20.7.5.3, 21.7.5.2, 21.7.5.3			
K753	Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. • The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 20.7.5.4, 21.7.5.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K754	Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. 20.7.5.5, 21.7.5.5			
K761	Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 <i>Standard for Fire Doors and Other Opening Protectives</i> . Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 20.7.6, 21.7.6, 8.3.3.1 (LSC), 5.2. 5.2.3 (NFPA 80)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure - Fire door assemblies (inspection and testing) Note 5: For fire doors and smoke barrier doors, see NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2. Note 6: For fire door assemblies, nonrated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	inspection and testing requirements of either NFPA 80 or NFPA 105. For hospitals that use Joint Commission accreditation for deemed status purposes: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. The critical access hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Fire door assemblies annually by a qualified individual (testing begins with a pre-test visual inspection and includes both sides of the opening)			
K771	Engineer Smoke Control Systems When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 20.7.7.1 through 20.7.7.3, 21.7.7.1 through 21.7.7.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K781	Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 20.7.8, 21.7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
K791	Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 20.7.9.1, 20.7.9.2, 21.7.9.1, 21.7.9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
	The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	Health Care Facilities Code - Other Any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included in the finding.	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K901	Fundamentals – Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K902	Gas and Vacuum Piped Systems – Other Any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K903	Gas and Vacuum Piped Systems – Categories Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K904	Gas and Vacuum Piped Systems – Warning Systems All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K905	Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K906	Gas and Vacuum Piped Systems – Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3,	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)			
K907	Gas and Vacuum Piped Systems – Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses building safety and facility management. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K908	Gas and Vacuum Piped Systems – Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
K909	Gas and Vacuum Piped Systems – Information and Warning Signs Piping is labeled by stencil or adhesive markers	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)			
K910	Gas and Vacuum Piped Systems – Modifications Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K911	Electrical Systems – Other Any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 6 (NFPA 99)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K912	Electrical Systems – Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	rooms, bathrooms, playrooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)			
K913	Electrical Systems – Wet Procedure Locations Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K914	Electrical Systems – Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	

K-tag	Code Requirement	CoP	JC EP	Comments
	maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
K915	Electrical Systems – Essential Electric System Categories ☐ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ☐ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ☐ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K916	Electrical Systems – Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)			
K917	Electrical Systems – Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K918	Electrical Systems – Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	

K-tag	Code Requirement	CoP	JC EP	Comments
	established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
K919	Electrical Equipment – Other Any NFPA 99 Chapter 10, <i>Electrical Equipment</i> , requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.04.01.01, EP 1 PE.03.01.01, EP 3	
K920	Electrical Equipment – Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non- PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
K921	Electrical Equipment – Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient care-related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6,	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	

K-tag	Code Requirement	CoP	JC EP	Comments
	10.5.8			
K922	Gas Equipment – Other Any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K923	Gas Equipment – Cylinder and Container Storage ≥ 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. > 300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. ≤ 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
K924	Gas Equipment – Testing and Maintenance Requirements Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
K925	Gas Equipment – Respiratory Therapy Sources of Ignition	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)			
K926	Gas Equipment – Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K927	Gas Equipment – Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, <i>Transfilling of High-Pressure Gaseous Oxygen Used for Respiration</i>. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)			
K928	Gas Equipment – Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K929	Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K930	Gas Equipment – Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K931	Hyperbaric Facilities All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	HAP 482.41(d)(2) HAP 482.41(c) CAH 485.623(b)(1) CAH 485.623(d)	PE.04.01.01, EP 1 PE.04.01.01, EP 2	
K932	Features of Fire Protection – Other Any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 15 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K933	Features of Fire Protection – Fire Loss Prevention in Operating Rooms Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	initiation of any surgical procedure to verify: ○ application site is dry prior to draping and use of surgical equipment. ○ pooling of solution has not occurred or has been corrected. ○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. ○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99) ***The preoperative time-out is addressed by the clinical surveyor.			
	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel.	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.			

Fire Drill Matrix

Hospital Name:				Score at PE.03.01.01EP 3											
Quarterly Hospital Fire Drills (NFPA 101-2012 18/19 19.7.1)															
Day = M, Tu, W, Th, F, Sa, Su			Q1			Q2			Q3			Q4			
Time: 24 hour formatted			Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	
1st Shift	Normal	Location/Building	flr/Main												
		Day													
		Date													
	ILSM	Location/Building													
		Day													
		Date													
2nd Shift	Normal	Location/Building													
		Day													
		Date													
	ILSM	Location/Building													
		Day													
		Date													
3rd Shift	Normal	Location/Building													
		Day													
		Date													
	ILSM	Location/Building													
		Day													
		Date													
Required Annual Fire Drills (NFPA 99-2012 15.13.3.10.3 & 14.3.1.4.5 and 14.2.4.5.4/14.2.4.5.4.1 - if applicable)															
Location	Previous	Current	Location	Previous	Current	Time?									
OR			Hyperbaric												
Day			Day												
Date			Date												
Time			Time												
Quarterly Ambulatory Fire Drills															
1st Shift		Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4					
	Location/Building					Location/Building									
	Day					Day									
	Date					Date									
	Time					Time									
Annual Business Occupancy Fire Drills (2 Years of drills)															
Previous	Current	Previous	Current	Previous	Current	Previous	Current	Previous	Current	Previous	Current				
Building	Medical Office Building	Building		Building		Building		Building		Building					
Day		Day		Day		Day		Day		Day					
Date		Date		Date		Date		Date		Date					
Time		Time		Time		Time		Time		Time					
Definitions of Shifts: Provide timeframes for shift hours below (e.g. 1st shift: 0700-1600, 2nd shift: 1600-2400, 3rd shift: 2400-0700)															
1st						NA	Not applicable for no shift, building, location or ILSM.								
2nd						NC	Not completed or missed								
3rd															

Critical Access Hospital Physical Environment Document List & Review Tool

Revised - Effective: 6/16/2026

The following pages present documentation required by the Hospital Accreditation program Physical Environment (PE) standards. The Life Safety surveyor will begin review of these documents soon after arrival for the on-site survey. Surveyors may request other documents, as needed, throughout the survey. This list also includes some elements of performance that do not require documentation but appear as reminders to both organizations and surveyors of these expectations.

Please conduct during Facility Orientation.

Legend: C=Compliant; NC=Not compliant; NA=Not applicable; IOU=Surveyor awaiting documentation

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IOU				
PE.03.01.01					Buildings serving patients comply w/ NFPA 101 (2012)			
EP 1 No CoP					Current and accurate drawings w/ fire safety features & related square footage a. Areas of building fully sprinklered (if building only partially sprinklered) b. Locations of all hazardous storage areas c. Locations of all fire-rated barriers d. Locations of all smoke-rated barriers e. Sleeping and non-sleeping suite boundaries, including size of identified suites f. Locations of designated smoke compartments g. Locations of chutes and shafts h. Any approved equivalencies or waivers	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
EP 5 No CoP					The hospital maintains written evidence of regular inspection and approval by state or local fire control agencies.			
EP 2 No CoP					The hospital maintains current Basic Building Information (BBI) within the Statement of Conditions (SOC).			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Yes	No	
	C	NC	NA	IO U				
PE.03.01.0 1					Hospital Manages Fire Risk – Fire Response Plan			
EP 4 No CoP					The hospital has written fire control plans that include provisions for prompt reporting of fires; extinguishing fires; protection of patients, staff, and guests; evacuation; and cooperation with firefighting authorities. Staff periodically instructed on/kept informed of duties under plan Copy of plan readily available with telephone operator or security NFPA 101-2012: 18/19.7.1; 7.2	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	
COMMENTS:								

Please conduct after Facility Orientation, during Document Review activity.

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP1)					Testing for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices	Quarterly				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
					NFPA 72-2010: Table 14.4.5					
					Testing for valve supervisory switches NFPA 72-2010: Table 14.4.5	Semiannual				
					Testing for other supervisory initiating devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP2)					Water flow devices NFPA 72-2010: Table 14.4.5 NFPA 25-2011: Table 5.1.1.2	Semiannual				
					Tamper switches NFPA 72-2010: Table 14.4.5	Semiannual				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP3)					Duct, heat, smoke detectors, and manual fire alarm boxes NFPA 72-2010: Table 14.4.5; 17.14	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP4)					Notification devices (audible & visual), and door-releasing devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP5)					Emergency services notification transmission equipment NFPA 72-2010: Table 14.4.5	Annually				
EP 2 CoP 485.623(b)(1)					Electric motor-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Monthly				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
(Formerly EC.02.03.05, EP6)					Diesel-engine-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Weekly				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP9)					Sprinkler systems main drain tests on all risers NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP10)					Fire department connections inspected (Fire hose connections N/A) NFPA 25-2011: 13.7; Table 13.1.1.2	Quarterly				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP11)					Fire pump(s) tested – under flow Fire pump supervisory signals for pump running and pump power loss tested NFPA 25-2011: 8.3.3; 8.3.3.4	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP12)					Standpipe flow test every 5 years NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2	5 years				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP13)					Kitchen suppression semi-annual testing NFPA 96-2011: 11.2	Semiannual				
EP 2 CoP 485.623(b)(1)					Carbon Dioxide Extinguishing systems tested NFPA 12-2011:4.8.3.2	Annually				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
(Formerly EC.02.03.05, EP14)					Halon Extinguishing systems NFPA 12A-2009: 6.1	Semiannual				
					Other special extinguishing systems per National Fire Protection Association standards and manufacturers' recommendations: NFPA 11-2010 (Foam); NFPA 16-2011(Foam-Water); NFPA 17-2009 (Dry Chemical); NFPA 17A-2009 (Wet Chemical); NFPA 2001-2012 (Clean Agent)	Semi Annual for Dry/Wet Chemical Annual for Clean Agent				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP15)					Portable fire extinguishers inspected monthly NFPA 10-2010: 7.2.2; 7.2.4	Monthly				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP16)					Portable fire extinguishers maintained annually NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP17)					Fire hoses hydro tested 5 years after install; every 3 years thereafter NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6	5 years / 3 years				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP18)					Smoke and fire dampers tested to verify full closure NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5	1 year after install				
						At least every 6 years thereafter				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP19)					Smoke detection shutdown devices for HVAC tested NFPA 90A-2012: 6.4.1	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP20)					All horizontal and vertical roller and slider doors tested NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP25)					Inspection and testing of door assemblies by qualified person. Does not include nonrated doors, including corridor doors to patient care rooms and smoke barrier doors. NFPA101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1	Annually				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP27)					Elevators with firefighters' emergency operations NFPA 101-2012: 9.4.3; 9.4.6	Monthly				
EP 2 CoP 485.623(b)(1) (Formerly EC.02.03.05, EP28)					Documentation of maintenance testing and inspection activities for all Fire Protection and Suppression system testing minus door and elevators includes: activity name; date; inventory of devices, equipment or other items; frequency; contact info for person					

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1 Semi	Q2	Q3 Semi	Q4 Annual
	C	NC	NA	IOU						
PE.04.01.01					Fire Protection and Suppression Testing and Inspection					
					performing activity; NFPA standard; activity results NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4					
COMMENTS:										

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	N A	IO U				
PE.04.01.01 EP 2 or PE.04.01.03 EP 3					Emergency Power Systems are Maintained and Tested			
PE.04.01.01 EP 2 CoP 485.623(b)(1) (Formerly EC.02.05.07, EP1)					At least monthly performs functional test of emergency lighting systems and exit signs required for egress and task lighting (anesthetizing and generator locations) for a minimum duration of 30 seconds, along with a visual inspection of other exit signs NFPA 101-2012: 7.9.3; 7.10.9;	Monthly		
PE.04.01.01 EP 2 CoP 485.623(b)(1) (Formerly EC.02.05.07, EP2)					Every 12 months performs functional test of battery powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours For new construction, renovation, or modernization battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested	Annually		

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	N A	IO U				
PE.04.01.01 EP 2 or PE.04.01.03 EP 3					Emergency Power Systems are Maintained and Tested			
					annually for 30 minutes with test results and completion dates documented NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5			
PE.04.01.03 EP 3 CoP 485.625(e)(2) (Formerly EC.02.05.07, EP3)					Functional test of Level 1 SEPSS, monthly; Level 2 SEPSS, quarterly, for 5 minutes or as specified for its class Annual test at full load for 60% of full duration of its class NFPA 111-2010: 8.4	Monthly Quarterly Annually		
					<i>Note 1: Non-SEPSS tested per manufacturer's specifications</i>	Per Mfr.		
					<i>Note 2: Level 1 SEPSS defined for critical areas and equipment</i>			
					<i>Note 3: Class defines minimum time which SEPSS is designed to operate at rated load without recharging</i>			
PE.04.01.03E P 3 CoP 485.625(e)(2) (Formerly EC.02.05.07, EP4)					Emergency power supply system (EPSS) inspected weekly, including all associated components and batteries NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1	Weekly		
PE.04.01.03E P 3 CoP 485.625(e)(2)					Emergency generators tested monthly for 30 continuous minutes under load (plus cool-down) NFPA 99-2012: 6.4.4.1	Monthly		

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	N A	IO U				
PE.04.01.01 EP 2 or PE.04.01.03 EP 3					Emergency Power Systems are Maintained and Tested			
(Formerly EC.02.05.07, EP5)								
PE.04.01.03E P 3 485.625(e)(2) (Formerly EC.02.05.07, EP6)					Monthly load test for diesel-powered emergency generators conducted with dynamic load at least 30% of nameplate rating or meets mfr. recommended prime movers' exhaust gas temperature; OR	Monthly		
					Emergency generators tested once every 12 months using supplemental loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes for total of 1 ½ continuous hours NFPA 99-2012: 6.4.4.1	Annually		
PE.04.01.03E P 3 CoP 485.625(e)(2) (Formerly EC.02.05.07, EP7)					All automatic and manual transfer switches monthly/12 times per year with results and completion dates documented NFPA 99-2012: 6.4.4.1	Monthly		
PE.04.01.03E P 3 CoP 482.625(e)(2) (Formerly EC.02.05.07, EP8)					Fuel quality test to ASTM standards NFPA 110-2010: 8.3.8	Annually		

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.04.01.01 EP 2 or PE.04.01.03 EP 3					Emergency Power Systems are Maintained and Tested			
PE.04.01.03 EP 3 CoP 485.625(e)(2) (Formerly EC.02.05.07, EP9)					Generator load test once every 36 months for 4 hours NFPA 110-2010, Chapter 8	36 Months		
PE.04.01.03E P 3 CoP 485.625(e)(2) (Formerly EC.02.05.07, EP10)					Generator 4-hour test performed at, at least 30% nameplate NFPA 110-2010, Chapter 8	36 Months		
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
PE.04.01.01					Medical Gas and Vacuum Systems are Inspected and Tested				
EP 2 CoP 485.623(d)					Test, inspect and maintain critical components of piped medical gas and vacuum systems, waste anesthetic gas	Per policy			

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
PE.04.01.01					Medical Gas and Vacuum Systems are Inspected and Tested				
(Formerly EC.02.05.09, EP7)					disposal (WAGD), and support gas systems on the inventory. Inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and inlets and outlets with activities, dates and results documented No prescribed frequency; recommend risk assessment if < annual NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13				
EP 1 CoP 485.623(d) (Formerly EC.02.05.09, EP8)					Location of and signage for bulk oxygen systems NFPA 99-2012: 5.1.3.5.12	On Bldg. Tour			
EP 1 CoP 485.623(d) (Formerly EC.02.05.09, EP9)					Emergency oxygen supply connection NFPA 99-2012: 5.1.3.5.13	On Bldg. Tour			
EP 1 CoP 485.623(d) (Formerly EC.02.05.09, EP10)					Review medical gas installation/modification/breach certification results for cross connection, purity, correct gas, and pressure NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13	As applicable			

STANDARD - EPs	See Legend				Document / Requirement	THIS MAY BE SCORED AS CONDITIONAL OR STANDARD			Testing Dates
	C	NC	NA	IOU			Yes	No	
PE.04.01.01					Medical Gas and Vacuum Systems are Inspected and Tested				
EP 1 CoP 485.623(d) (Formerly EC.02.05.09, EP11)					Medical gas supply and zone valves are accessible and clearly labeled NFPA 99-2012: Table 5.1.11 NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11	On Bldg. Tour			
EP 1 CoP 485.623(d) (Formerly EC.02.05.09, EP13)					Handling, transfer, storage, labeling, transfilling of cylinders NFPA 99-2012: 11.5.3.1; 11.6.1; 11.6.2; 11.6.5; 11.7.3	Per policy			
COMMENTS:									

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IOU						
PE.03.01.01					Fire Drills					
EP 3 CoP 485.623(c)(1) (i) (Formerly EC.02.03.03, EP1)					Fire drills once per shift per quarter in health care occupancies; Quarterly in each building defined as ambulatory health care occupancy (If available, please provide five quarters of fire drill data) NFPA 101-2012: 18/19: 7.1.7	Quarterly				
EP 3					Fire drills every 12 months from date of last drill: Business Occupancies	Annually				

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Q1	Q2	Q3	Q4 Annual
	C	NC	NA	IO U						
PE.03.01.01					Fire Drills					
CoP 485.623(c)(1) (i) (Formerly EC.02.03.03, EP2)										
EP 3 CoP 485.623(c)(1) (i) (Formerly EC.02.03.03, EP3)					When quarterly fire drills are required, ALL are unannounced Drills include transmission of fire alarm signal and simulation of emergency fire conditions NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3	Quarterly (See fire drill matrix)				
PE.04.01.01 EP 1 CoP 485.623(d) (Formerly EC.02.03.03, EP7)					Fire exit drills for operating rooms/surgical suites. NFPA 99-2012: 15.13.3.10.3	Annually				
PE.04.01.01 EP 1 CoP 485.623(d) (Formerly EC.02.03.03, EP8)					Annual emergency procedures and fire training drills for hyperbaric facilities that include recording of time to evacuate all persons from area, involves applicable staff, and focuses on prevention and simulated extinguishment and evacuation. NFPA 99-2012: 14.2.4.5.4; 14.3.1.4.5 NFPA 99-2012: B.14.2 and B.14.3	Annually				
COMMENTS:										

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	N C	NA	IO U				
					Manages risks associated with utility systems			
PE.04.01.01 EP 3 CoP 485.623(b)(5)) (Formerly EC.02.05.01, EP15)					In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. <i>(form of and frequency of assessment per hospital policy)</i> Note 1: For new and existing health care facilities, or altered, renovated, or modernized portions of existing systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent. Note 2: Existing facilities may comply with the 2012 NFPA 99 ventilation requirements or the ventilation requirements in the edition of the NFPA code previously adopted by CMS at the time of installation (for example, 1999 NFPA 99)			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	N C	NA	IO U			
PE.04.01.05					Manages risks associated with utility systems – Water Management Program		
EP 1					Verify individual or team responsible for oversight and implementation of the water management program		

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	N C	NA	IO U			
PE.04.01.05					Manages risks associated with utility systems – Water Management Program		
CoP 485.640(a)(3)) (Formerly EC.02.05.02, EP1)							
EP 2 CoP 485.640(a)(3)) (Formerly EC.02.05.02, EP2)					Review water management program to verify the following components are included: • Diagram of water supply sources, treatment systems, processing steps, control measures, and end-use points • Water risk management plan identifies areas where potentially hazardous conditions may occur ○ Note: Refer to the Centers for Disease Control and Prevention’s “Water Infection Control Risk Assessment (WICRA) for Healthcare Settings” tool as an example for conducting a water-related risk assessment. • Plan for addressing the use of water in areas of buildings where water may have been stagnant for a period of time • Evaluation of immunocompromised patients • Monitoring protocols and acceptable ranges for control measures		
EP 3 CoP 485.623(b)(1)) (Formerly EC.02.05.02, EP3)					Verify that the water management program includes documentation of the following: • Results of all monitoring activities • Corrective actions and procedures to follow if test results are outside of acceptable limits • Corrective actions taken when control limits are not maintained		
EP 4 CoP 485.623(b)(1))					Verify water management program reviewed annually and when changes have been made to the water system that add risk, new equipment or at-risk systems have been added that could generate aerosols or be source for Legionella		

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	N C	NA	IO U			
PE.04.01.05					Manages risks associated with utility systems – Water Management Program		
(Formerly EC.02.05.02, EP4)							
COMMENTS:							

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IO U			
PE.04.01.0 1					Management of Medical Equipment Risks		
EP 2 CoP 485.623(b)(1)					Non-deemed status requirement: Maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. Evaluates new types of equipment before initial use to determine whether they should be included in the inventory. OR Deemed status requirement: Maintains a written inventory of all medical equipment.		
EP 2 CoP 485.623(b)(1)					High-risk medical equipment identified on the inventory		
EP 2 CoP 485.623(b)(1)					Inventory includes activities and associated frequencies for maintaining, inspecting, and testing all medical equipment on the inventory.		

STANDARD - EPs	See Legend				Document / Requirement	Yes	No
	C	NC	NA	IO U			
PE.04.01.0 1					Management of Medical Equipment Risks		
COMMENTS:							

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.04.01.0 1					Medical equipment inspection, testing and maintenance			
EP 2 CoP 485.623(b)(1)					All high-risk equipment. Note 1: High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment must have a 100% completion rate.			
EP 2 CoP 485.623(b)(1)					Non-high-risk equipment identified on the medical equipment inventory			
EP 2 CoP 485.623(b)(1)					Conducts performance testing of and maintains all sterilizers			
EP 1 CoP 485.623(d)					All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.04.01.0 1					Medical equipment inspection, testing and maintenance			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
PE.04.01.0 1					Utility system Inspection, testing and maintenance			
EP 2 CoP 485.623(b)(1)					High-risk utility system components on the inventory with completion date and results of activities documented Note 1: A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment. Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			
EP 2 CoP 485.623(b)(1)					Infection control utility system components on the inventory with completion date and results of activities documented Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.			
EP2 CoP 485.623(b)(1)					Non-high-risk utility system components on the inventory with completion date and results of activities documented			

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IO U				
PE.04.01.0 1					Utility system Inspection, testing and maintenance			
EP 2 CoP 485.623(b)(1)					Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch. For LIM circuits with automated self-testing, a manual test is performance at least annually. NFPA 99-2012: 6.3.2; 6.3.3; 6.3.3.3.2; 6.3.4			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequenc y	Yes	No / Missing Date
	C	N C	NA	IO U				
NPG.11.01.0 1 NPG.02.04.01					The hospital manages security risks.			
NPG.11.01.01 EP 2 No CoP					The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.			
NPG.02.04.01 EP 3 No CoP					The hospital conducts an annual worksite analysis related to its workplace violence prevention program. The hospital takes actions to mitigate or resolve the workplace violence safety and security risks based upon findings from the analysis. Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.			
COMMENTS:								

STANDARD - EPs	See Legend				Document / Requirement	Frequency	Yes	No / Missing Date
	C	NC	NA	IOU				
NPG.11.01.01					The hospital collects information to monitor conditions in the environment.			
NPG.11.01.01, EP 3 No CoP					EP 1 The hospital develops and implements processes for monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors			

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IOU		Yes	No	Yes	No
PE.03.02.01					Interim Life Safety Measures (ILSM)				
EP 1 No CoP					ILSM policy identifying when and to what extent ILSM implemented				
PE.03.02.01, EP 2 No CoP					Alarms out-of-service 4 or more hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification NFPA 101-2012: 9.6.1.6				
PE.03.01.01, EP 8					Sprinklers out of service more than 10 hours in 24 hours in an occupied building - Fire watch / Fire Dept. notification				

STANDARD - EPs	See Legend				Document / Requirement	Addressed in policy?		Implemented as required?	
	C	NC	NA	IO U		Yes	No	Yes	No
PE.03.02.0 1					Interim Life Safety Measures (ILSM)				
485.623(c)(6)(ii)					NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2				
EP 3 No CoP					Signs for alternate exits posted				
EP 4 No CoP					Daily inspection of routes of egress (See also 19.7.9.2 RE: daily inspections)				
EP 5 No CoP					Temporary but equivalent systems while system is impaired				
EP 6 No CoP					Additional firefighting equipment provided				
EP 7 No CoP					Smoke tight non-combustible temporary barriers				
EP 8 No CoP					Increased surveillance implemented				
EP 9 No CoP					Storage and debris removal				
EP 10 No CoP					Additional training on firefighting equipment				
EP 11 No CoP					Additional fire drill per shift per quarter				
EP 12 No CoP					Temporary systems tested and inspected monthly				
EP 13 No CoP					Additional training on building deficiencies, construction hazards, temp measures				
EP 14 No CoP					Training for impaired structural or impaired compartment fire safety features				
EP 15 No CoP					Other ILSM's				
COMMENTS:									

NOTE: Please complete the following during building tour

STANDAR D - EPs	See Legend				Document / Requirement	Frequency		Yes	No / Missing Date
	C	NC	NA	IO U					
PE.02.01. 01					The hospital manages risks related to hazardous materials and waste.				
EP 1 No CoP					The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. (See also IC.02.01.01, EP 6; MM.01.01.03, EPs 1 and 2)				
EP 4 485.635(b) (3) for Radiation Hazards only					The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.				
EP 2 No CoP					For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.				
	COMMENTS:								

Health Care Occupancy LSC and HCFC Evaluation Tool

The **Health Care Occupancy LSC and HCFC Evaluation Tool** reflects the Centers for Medicare & Medicaid Services (CMS) K-tags which represent the detailed NFPA 101 Life Safety Code and NFPA 99 Health Care Facilities Code requirements that are evaluated for compliance to determine if hospitals and critical access hospitals meet the Conditions of Participation. Hospitals and critical access hospitals and surveyors must refer to the tool for the content of Code requirements as these details no longer appear in individual elements of performance under the new, streamlined Joint Commission Physical Environment (PE) standards.

The tool will assist both organizations and surveyors in identifying the hospital and critical access hospital Conditions of Participation (CoPs) and the Physical Environment requirements that relate to the K-tags. Refer to the hospital and critical access hospital crosswalks for more detailed information related to the Physical Environment CoP requirements and Joint Commission Physical Environment standards relationships.

K-tag	Code Requirement	CoP	JC EP	Comments
SECTION 1 – GENERAL REQUIREMENTS				
K100	General Requirements – Other Any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01 The hospital/CAH addresses life safety from fire. EP 3 The hospital/CAH meets the applicable provisions of the Life Safety Code (NFPA 101: 2012 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).	
K111	Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: Requirements of Chapter 18 and 19. Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6. 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01 The hospital/CAH addresses building safety and facility management. EP 1 The hospital/CAH meets the applicable provisions and proceeds in accordance with the Health	

K-tag	Code Requirement	CoP	JC EP	Comments
	Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2. 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8)		Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2,	
K112	Sprinkler Requirements for Major Rehabilitation If a non-sprinklered smoke compartment has undergone major rehabilitation the automatic sprinkler requirements of 18.3.5 have been applied to the smoke compartment. In cases where the building is not protected throughout by a sprinkler system, the requirements of 18.4.3.2, 18.4.3.3, and 18.4.3.8 are also met. Note: Major rehabilitation involves the modification of more than 50 percent, or more than 4500 ft² of the area of the smoke compartment. 18.1.1.4.3.3, 19.1.1.4.3.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K131	Multiple Occupancies – Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	- They are separated from areas of health care occupancies by construction having a minimum two-hour fire resistance rating in accordance with Chapter 8. - The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR			
K132	Multiple Occupancies – Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than two-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K133	Multiple Occupancies – Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a two-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments																							
	The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3																										
K161	Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7, 19.1.6.4, 19.1.6.5 <table><tr><td></td><td>Construction Type</td><td></td></tr><tr><td>1</td><td>I (442), I (332), II (222)</td><td>Any number of stories non-sprinklered or sprinklered</td></tr><tr><td>2</td><td>II (111)</td><td>One story non-sprinklered Maximum 3 stories sprinklered</td></tr><tr><td>3</td><td>II (000)</td><td rowspan="4">Not allowed non-sprinklered Maximum 2 stories sprinklered</td></tr><tr><td>4</td><td>III (211)</td></tr><tr><td>5</td><td>IV (2HH)</td></tr><tr><td>6</td><td>V (111)</td></tr><tr><td>7</td><td>III (200)</td><td rowspan="2">Not allowed non-sprinklered Maximum 1 story sprinklered</td></tr><tr><td>8</td><td>V (000)</td></tr></table> <i>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</i>		Construction Type		1	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered	2	II (111)	One story non-sprinklered Maximum 3 stories sprinklered	3	II (000)	Not allowed non-sprinklered Maximum 2 stories sprinklered	4	III (211)	5	IV (2HH)	6	V (111)	7	III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered	8	V (000)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	Determine type of building construction and where you would be able to confirm by direct observation the structure and building materials used in constructing the building (exposed areas above the ceilings or vertical pipe shafts may provide insight). Visit areas where you can confirm by direct observation the structure and building materials used in constructing the building (exposed areas above the ceilings or vertical pipe shafts may provide insight).
	Construction Type																										
1	I (442), I (332), II (222)	Any number of stories non-sprinklered or sprinklered																									
2	II (111)	One story non-sprinklered Maximum 3 stories sprinklered																									
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5	IV (2HH)																										
6	V (111)																										
7	III (200)	Not allowed non-sprinklered Maximum 1 story sprinklered																									
8	V (000)																										
K162	Roofing Systems Involving Combustibles 2012 EXISTING Buildings of Type I (442), Type I (332), Type II (222), or Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3																								

K-tag	Code Requirement	CoP	JC EP	Comments
	the following: 1. roof covering meets Class C requirements. 2. roof is separated from occupied building portions with a noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 19.1.6.2*, ASTM E108, ANSI/UL 790 2012 NEW Buildings of Type I (442), Type I (332), Type II (222), Type II (111) having roof systems employing combustible roofing supports, decking or roofing meet the following: 1. roof covering meets Class A requirements. 2. roof is separated from occupied building portions with 2-hour fire resistive noncombustible floor assembly using not less than 2½ inches concrete or gypsum fill. 3. the structural elements supporting the rated floor assembly meet the required fire resistance rating of the building. 18.1.6.2, ASTM E108, ANSI/UL 790			
K163	Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2-hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 18.1.6.4, 18.1.6.5, 19.1.6.4, 19.1.6.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
SECTION 2 – MEANS OF EGRESS REQUIREMENTS				

K-tag	Code Requirement	CoP	JC EP	Comments
K200	Means of Egress Requirements – Other Any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K211	Means of Egress – General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K221	Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key- locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K222	Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: ☐ CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6,	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	19.2.2.2.5.1, 19.2.2.2.6 ☐ SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 ☐ DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ☐ ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ☐ ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.			

K-tag	Code Requirement	CoP	JC EP	Comments
	18.2.2.2.4, 19.2.2.2.4			
K223	Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: • Required manual fire alarm system; and • Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and • Automatic sprinkler system, if installed; and • Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K224	Horizontal-Sliding Doors Horizontal-sliding doors permitted by 7.2.1.14 that are not automatic-closing are limited to a single leaf and shall have a latch or other mechanism to ensure the door will not rebound. Horizontal-sliding doors serving an occupant load fewer than 10 shall be permitted, providing all of the following criteria are met: • Area served by the door has no high hazard contents. • Door is operable from either side without special knowledge or effort. • Force required to operate the door in the direction of travel is ≤ 30 lbf to set the door in motion and ≤ 15 lbf to close or open to the required width.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	- Assembly is appropriately fire rated, and where rated, is self-or automatic-closing by smoke detection per 7.2.1.8, and installed per NFPA 80. - Where required to latch, the door has a latch or other mechanism to ensure the door will not rebound. 18.2.2.2.10, 19.2.2.2.10			
K225	Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K226	Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K227	Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K231	Means of Egress Capacity The capacity of required means of egress is in accordance with 7.3. 18.2.3.1, 19.2.3.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K232	Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of non-ambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	19.2.3.4, 19.2.3.5 2012 NEW The width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet, except as modified by the 18.2.3.4 or 18.2.3.5 exceptions. 18.2.3.4, 18.2.3.5			
K233	Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 2012 NEW Exit access doors and exit doors are of the swinging type and are at least 41.5 inches in clear width. In psychiatric hospitals or limited care facilities, doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries shall be no less than 32 inches in clear width. If using a pair of doors, the doors shall be provided with a rabbet, bevel, or astragal at the meeting edge, at least one of the doors shall provide 32 inches in clear width, and the inactive leaf of the pair shall be secured with automatic flush bolts. 18.2.3.6, 18.2.3.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K241	Number of Exits – Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4			
K251	Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 2012 NEW Dead-end corridors shall not exceed 30 feet. Common path of travel shall not exceed 100 feet. 18.2.5.2, 18.2.5.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K252	Number of Exits – Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K253	Number of Exits – Patient Sleeping and Non-Sleeping Rooms Patient sleeping rooms of more than 1,000 square feet or nonsleeping rooms of more than 2,500 square feet have at least two exit access doors remotely located from each other. 18.2.5.5.1, 18.2.5.5.2, 19.2.5.5.1, 19.2.5.5.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K254	Corridor Access All habitable rooms not within suites have a door leading directly outside to grade or have a door leading to an exit access corridor. Patient sleeping rooms with less than eight patient beds may have one room intervening to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	system. 18.2.5.6.1 through 18.2.5.6.4, 19.2.5.6.1 through 19.2.5.6.4			
K255	Suite Separation, Hazardous Content, and Subdivision All suites are separated from the remainder of the building (including from other suites) by construction meeting the separation provisions for corridor construction (18.3.6.2-18.3.6.5 or 19.3.6.2-19.3.6.5). Existing approved barriers shall be allowed to continue to be used provided they limit the transfer of smoke. Intervening rooms have no hazardous areas and hazardous areas within suites comply with 18/19.2.5.7.1.3. Subdivision of suites shall be by noncombustible or limited-combustible construction. 18.2.5.7.1.2 through 18.2.5.7.1.4, 19.2.5.7.1.2, 19.2.5.7.1.3, 19.2.5.7.1.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K256	Sleeping Suites Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites shall be provided with constant staff supervision. Staff shall have direct visual supervision of patient sleeping rooms, from a constantly attended location or the room shall be provided with an automatic smoke detection system. Suites more than 1,000 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed the following size limitations: 5,000 square feet if the suite is not fully smoke detected or fully sprinklered.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	7,500 square feet if the suite is either fully smoke detected or fully sprinklered. 10,000 square feet if the suite is both fully smoke detected and fully sprinklered and the sleeping rooms have direct supervision from a constantly attended location. Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.2, 19.2.5.7.2			
K257	Non-Sleeping Suites Occupants shall have exit access to a corridor or direct access to a horizontal exit. Where ≥ 2 exits are required, one exit access door may be to a stairway, passageway or to the exterior. Suites more than 2,500 ft² shall have 2 or more remote exits. One means of egress from the suite shall be to a corridor and one may be into an adjacent suite separated in accordance with corridor requirements. Suites shall not exceed 10,000 ft². Travel distance between any point in a suite to exit access shall not exceed 100 feet and distance to an exit shall not exceed 150 feet (200 feet if building is fully sprinklered). 18.2.5.7.3, 19.2.5.7.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K261	Travel Distance to Exits Travel distance (excluding suites) to exits are measured in accordance with 7.6. - From any point in the room or suite to exit less than or equal to 150 feet (less than or equal to 200 feet if the building is fully sprinklered). - Point in a room-to-room door less than or equal to 50feet. 18.2.6, 19.2.6	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
K271	Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K281	Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K291	Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	HAP 482.41(a)(1) HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d) EP 3 applies to CAH but is not linked to a CAH CoP (Above and beyond requirement)	PE.03.01.01, EP 3 PE.04.01.01, EP 1 PE.04.01.03, EP 1 The hospital/CAH has emergency power and lighting in, at a minimum, the following areas: • Operating rooms • Recovery rooms • Intensive care • Emergency rooms • Stairwells Battery lamps and flashlights are available in all other areas not serviced by the emergency power supply source.	
K292	Life Support Means of Egress 2012 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	systems (electro- mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (Indicate N/A if life support equipment is for emergency purposes only.) 18.2.9.2, 18.2.10.5	HAP 482.41(c) CAH 485.623(d)		
K293	Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
SECTION 3 - PROTECTION				
K300	Protection – Other Any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K311	Vertical Openings – Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1-hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1- hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5			
K321	Hazardous Areas – Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with ¾ hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic- closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. <i>Describe the floor and zone locations of hazardous areas that are deficient.</i> 19.3.2.1, 19.3.5.9	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement				CoP	JC EP	Comments
	Area	Automatic Sprinkler	Separation	N/A			
	a. Boiler and Fuel-Fired Heater Rooms						
	b. Laundries (larger than 100 sq. ft.)						
	c. Repair, Maintenance, and Paint Shops						
	d. Soiled Linen Rooms (exceeding 64 gal.)						
	e. Trash Collection Rooms (exceeding 64 gal.)						
	f. Combustible Storage Rooms/Spaces (over 50 sq. ft.)						
	g. Laboratories (if classified as Severe Hazard - see K322)						
	2012 NEW						
	Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a ¾ hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. <i>Describe the floor and zone locations of hazardous areas that are deficient.</i> 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7						

K-tag	Code Requirement	CoP	JC EP	Comments																																				
	<table><tr><td>Area</td><td>Automatic Sprinkler</td><td>Separation</td><td>N/A</td></tr><tr><td>a. Boiler and Fuel-Fired Heater Rooms</td><td></td><td></td><td></td></tr><tr><td>b. Laundries (larger than 100 sq. ft.)</td><td></td><td></td><td></td></tr><tr><td>c. Repair, Maintenance, and Paint Shops</td><td></td><td></td><td></td></tr><tr><td>d. Soiled Linen Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr><tr><td>e. Trash Collection Rooms (exceeding 64 gal.)</td><td></td><td></td><td></td></tr><tr><td>f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)</td><td></td><td></td><td></td></tr><tr><td>g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)</td><td></td><td></td><td></td></tr><tr><td>h. Laboratories (if classified as Severe Hazard - see K322)</td><td></td><td></td><td></td></tr></table>	Area	Automatic Sprinkler	Separation	N/A	a. Boiler and Fuel-Fired Heater Rooms				b. Laundries (larger than 100 sq. ft.)				c. Repair, Maintenance, and Paint Shops				d. Soiled Linen Rooms (exceeding 64 gal.)				e. Trash Collection Rooms (exceeding 64 gal.)				f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq. ft.)				g. Combustible Storage Rooms/Spaces (over 100 sq. ft.)				h. Laboratories (if classified as Severe Hazard - see K322)						
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K322	Laboratories Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are protected by 1-hour fire resistance-rated separation, automatic sprinkler system, and are in accordance with 8.7 and with NFPA 99. Laboratories not considered a severe hazard are protected as hazardous areas (see K321). Laboratories using chemicals are in accordance with NFPA 45, <i>Standard on Fire Protection for Laboratories Using Chemicals</i>. Gas appliances are of appropriate design and installed in accordance with NFPA 54. Shutoff valves are marked to identify material they control. Devices requiring medical grade oxygen from the piped distribution system meet the requirements under 11.4.2.2 (NFPA 99). 18.3.2.2, 19.3.2.2, 8.7, 8.7.4.1 (LSC) 9.3.1.2, 11.4.3.2, 15.4 (NFPA 99)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1																																					

K-tag	Code Requirement	CoP	JC EP	Comments
K323	Anesthetizing Locations Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are: located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical- surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12-inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 18.3.2.3, 19.3.2.3 (LSC) 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3, 5.1.9.3.4, 6.4.2.2.4.2 (NFPA 99)	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) HAP 482.41(c) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K324	Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, <i>Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations</i>, unless: - residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. - cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or - cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Any automatic fire-extinguishing system in the kitchen every 6 months Note: For automatic kitchen fire-extinguishing systems, see NFPA 96-2011: 11.2.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K325	Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: - Corridor is at least 6 feet wide. - Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. - Dispensers shall have a minimum of four foot	HAP 482.41(b)(7) CAH 485.623(c)(5)	PE.03.01.01 The hospital/CAH addresses life safety from fire. EP 7 When the hospital/CAH installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that	

K-tag	Code Requirement	CoP	JC EP	Comments
	horizontal spacing. - Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. - Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. - Dispensers are not installed within 1 inch of an ignition source. - Dispensers over carpeted floors are in sprinklered smoke compartments. - ABHR does not exceed 95 percent alcohol. - Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). - ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6,		protects against inappropriate access.	
K331	Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions and columns have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2			
K332	Interior Floor Finish 2012 NEW (N/A for 2012 EXISTING) Interior finishes shall comply with 10.2. Floor finishes in exit enclosures and exit access corridors and spaces not separated by walls that resist the passage of smoke shall be Class I or II. 18.3.3.3.1, 18.3.3.3.2, 18.3.3.3.3, 10.2, 10.2.7.1, 10.2.7.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K341	Fire Alarm System – Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, <i>National Electric Code</i> , and NFPA 72, <i>National Fire Alarm Code</i> to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring, or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K342	Fire Alarm System – Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5			
K343	Fire Alarm – Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) 2012 NEW Positive alarm sequence in accordance with 9.6.3.4 are permitted. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation and annunciation zoning for fire alarm and sprinklers shall be provided by audible and visual indicators and zones shall not be larger than 22,500 square feet per zone. 18.3.4.3 through 18.3.4.3.3, 9.6.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K344	Fire Alarm – Control Functions The fire alarm automatically activates required control functions and is provided with an alternative power supply in accordance with NFPA 72. 18.3.4.4, 19.3.4.4, 9.6.1, 9.6.5, NFPA 72	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K345	Fire Alarm System – Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, <i>National Electric Code</i> , and NFPA 72, <i>National Fire Alarm and Signaling Code</i> . Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory - Visual and audible fire alarms (including speakers and door-releasing devices on the inventory) - Fire alarm equipment on the inventory for notifying off-site responders - Automatic smoke-detection shutdown devices for air-handling equipment Note: For additional guidance on duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors; visual and audible fire alarms; and fire alarm equipment, see NFPA 72-2010: Table 14.4.5; 17.14.	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K346	Fire Alarm – Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K347	Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	open to corridors as required by 19.3.6.1. 19.3.4.5.2 2012 NEW Smoke detection systems are provided in spaces open to corridors as required by 18.3.6.1 In nursing homes, an automatic smoke detection system is installed in the corridors of all smoke compartments containing resident sleeping rooms, unless the resident sleeping rooms have: • smoke detection, or • automatic door closing devices with integral smoke detectors on the room side that provide occupant notification. Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.2, 18.3.4.5.3			
K351	Sprinkler System – Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems</i>. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems</i>. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 2012 NEW Buildings are to be protected throughout by an approved	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	automatic sprinkler system in accordance with NFPA 13, <i>Standard for the Installation of Sprinkler Systems</i>. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where State and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 ft² and sprinkler coverage covers the closet footprint as required by NFPA 13, <i>Standard for Installation of Sprinkler Systems</i>. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10			
K352	Sprinkler System – Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, <i>National Fire Alarm and Signaling Code</i>, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Supervisory signal devices on the inventory, quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices; semiannually for valve supervisory switches; and annually for other supervisory initiating devices	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	Note: For supervisory signal devices, water storage tanks and associated water storage equipment do not require testing. For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.			
K353	Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, <i>Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems</i> . Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - For automatic sprinkler systems, main drains at system low point or at all system risers - For automatic sprinkler systems, fire pumps under flow (fire pump supervisory signals for “pump running” and “pump power loss”) Note: For automatic sprinkler systems, main drains, and system risers, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1. Note 3: For automatic sprinkler system fire pumps, see NFPA 25-2011: 8.3.3; 8.3.3.4. The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Vane-type and pressure-type water flow devices every 6 months - For automatic sprinkler systems, electric motor-driven fire pumps monthly and diesel engine-driven fire pumps every week under no-flow conditions - Hydrostatic and water flow for standpipe systems every 5 years - Automatic fire extinguishing systems (carbon dioxide	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	systems every 12 months, halon systems every 6 months, other special systems per NFPA standards and manufacturer's recommendations) - Hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter Note 1: For vane-type and pressure-type water flow devices, mechanical water flow devices (including but not limited to water motor gongs) should be tested quarterly. (For full text, refer to NFPA 25-2011: Table 5.1.1.2). For additional guidance also see NFPA 72-2010: Table 14.4.5. Note 2: For hydrostatic tests on standpipe occupant hoses, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6 The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - For automatic sprinkler systems, all fire department water supply connections every quarter Note: For automatic sprinkler systems, see NFPA 25-2011: 13.7; Table 13.1.1.2.			
K354	Sprinkler System – Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	HAP 482.41(b)(8)(i) HAP 482.41(b)(8)(ii) CAH 485.623(c)(6)(i) CAH 485.623(c)(6)(ii)	PE.03.01.01 The hospital/CAH addresses life safety from fire. EP 8 When a sprinkler system is shut down for more than 10 hours, the critical access hospital either evacuates the building or portion of the building affected by the system outage until the system is back in service or establishes a fire watch until the system is back in service.	

K-tag	Code Requirement	CoP	JC EP	Comments
K355	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, <i>Standard for Portable Fire Extinguishers</i> . 18.3.5.12, 19.3.5.12, NFPA 10	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
	The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Portable fire extinguishers at least monthly (this includes recharging every 12 months) Note 3: For portable fire extinguishers, there are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K361	Corridors – Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse’s stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K362	Corridors – Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	compartments there are no restrictions in area or fire resistance of glass or frames. 19.3.6.2, 19.3.6.2.7 2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2			
K363	Corridor – Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1¾ inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i) Score corridor door issues not addressed by highlighted text using these CoPs at PE.04.01.01 EP 5. Score issues related to yellow highlighted text at PE.04.01.01 EP 10 using the below CoPs: HAP 482.41(b)(1)(ii) CAH 485.623(c)(1)(ii)	PE.03.01.01, EP 3 PE.03.01.01, EP 6 For hospitals that use Joint Commission accreditation for deemed status purposes: Regardless of the provisions of the Life Safety Code, corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.	

K-tag	Code Requirement	CoP	JC EP	Comments
	2012 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5lbf is applied, whether or not power is applied. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
K364	Corridor – Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 in² and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 in². Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K371	Subdivision of Building Spaces – Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 2012 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. Smoke subdivision requirements do not apply to any of the stories or areas described in 18.3.7.2. 18.3.7.1, 18.3.7.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K372	Subdivision of Building Spaces – Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a ½ hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) 2012 NEW Smoke barriers shall be constructed to provide at least a 1-hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3			
	The hospital maintains fire safety equipment and fire safety building features by testing the following based on the identified timeframes: - Fire and smoke dampers 1 year after installation and at least every 6 years thereafter to verify they fully close Note: For operation of fire and smoke dampers, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5.	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K373	Subdivision of Building Spaces – Accumulation Space Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.5.1, 18.3.7.5.2, 19.3.7.5.1, 19.3.7.5.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K374	Subdivision of Building Spaces – Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1¾-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 in for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 2012 NEW Doors in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates of unlimited height are	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	permitted. Horizontal- sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8			
K379	Smoke Barrier Door Glazing 2012 EXISTING Openings in smoke barrier doors shall be fire-rated glazing or wired glass panels in steel frames. 19.3.7.6, 19.3.7.6.2, 8.5 2012 NEW Windows in smoke barrier doors shall be installed in each cross corridor swinging or horizontal-sliding door protected by fire-rated glazing or by wired glass panels in approved frames. 18.3.7.9	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K381	Sleeping Room Outside Windows and Doors Every patient sleeping room has an outside window or outside door. In new occupancies, sill height does not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows. Newborn nurseries and rooms intended for occupancy less than 24 hours have no outside window or door requirements. Window sills in special nursing care areas (e.g., ICU, CCU, hemodialysis, neonatal) do not exceed 60 inches above the floor. 42 CFR 403, 418, 460, 482, 483, and 485 (in CoPs)	HAP 482.41(b)(9) HAP 482.41(b)(9)(i) HAP 482.41(b)(9)(ii) CAH 485.623(c)(7) CAH 485.623(c)(7)(i) CAH 485.623(c)(7)(ii)	PE.03.01.01 The hospital addresses life safety from fire. EP 9 Buildings have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. Note 1: Windows in atrium walls are considered outside windows for the purposes of this requirement. Note 2: The sill height	

K-tag	Code Requirement	CoP	JC EP	Comments
			requirement does not apply to newborn nurseries and rooms intended for occupancy for less than 24 hours. Note 3: The sill height in special nursing care areas of new occupancies does not exceed 60 inches.	
SECTION 4 – SPECIAL PROVISIONS				
K400	Special Provisions – Other Any LSC Section 18.4 and 19.4 Special Provisions requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K421	High-Rise Buildings 2012 EXISTING High-rise buildings are protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7 within 12 years of LSC final rule effective date. 19.4.2 2012 NEW High-rise buildings comply with section 11.8. 18.4.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
SECTION 5 – BUILDING SERVICES				

K-tag	Code Requirement	CoP	JC EP	Comments
K500	Building Services – Other Any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K511	Utilities – Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, <i>National Fuel Gas Code</i> , electrical wiring and equipment complies with NFPA 70, <i>National Electric Code</i> . Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K521	HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer’s specifications. 18.5.2.1, 19.5.2.1, 9.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K522	HVAC – Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: • is chimney or vent connected. • takes air for combustion from outside. • provides for a combustion system separate from occupied area atmosphere. 18.5.2.2, 19.5.2.2	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K523	HVAC – Suspended Unit Heaters Suspended unit heaters are permitted provided the following are met: • Not located in means of egress or in patient rooms. • Located high enough to be out of reach of people in the	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	area. Has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. 18.5.2.3(1), 19.5.2.3(1)			
K524	HVAC – Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K525	HVAC – Solid Fuel-Burning Fireplaces Solid fuel-burning fireplaces are permitted in other than patient sleeping areas provided: - Areas are separated by 1-hour fire resistance construction. - Fireplace complies with 9.2.2. - Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass. Room has supervised CO detection per 9.8. 18.5.2.3(3) and 19.5.2.3(3)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K531	Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter’s Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter’s Service Requirements of ASME/ANSI A17.3.	HAP 482.41(b)(1)(i) HAP 482.41(d)(2) CAH 485.623(c)(1)(i) CAH 485.623(b)(1)	PE.03.01.01, EP 3 PE.04.01.01, EP 2	

K-tag	Code Requirement	CoP	JC EP	Comments
	(Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 2012 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, <i>Safety Code for Elevators and Escalators</i>. Firefighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, <i>Safety Code for Elevators and Escalators</i>, including Firefighter's Service Requirements. (Includes firefighter's Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 18.5.3, 9.4.2, 9.4.3			
K532	Escalators, Dumbwaiters, and Moving Walks 2012 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators</i>. (Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters, includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.) 19.5.3, 9.4.2.2 2012 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. 18.5.3, 9.4.2.2	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K541	Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 2012 NEW Rubbish chutes, incinerators, and laundry chutes shall comply with the provisions of Section 9.5, unless otherwise specified in 18.5.4.2. - The fire resistance rating of chute charging room shall not be required to exceed 1-hour. - Any rubbish chute or linen chute shall be provided with automatic extinguishing protection in accordance with Section 9.7. - Chutes shall discharge into a trash collection room used for no other purpose and shall be	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	protected in accordance with 8.7. 18.5.4.2, 8.7, 9.5, 9.7, NFPA 82			
SECTION 7 – OPERATING FEATURES				
K700	Operating Features – Other Any LSC Section 18.7 and 19.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K711	Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.7.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K712	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	***Varying conditions means: Fire drills vary by at least one hour for each shift from quarter to quarter through four consecutive quarters			
K741	Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (7) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (8) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (9) Smoking by patients classified as not responsible shall be prohibited. (10) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (11) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (12) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
K751	Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K752	Upholstered Furniture and Mattresses Newly introduced upholstered furniture meets Class I or char length, and heat release criteria in accordance with 10.3.2.1 and 10.3.3, unless the building is fully sprinklered. Newly introduced mattresses shall meet char length and heat release criteria in accordance with 10.3.2.2 and 10.3.4, unless the building is fully sprinklered. Upholstered furniture and mattresses belonging to nursing home residents do not have to meet these requirements as all nursing homes are required to be fully sprinklered. Newly introduced upholstered furniture and mattresses means purchased on or after the LSC final rule effective date. 18.7.5.2, 18.7.5.4, 19.7.5.2, 19.7.5.4	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K753	Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: • Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. • Decorations meet NFPA 701. • Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	- Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). - The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 18.7.5.6, 19.7.5.6			
K761	Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80 <i>Standard for Fire Doors and Other Opening Protectives</i>. Fire doors that are not located in required fire barriers, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspection and testing have an understanding of the operating components of the doors. Written records of inspection and testing are maintained and are available for review. 18.7.6, 19.7.6, 8.3.3.1 (LSC), 5.2, 5.2.3 (NFPA 80)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
	The hospital maintains fire safety equipment and fire safety building features by testing the following every 12 months: - Sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure - Fire door assemblies (inspection and testing) Note 5: For fire doors and smoke barrier doors, see NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2. Note 6: For fire door assemblies, nonrated doors, including corridor doors to patient care rooms and smoke barrier doors, are not subject to the annual inspection and testing requirements of either NFPA 80 or NFPA 105. For hospitals that use Joint Commission accreditation for deemed status	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses life safety from fire. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	

K-tag	Code Requirement	CoP	JC EP	Comments
	purposes: Nonrated doors should be routinely inspected and maintained in accordance with the facility maintenance program. For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1. The hospital maintains fire safety equipment and fire safety building features by inspecting the following: - Fire door assemblies annually by a qualified individual (testing begins with a pre-test visual inspection and includes both sides of the opening)			
K754	Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is ≤ 96 gal. unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K771	Engineer Smoke Control Systems 2012 EXISTING When installed, engineered smoke control systems are tested in accordance with established engineering principles. Test documentation is maintained on the premises. 19.7.7 2012 NEW When installed, engineered smoke control systems	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	

K-tag	Code Requirement	CoP	JC EP	Comments
	are tested in accordance with NFPA 92, <i>Standard for Smoke Control Systems</i> . Test documentation is maintained on the premises. 18.7.7			
K781	Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies. Unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	HAP 482.41(b)(1)(i) CAH 485.623(c)(1)(i)	PE.03.01.01, EP 3	
K791	Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
	The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
PART II – HEALTH CARE FACILITIES CODE REQUIREMENTS				
K900	Health Care Facilities Code - Other Any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included in the finding.	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K901	Fundamentals – Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K902	Gas and Vacuum Piped Systems – Other Any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K903	Gas and Vacuum Piped Systems – Categories Medical gas, medical air, surgical vacuum, WAGD, and air supply systems are designated: ☐ Category 1. Systems in which failure is likely to cause major injury or death. ☐ Category 2. Systems in which failure is likely to cause minor injury. ☐ Category 3. Systems in which failure is not likely to cause injury but can cause discomfort. Deep sedation and general anesthesia are not to be administered using a Category 3 medical gas system. 5.1.1.1, 5.2.1, 5.3.1.1, 5.3.1.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K904	Gas and Vacuum Piped Systems – Warning Systems All master, area, and local alarm systems used for medical gas and vacuum systems comply with appropriate Category warning system requirements, as applicable. 5.1.9, 5.2.9, 5.3.6.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K905	Gas and Vacuum Piped Systems – Central Supply System Identification and Labeling Containers, cylinders and tanks are designed, fabricated, tested, and marked in accordance with 5.1.3.1.1 through 5.1.3.1.7. Locations containing only oxygen or medical air have doors labeled with "Medical Gases, NO Smoking or Open Flame". Locations containing other gases have doors labeled "Positive Pressure Gases, NO Smoking or Open Flame, Room May Have Insufficient Oxygen, Open Door and Allow Room to Ventilate Before Opening." 5.1.3.1, 5.2.3.1, 5.3.10 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K906	Gas and Vacuum Piped Systems – Central Supply System Operations Adaptors or conversion fittings are prohibited. Cylinders are handled in accordance with 11.6.2. Only cylinders, reusable shipping containers, and their accessories are stored in rooms containing central supply systems or cylinders. No flammable materials are stored with cylinders. Cryogenic liquid storage units intended to supply the facility are not used to transfill. Cylinders are kept away from sources of heat. Valve protection caps are secured in place, if supplied, unless cylinder is in use. Cylinders are not stored in tightly closed spaces. Cylinders in use and storage are prevented from exceeding 130°F, and nitrous oxide and carbon dioxide cylinders are prevented from reaching temperatures lower than manufacture recommendations or 20°F. Full or empty cylinders, when not connected, are stored in locations complying with 5.1.3.3.2 through 5.1.3.3.3, and are not stored in enclosures containing motor-driven machinery, unless for instrument air reserve headers. 5.1.3.2, 5.1.3.3.17, 5.1.3.3.1.8, 5.1.3.3.4, 5.2.3.2, 5.2.3.3, 5.3.6.20.4, 5.6.20.5, 5.3.6.20.7, 5.3.6.20.8, 5.3.6.20.9 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K907	Gas and Vacuum Piped Systems – Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01 The hospital/CAH addresses building safety and facility management. EP 2 The hospital/CAH maintains essential equipment in safe operating condition.	
K908	Gas and Vacuum Piped Systems – Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
K909	Gas and Vacuum Piped Systems – Information and Warning Signs Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (Table 5.1.11), and operating pressure if other than standard. Labels are at intervals not more than 20 feet, are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. 5.1.14.3, 5.1.11.1, 5.1.11.2, 5.2.11, 5.3.13.3, 5.3.11 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K910	Gas and Vacuum Piped Systems – Modifications Whenever modifications are made that breach the pipeline, any necessary installer and verification test specified in 5.1.2 is conducted on the downstream portion of the medical gas piping system. Permanent records of all tests required by system verification tests are maintained. 5.1.14.4.1, 5.1.14.4.6, 5.2.13, 5.3.13.4.3 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K911	Electrical Systems – Other Any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.03.01.01, EP 3 PE.04.01.01, EP 1	
K912	Electrical Systems – Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, playrooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K913	Electrical Systems – Wet Procedure Locations Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment conducted by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. 6.3.2.2.8.4, 6.3.2.2.8.7, 6.4.4.2	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K914	Electrical Systems – Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of ≤ 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals ≤ 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
K915	Electrical Systems – Essential Electric System Categories ☐ Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. ☐ General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. ☐ Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1 1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K916	Electrical Systems – Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K917	Electrical Systems – Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K918	Electrical Systems – Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20–40-day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	

K-tag	Code Requirement	CoP	JC EP	Comments
	program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
K919	Electrical Equipment – Other Any NFPA 99 Chapter 10, <i>Electrical Equipment</i>, requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding.	HAP 482.41(b)(1)(i) HAP 482.41(c) CAH 485.623(c)(1)(i) CAH 485.623(d)	PE.04.01.01, EP 1 PE.03.01.01, EP 3	
K920	Electrical Equipment – Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non- PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70),	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	590.3(D) (NFPA 70), TIA 12-5			
K921	Electrical Equipment – Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient care-related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuing training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
K922	Gas Equipment – Other Any NFPA 99 Chapter 11 Gas Equipment requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	included in the finding. Chapter 11 (NFPA 99)			
K923	Gas Equipment – Cylinder and Container Storage ≥ 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. > 300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. ≤ 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of ≤ 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING". Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K924	Gas Equipment – Testing and Maintenance Requirements Anesthesia apparatus are tested at the final path to patient after any adjustment, modification or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas and an oxygen analyzer is used to verify oxygen concentration. Defective equipment is immediately removed from service. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. Manufacturer service manuals are used to maintain equipment and a scheduled maintenance program is followed. 11.4.1.3, 11.5.1.3, 11.6.2.5, 11.6.2.6 (NFPA 99)	HAP 482.41(d)(2) CAH 485.623(b)(1)	PE.04.01.01, EP 2	
K925	Gas Equipment – Respiratory Therapy Sources of Ignition Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient’s room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient’s room, no sources of ignition are within the area are of administration (15-feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K926	Gas Equipment – Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K927	Gas Equipment – Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, <i>Transfilling of High-Pressure Gaseous Oxygen Used for Respiration</i> . Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K928	Gas Equipment – Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL". Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K929	Gas Equipment – Precautions for Handling Oxygen Cylinders and Manifolds Handling of oxygen cylinders and manifolds is based on CGA G-4, Oxygen. Oxygen cylinders, containers, and associated equipment are protected from contact with oil and grease, from contamination, protected from damage, and handled with care in accordance with precautions provided under 11.6.2.1 through 11.6.2.4 (NFPA 99). 11.6.2 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
K930	Gas Equipment – Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K931	Hyperbaric Facilities All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99. Chapter 14 (NFPA 99)	HAP 482.41(d)(2) HAP 482.41(c) CAH 485.623(b)(1) CAH 485.623(d)	PE.04.01.01, EP 1 PE.04.01.01, EP 2	
K932	Features of Fire Protection – Other Any NFPA 99 Chapter 15 Features of Fire Protection requirements that are not addressed by the provided K-Tags but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included in the finding. Chapter 15 (NFPA 99)	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	
K933	Features of Fire Protection – Fire Loss Prevention in Operating Rooms Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: • packaging is non-flammable. • applicators are in unit doses. • Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: ○ application site is dry prior to draping and use of surgical equipment. ○ pooling of solution has not occurred or has been	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

K-tag	Code Requirement	CoP	JC EP	Comments
	corrected. ○ solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. ○ policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99) ***The preoperative time-out is addressed by the clinical surveyor.			
	The hospital labels utility system controls to facilitate partial or complete emergency shutdowns. Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel. Note 2: For example, the fire alarm system's circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.	HAP 482.41(c) CAH 485.623(d)	PE.04.01.01, EP 1	

Kitchen Tracer Survey Guide – Hospital and Critical Access Hospital

The first seven sections of this tool should be completed by a clinical surveyor.

Provision of Dietary Services					
YES	NO		YES	NO	
		Do the organization's policies and procedures address the following:			Verify the following:
☐	☐	Meal frequency? PC.12.01.09 EP 1 (HAP 482.28(b)(1)) (CAH 485.635(a)(3)(vi))	☐	☐	Organized dietary service directed and staffed by qualified personnel NPG.12.01.01, EP 7 (HAP and CAH DPU 482.28) (CAH N/A) Organized dietary service appropriate to the scope and complexity of services offered, and in accordance with accepted standards of practice. LD.13.03.01, EP 1 (HAP 482.28) (CAH N/A) Does the hospital have a full-time employee, qualified through education, training, or experience, who serves as director to oversee the daily management of food and dietetic services? NPG.12.01.01, EP 8 (HAP and CAH DPU 482.28(a)(1)(i), §482.28(a)(1)(ii), §482.28(a)(1)(iii)) (CAH N/A) Administrative and technical personnel must be competent in their assigned duties. This competency is demonstrated through education, experience and specialized training appropriate to the task(s) assigned. (HAP and CAH DPU HR.11.01.01, EP 1, 482.28(a)(3)) (CAH HR.11.01.01 EP 1 (No CoP)) Food safety certification/license; if required, do the appropriate staff members have this? (HAP HR.11.01.01 EP 1, 482.28(a)(3)) (CAH HR.11.01.03 EP 1, 485.608(d))
☐	☐	Diet ordering PC.12.01.01 EP 1 (HAP 482.28(b)(2)) (CAH 485.635(a)(3)(vi))	☐	☐	Diet Manual; approved by medical staff and dietitian (HAP and CAH DPU PC.12.01.09 EP 2, 482.28(b)(3)) (CAH N/A)

		Patient tray delivery system? PC.12.01.09 EP 1 (HAP 482.28)(b)(1)) (CAH 485.635(a)(3)(vi))			
☐	☐	Non-routine occurrences? <i>e.g., parenteral nutrition, change in diet orders, early/late trays</i> PC.12.01.09 EP 1 (HAP 482.28)(b)(1)) (CAH 485.635(a)(3)(vi))	☐	☐	Do menu options meet patient needs? PC.12.01.09 EP 1 (HAP 482.28)(b)(1)) (CAH 485.635(a)(3)(vi))
☐	☐	Hygiene Practices for food service personnel? IC.04.01.01 EP 3 (HAP 482.42)(a)(2)) (CAH 485.640(a)(2))	☐	☐	Does the organization have a full-time qualified dietitian or other qualified professional? <i>If a dietitian or other qualified professional is not full-time, interview staff to determine adequacy of the dietary director's qualifications.</i> (HAP and CAH DPU NPG.12.01.01, EP 9 482.28(a)(2)) (CAH N/A)
☐	☐	Kitchen sanitation? Applies to sanitation surfaces IC.04.01.01 EP 3 (HAP 482.42(a)(2)) (CAH 485.640(a)(2))	☐	☐	QAPI integration of food/dietetic service? LD.11.01.01 EP 8 (HAP 482.21) (CAH 485.641(b)(3))
☐	☐	Safe food handling? (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01, EP 1)			
☐	☐	Emergency food supplies? EM.12.01.01 EP 4 (HAP 482.15(b)(1)(i)) (CAH 485.625(b)(1)(i))			
☐	☐		Advanced: You can ask for recent health department inspection to provide baseline for whether issues are ongoing or isolated.		

PHYSICAL ENVIRONMENT					
YES	NO		YES	NO	
☐	☐	Are areas kept clean? PE.01.01.01 EP 3 (HAP 482.41(a)) (CAH 485.623(b)(4))	☐	☐	Is the area free of any signs of pests ? If there are pests, has the organization taken steps to address the issue? PE.01.01.01 EP 3 (HAP 482.41(a)) (CAH 485.623(b)(4))
☐	☐	Kitchen equipment ; is it in safe operating condition? If there is an issue, does the staff have a plan to address it? <i>Manufacturer's recommended periodic maintenance schedule or an acceptable Alternate Equipment Management (AEM) program should be followed.</i> PE.04.01.01 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))	☐	☐	Are Cookware/dishware/Dishes/ Utensils stored in a clean, dry location? <i>There is no requirement for a solid bottom shelf for storage of food or cooking equipment. Use of solid bottom shelving is an example of a strategy that would be used.</i> Clean items are managed as per local/state food code, e.g., protected from contamination, such as splash, dust or other contaminants. The HCO determines how items will be protected in accordance with food code. IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
☐	☐	Is garbage/refuse properly disposed of? PE.02.01.01 EP 6 (HAP 482.41(b)(4)) (CAH 485.623(b)(2))	☐	☐	Are wet wiping cloths stored in an approved sanitizing solution & washed daily? IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
☐	☐	Are sinks clear from items that can be contaminated from splashes? e.g., <i>paper-wrapped straws</i> IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))	☐	☐	Are food carts cleaned & sanitized <i>after every meal</i> . IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))
Advanced: You can ask a question regarding pest control services that have been accomplished.					

REFRIGERATOR					
YES	NO		YES	NO	
☐	☐	Refrigerator temps : have they been monitored? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is uncooked food (chicken or other meat) stored away from cooked food to prevent contamination? <i>e.g., not stored over cooked food</i> (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is frequency of temp checks & limits (41° or lower) maintained as per policy? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is prepared food covered & labeled with expiration date? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)

☐	☐	Is there a process if the temp is inadequate? <i>If possible</i> , (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Are open containers labeled with expiration date? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is food stored away from soiled areas & rust? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Are there any expired items (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is food stored to allow for ventilation? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is the locking mechanism on the door in proper working condition? PE.04.01.01 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))
☐	☐	Is food stored to allow for ventilation? (HAP NPG.12.01.01, EP 8: 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is staff aware of how to use safety process/mechanisms in an emergency? (HAP HR.11.01.01, EP 1, 482.28(a)(3)) (CAH HR.11.01.01 EP 1)

DRY STORAGE					
YES	NO		YES	NO	
☐	☐	Are there any expired items ? HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is the area clean, dry, & well ventilated? <i>This will help with humidity and prevent growth of mold/bacteria.</i> PE.04.01.01 EP 3 (HAP 482.41(d)(4)) (CAH 485.623(b)(5))
☐	☐	Are canned goods properly sealed? HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Is food stored away from sources of heat/light? <i>This helps preserve shelf life.</i> (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1))
☐	☐	Does the kitchen have food storage items/plans for disaster preparedness ? A 96-hour stockpile isn't required for emergency operations. The kitchen should have a role in response to an event, & it should correspond with the organization's Emergency Operations Plan. EM.12.01.01 EP 34	☐	☐	Are food containers stored off the floor & away from walls to allow for adequate circulation? e.g., 6" above floor, protected from splashes. <i>There is no requirement for a solid bottom shelf for storage of food or cooking equipment. The HCO determines how such containers will be protected from splash, etc. Use of solid bottom shelving is an example of a strategy that would be used.</i> (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)

FOOD PREP ASSESSMENT - Interview		
NO		

☐	Foodborne illness: does the organization take prevention measures? Question if cases have occurred/been resolved. IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))	Advanced: Ask about ladle size & how to determine appropriate proportions.
☐	Sick employees or those with open wounds; is there a procedure for them? <u>Open wounds observed:</u> (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)) or IC.06.01.01 EP 5 (<u>procedures</u> to manage employees with acute illnesses that may be transmitted in the workplace) (HAP 482.42(a)(3)) (CAH 485.640(a)(3))	Advanced: Conduct HAZMAT tracer for corrosive lime-a-way used for decalcifying automated dishwashers. Assess adequacy of eyewash station, PPE usage, SDS, staff knowledge, etc.
☐	Thawing food; is there a process? <i>Validate the staff is following the process during observation. Food should not be thawing at room temperature & can be thawed under cold running water or the refrigerator.</i> (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	

FOOD PREP ASSESSMENT - Observation					
YES	NO		YES	NO	
☐	☐	Hand hygiene during food prep; is staff using proper practices to prevent contamination of food and food surfaces, e.g., <i>washing after touching face or hair</i> IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3))	☐	☐	Monitor food temp checks for hot, cold and pre-cooked items undergoing the cooling process. <i>Food should be cooled to 70° within 2 hours & to 41° within 4 & total cooling time should not exceed 6 hours.</i> (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Is hand washing facilities separate from the ones used for food prep? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Review temp logs – did staff maintain logs for each service during food prep? Is the process for monitoring temps in alignment with food code? <i>Temps are usually logged at start, midpoint & end if meal service is extended. Ensure adequate process for Potentially Hazardous Foods (PHF) and Time/Temp Controlled for Safety (TCS) Foods</i> (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)
☐	☐	Gloves: do staff use when appropriate to prevent contamination? e.g., <i>handling raw meat or ready-to-eat foods?</i> (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)			

☐	☐	Hair nets; are all staff members wearing? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	Final cooking temps should be as follows: (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)		
☐	☐	Cutting boards/prep surfaces; are they cleaned and sanitized properly to avoid contamination? E.g., one for meat, one for veggies & sanitized between uses IC.06.01.01 EP 3 (HAP 482.42(a)(3)) (CAH 485.640(a)(3)) Does the staff use clean utensils with bulk foods/ice? (HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)	☐	☐	Poultry - 165° Ground meat, ground fish, eggs - 155° Fish & other meat - 145° Precooked, cooled, then reheated - 165° Hot food hold temp - 135° or higher Cold food hold temp - 41° or below
☐	☐	Evaluate dishwasher temps/chemical monitoring processes PE.04.01.05 EP 3 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))	☐	☐	

FREEZER For food storage (HAP NPG.12.01.01, EP 8, 482.28(a)(1)(ii)) (CAH NPG.11.04.01 EP 1)					
YES	NO		YES	NO	
☐	☐	Freezer temps: have they been monitored?	☐	☐	Is the freezer free of any ice buildup? PE.04.01.05 EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))
☐	☐	Is frequency of checks & temp limits maintained as per policy? <i>Temps should ensure that food remains solid.</i>	☐	☐	Are items labeled appropriately with expiration dates ? <i>There should be no expired items</i>
☐	☐	Is there a process if the temp is inadequate? <i>If possible, validate the process was followed.</i>	☐	☐	If there is pre-cooked food , is the cooling process sufficient? <i>See refrigerator note above</i>
☐	☐	Is food stored away from soiled areas and degradation?	☐	☐	Is the locking mechanism on the door in proper working condition? PE.04.01.01, EP 2 (HAP 482.41(d)(2)) (CAH 485.623(b)(1))
☐	☐	Is food stored to allow for ventilation?	☐	☐	Is there a process/mechanism in place to prevent staff from being locked in? Can the mechanism be accessed, and is it in working order? <i>It shouldn't be blocked or have any ice buildup.</i>
☐	☐	Is the freezer free from any signs of freezer burn/food discoloration ?			

☐	☐	Are raw foods stored properly? <i>There should be no signs of them dripping on other foods.</i>	☐	☐	Is staff aware of how to use safety process/mechanism in emergency? (HAP HR.11.01.01, EP 1, 482.28(a)(3)) (CAH HR.11.01.01 EP 1)
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To be Completed by Life Safety Code Surveyor

LIFE SAFETY					
YES	NO		YES	NO	
☐	☐	Is the kitchen in good repair? e.g., lack of broken floor tiles, delamination, flaking walls, etc. PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Are the gaskets intact for kitchen entry/delivery doors to prevent entry from pests? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))
☐	☐	Do sprinkler heads have adequate 18" clearance? <i>Ensure racks perpendicular to walls do not encroach 18" open space for sprinklers. NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3</i> PE.03.01.01 EP 3 (HAP 482.41(b)(2)) (CAH 485.623(c)(1)(i))	☐	☐	Eyewash/shower station ; if required, is it in good working order & located away from hazards? PE.02.01.01 EP 4
Evaluate sprinkler head obstructions in BOTH refrigerators & freezers. Be wary of surface mounted fluorescent light fixtures close to sprinkler heads as this does not follow the 18" rule. <i>Refer to attachment for specific criteria.</i>			☐	☐	Can staff access eyewash station within 10 seconds of hazardous material storage/usage area? PE.02.01.01 EP 4
			☐	☐	Has the eyewash inspection log been kept up to date? PE.02.01.01 EP 4
☐	☐	Soda fountain machine : is the CO2 secured? PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	Natural gas : does the organization use this?
☐	☐	Are floor drains clear and not backed up? PE.01.01.01 EP 1 (HAP 482.41(a)) (CAH 485.623(a))	☐	☐	Is a gas valve accessible for emergency shutoff & do staff know its location/operation? PE. 04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐		☐	☐	Is emergency shutoff valve properly labeled? PE.04.01.01 EP 1 (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	Deep fat fryer ; is there a K fire extinguisher within 30'? <i>NFPA 96–2011 10.10.1; NFPA 10–2010, 6.6.1; 6.6.</i> PE.03.01.01 EP 3	Evaluate the hood system		
☐	☐		☐	☐	Is the hood clean with no grease buildup? <i>NFPA 96–2011 11.6.2</i> PE.03.01.01 EP 3 (HAP 482.41(b)(1)(i))

		(HAP 482.41(b)(1)(i)) (CAH 485.623(c)(1)(i))			(CAH 485.623(c)(1)(i))
☐	☐	Deep fat fryer: is it installed with at least a 16" space between the fryer & surface flames from adjacent cooking equipment? <i>NFPA 96-2011 12.1.2.4</i> <u>PE.03.01.01 EP 3</u> (HAP 482.41(b)(1)(i)) (CAH 485.623(c)(1)(i))	☐	☐	Are the steel filter baffles all installed with no gaps & are they in the proper direction? <i>NFPA 96-2011 6.2.3.1; 6.2.3.5</i> <u>PE.03.01.01 EP 3</u> (HAP 482.41(b)(1)(i)) (CAH 485.623(c)(1)(i))
☐	☐	K fire extinguisher placard identifying need to activate the fixed suppression (ansul) system before using the extinguisher? <i>NFPA 96-2011 10.2.2</i> <u>PE.03.01.01 EP 3</u> (HAP 482.41(b)(1)(i)) (CAH 485.623(c)(1)(i))	☐	☐	Is grease producing equipment located properly under the hood? <i>NFPA 96-2011 5.2</i> <u>PE.03.01.01 EP 3</u> (HAP 482.41(b)(1)(i)) (CAH 485.623(c)(1)(i))
☐	☐	Suppression system: does staff know how to use it? <i>Instructions for manual operations should be conspicuously posted & reviewed by staff. NFPA 96-2011 11.1.4</i> <u>PE.03.01.01 EP 4</u> (HAP, 482.41(b)(5)) (CAH 485.625(d)(1)(i))	☐	☐	Are extinguishing heads pointed properly toward the cooking surface? <u>PE.03.01.01 EP 3</u> (HAP 482.41(b)(2)) (CAH 485.623(c)(1)(i))
			☐	☐	Electrical panels; are they clear from obstruction? <i>There should be 36"</i> <u>PE.04.01.01 EP 1</u> (HAP 482.41(c)) (CAH 485.623(d))
☐	☐	Compressed gas cylinders: are they properly secured? <i>NFPA 99-2012 11.3; 11.6.2.3</i> <u>PE.04.01.01 EP 1</u> (HAP 482.41(c)) (CAH 485.623(d))	☐	☐	Fire Evacuation & Relocation Plan; is the staff knowledgeable? <i>NFPA 101-2012: 18/19.7.1; 7.2</i> <u>PE.03.01.01 EP 4</u> (HAP, 482.41(b)(5)) (CAH 485.625(d)(1)(i))

HAP/CAH SPG 2026 – Building Tour Guidance Document

MAIN Fire Alarm Control Panels	
• If panel is not working/in trouble without staff knowledge	PE.04.01.01 EP 2
• Installed in properly protected area	PE.03.01.01 EP 3
MAIN Piped Medical Gas Panels	
• Working condition of main medical gas alarm panels (i.e., trouble indications)	PE.04.01.01 EP 2
• Not at a continuously attended location (e.g., PBX, ED, etc.)	PE.04.01.01 EP 1
Bulk Oxygen/Medical Gas Tank Farm or Main Medical Gas Storage Area	
• Condition of equipment – status, open valves, piping, tanks flexible attached connections	PE.04.01.01 EP 2
• Storage configuration and labeling (i.e., cylinder, precautionary room/are signage, full/empty)	PE.04.01.01 EP 1
• Outdoor storage (weather protection for outside cylinders)	PE.04.01.01 EP 1
• Proper labeling and accessibility of main control and source valves	PE.04.01.01 EP 1
• Testing piped medical gas and vacuum systems and oxygen supply connection	PE.04.01.01 EP 1, EP 2
OR Suite - Done early in the survey to allow the organization time to correct while on site. The review of corrective action must include documentation that other areas supplied by same air handler were not negatively impacted by corrective work	
• Pressure relationships (check during survey), air exchange rates (balance reports)	PE.04.01.01, EP 3 (Critical and non-critical)
• Temperature/humidity levels	PE.04.01.01 EP 3
• Surgical fire prevention activities	PE.04.01.01 EP 1
MAIN Engineering Locations – boilers, chillers, electrical distribution hub	
• Equipment - leaks, general maintenance issues, equipment out of service (ask about risk to patients)	PE.04.01.01 EP 2
• Room - rated wall separation, penetrations, opening protection, fireproofing damage	PE.03.01.01 EP 3
• Minimal storage in Air Handling Control rooms (i.e., only AHU filters)	PE.03.01.01, EP3
• Eye wash station (and shower if required)	PE.02.01.01, EP 4
• Open J-boxes	PE.04.01.01 EP 2
All Generators	
• Overall condition/readiness of the generators - is it on auto start? Oil and coolant leaks, clearances, check how batteries are maintained, amount of fuel on hand, cold weather protection	PE.04.01.03 EP 3
• Battery powered task lighting lacking	PE.04.01.01 EP 3
• Room – rated wall separations, sealed penetrations, opening protection, fireproofing damage	PE.03.01.01 EP 3
• Sprinkler/heat detectors (if required)	PE.03.01.01 EP 3
• Open J-boxes	PE.04.01.01 EP 2
• Remote annunciator alarm panel - continuously attended location (e.g., PBX, ED)	PE.04.01.01 EP 3
Automatic Transfer Switches	
a. Explore ATS's (inventory circuit diagrams, interview)	PE.04.01.01 EP 1

	PE.03.01.01 EP 3
Fire Pump(s)	
a. Equipment overall condition/readiness of the fire pump – status, valves supervised/secure, leaks	PE.04.01.01 EP 2
b. Room condition – rated separation, opening protective	PE.03.01.01 EP 3
c. Check Fire Pump ATS in “auto”	PE.04.01.01 EP 1
Kitchen	
a. Sprinkler head clearance over high storage	PE.03.01.01 EP 3
b. “K” extinguisher distance with signage; staff knowledge on proper use	PE.03.01.01 EP 3
c. Range hood extinguishing system – direction of nozzles, cleanliness, proper placement of filters	PE.03.01.01 EP 3
d. Ansul Systems activates fire alarm system	PE.03.01.01 EP 3
e. Fuel source disconnects upon activation of the Ansul system	PE.03.01.01 EP 3
f. Storage configurations – separate storage rooms or open to kitchen if allowed by code exceptions	PE.03.01.01 EP 3
g. Sprinkler heads – condition, in refrigerators/freezers (if required)	PE.03.01.01 EP 3
Main Entries/Lobby	
a. Missing “No smoking” signage	PE.03.01.01 EP 3
b. Canopy sprinkler coverage	PE.03.01.01 EP 3
c. Exit doors acceptable locking arrangements, emergency break open features	PE.03.01.01 EP 3
d. Main entrance not obstructed or blocked	PE.03.01.01 EP 3
Construction Areas	
a. Verify implementation of ILSMs at demolition, construction and renovation locations within the facility	PE.03.02.01 EP 1
Loading Dock and Receiving Dept.	
a. Proper safety features on compactor	PE.01.01.01 EP 1
b. Sprinkler head clearance over high storage	PE.03.01.01 EP 3
Roof	
a. Water ponding under air intakes; clogged bird screens on air intakes	PE.04.01.01 EP 2
b. Roof access hatch or doors must be secured (unless part of roof egress)	PE.03.01.01 EP 3
c. Egress from roof unlocked in direction of egress	PE.03.01.01 EP 3
Empty Patient Rooms	
a. Call lights, blocked doors/damages, damaged medical gas outlets, oxygen tanks not in stands	PE.04.01.01 EP 2 PE.01.01.01 EP 1
b. Areas clean, excessive wall/ceiling damage	PE.01.01.01 EP 1, 3
c. Furniture safe and in good repair	PE.01.01.01 EP 2
Exit Stairs, Rated Exit Passageways, Exterior Discharge Areas	
a. Proper construction – walls/decks and opening protective	PE.03.01.01 EP 3
b. Proper door labeling; operation	PE.03.01.01 EP 3
c. Clearances/obstructions	PE.03.01.01 EP 3
d. Interior exit lighting and signage	PE.03.01.01 EP 3
e. Locking configurations	PE.03.01.01 EP 3
f. Stair not used as a chase for utilities serving other areas	PE.03.01.01 EP 3
g. Exterior public discharge surfaces and two sources lighting	PE.03.01.01 EP 3
Smoke Barriers	
a. Above-the-ceiling – smoke dampers, type and condition of penetration sealant; fireproofing damage; no support from fire sprinkler pipes; no open junction boxes	PE.03.01.01 EP 3
b. Below-the-ceiling – Automatic door closers, door coordinators, door clearances/undercuts	PE.03.01.01 EP 3

Two-hour Rated Barriers	
a. Above-the-ceiling – fire dampers, type and condition of penetration sealant; fireproofing damage; no support from fire sprinkler pipes; no open junction boxes	PE.03.01.01 EP 3
b. Below-the-ceiling – door latching, door rating labels, protective plate heights, door undercuts	PE.03.01.01 EP 3
Hazardous Areas	
a. Above-the-ceiling (if not sprinklered) - walls, penetrations; fireproofing damage; no support from sprinkler piping; no open junction boxes	PE.03.01.01 EP 3
b. Below-the-ceiling - sprinkler head clearances, door latching, door rating labels, protective plate heights (non-sprinkler), door undercuts, storage limitations	PE.03.01.01 EP 3
c. As applicable, check for proper eye wash units	PE.02.01.01, EP 4
Corridors	
a. Above-the-ceiling (non-sprinkler): Corridor walls to underside of deck above a, penetrations sealed; no fireproofing damage; no support from sprinkler pipes; no open junction boxes	PE.04.01.01 EP 1 PE.03.01.01 EP 3
b. Below-ceiling: Corridor door latching, door undercuts: maximum 6 inches projections, corridor clutter; exit lighting and signage	PE.03.01.01 EP 3
c. Medical gas shut-offs zone valves (labeling, access, signage)	PE.04.01.01 EP 1
Alcohol-based Handrub Dispensers (ABHRs) PE.03.01.01, EP 3	
ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: - Corridor is at least 6 feet wide. - Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. - Dispensers shall have a minimum of four foot horizontal spacing. - Not more than an aggregate of 10 gallons of fluid or 1135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. - Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30. - Dispensers are not installed within 1 inch of an ignition source. - Dispensers over carpeted floors are in sprinklered smoke compartments. - ABHR does not exceed 95 percent alcohol. - Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). PE.03.01.01 EP 7 - ABHR is protected against inappropriate access per 18.3.2.6, 19.3.2.6,	
Electrical Closets	
a. Storage blocking panels	PE.04.01.01 EP 1
b. Properly sealed floor, ceiling penetrations if not a shaft properly sealed wall penetrations if a shaft	PE.03.01.01 EP 3
c. Check sub-electrical panel schedules to see if they correct	PE.04.01.01 EP 1
d. Open junction boxes	PE.04.01.01 EP 1
Various Indoor Air Quality Locations Areas	
a. Sterile supply, endoscopy, bronchoscopy, cath labs	PE.04.01.01 EP 3
b. Isolation rooms	PE.04.01.01 EP 3
c. Special storage spaces with hazardous materials	PE.04.01.01 EP 3

HAP/CAH Construction Building Tour Tool

Scope: Life Safety Code Surveyors will evaluate any open construction projects within occupied health care buildings. For projects that are not within occupied buildings, surveyors would only evaluate there are no safety/security concerns (item #3). Note that construction deficiencies can be serious in nature depending on the location and scope of the construction project, adjacent areas that could be impacted, and how long it has been out of compliance.

Area of Evaluation		Scoring Guidance
1. Posting of Documentation and Risk Evaluations		
- Ensure notification of construction project is posted on entrance and doors connected to project with relevant safety information/contact information per HCO policy. - Ensure ICRA/ILSM/PCRA (see below) are posted, or some notification of where safety evaluations are documented.		PE.01.01.01.EP1 for ICRA/PCRA 482.41(a) HAP or 485.623(a) CAH PE.03.02.01.EP1 for ILSM
2. Risk Mitigation Evaluation and Documentation		
- Review Mitigation Evaluation processes are completed and appropriate based on scope of project. These should be approved and signed off by appropriate stakeholders: - Infection Control Risk Assessment (ICRA) - Interim Life Safety Measures (ILSM) - Pre-Construction Risk Assessment (PCRA) - Review mitigation implementation based on the above evaluations and ensure organization compliance with mitigation. ILSM mitigation needs to be documented! - Review signage, training logs, fire watches, rounding, fire drills and any documentation associated with mitigation strategies.		PE.01.01.01.EP1 for ICRA/PCRA 482.41(a)/485.623(a) PE.03.02.01.EP1 for ILSM evaluation and implementation. Use EPs 2-15 if not following those requirements.
3. Safety and Security		
- Review PCRA mitigation for any specific security and safety concerns - Ensure construction areas doors are secured. - Ensure no tools or unsafe conditions are accessible to the public. - Ensure any motorized or heavy equipment is either secured or under supervision when not secure or being utilized.		PE.01.01.01 EP 1 482.41(a) HAP 485.623(a) CAH
4. Construction Barriers		
- Evaluate integrity of barriers per ICRA and ILSM - Evaluate if hot work or major demolition is occurring, and if barrier is sufficient per NFPA 241-2009 with a 1-hour fire rated barrier. Hot work includes any open-flame work that can create embers or sparks.		PE.03.01.01 EP 3 482.41(b)(1)(i) HAP 485.623(c)(1)(i) CAH
Evaluating the barrier is clean outside and fully intact		PE.01.01.01 EP 1 see above
Evaluate anterooms if utilized.		PE.01.01.01.EP 1 see above
Evaluating pressure of the space at the barrier and/or anteroom are negative to adjacent occupied spaces.		PE.04.01.01 EP 3 482.41(d)(4) HAP 485.623(b)(5) CAH
Evaluate areas around barrier for construction debris/dust.		PE.01.01.01 EP 3 482.41(a) HAP or 485.623(a) CAH
5. Fire Protection		
- Evaluate that fire protection outside the construction area is not impacted negatively: - Obstructed or impaired sprinklers - Obstructed or impaired smoke/heat detectors - Obstructed or impaired audio/visual devices - Observe egress paths for clearance and signage		PE.03.01.01 EP 3 482.41(b)(1)(i) HAP 485.623(c)(1)(i) CAH
- Evaluate fire protection inside the construction area for the following: - Alternate fire alarm installed in the space to meet building requirements (recommend heat detectors). - Alternate fire suppression in the space to meet building requirements (sprinkler installed and turned up if ceiling removed) - Fire extinguishers are installed per distance requirements of NFPA 10 (every 75 ft) and hot work requirements and mounted and maintained (monthly/annual ITM). - Fire and smoke barriers (both vertical and horizontal) are maintained and if impacted appropriate mitigation in place (should be evaluated in ILSM). - Ensure egress (if through construction area) has been thought out and maintained.		PE.03.01.01 EP 3 for Life Safety Features See above PE.03.02.01.EP 1 for ILSM requirements

HAP/CAH Hyperbaric Facility Building Tour Tool

Area of Evaluation		Scoring Guidance
Construction and Separation		
If mobile hyperbaric chamber is contiguous to a facility, they must have 2-hour fire-resistive-rating barrier between the mobile equipment and the facility. (NFPA 99, 2012; 14.2.1.1.4)		PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
EOSC and in building emergency reserve		
- NFPA 99, 2012; 14.2.1.4.4.2, <i>Central Supply Systems</i>, states that oxygen systems must comply with NFPA 99, 2012; 5.1.35, EXCEPT the following items do not have to be installed: - Emergency oxygen supply connection is NOT required for the hyperbaric oxygen system. - In building emergency reserve is NOT required for the hyperbaric oxygen system.		If EOSC is required based on NFPA 99-2012 Chapter 5, then score at PE.04.01.01 .EP 1 482.41(c) HAP 485.623(d) CAH
Electrical Systems		
a. All hyperbaric facilities shall contain an electrical service that is supplied by two independent sources of electric power. b. Hyperbaric Facilities that use generator power shall utilize the life safety and critical branches and meet requirements of those branches per NFPA 99 Chapter 6. c. A continuous ground shall be maintained between all conductive surfaces and the chamber hull using approved means.		PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
Safety		
- Each hyperbaric facility shall designate an on-site hyperbaric safety director to oversee all hyperbaric equipment and the operational safety requirements. (NFPA 99, 2012; 14.3.1.3.2) - The safety director shall participate with facility management personnel and the hyperbaric physician(s) in developing procedures for operation and maintenance of the hyperbaric facility. (NFPA 99, 2012; 14.3.1.3.2.1)		PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
Medical Air Systems		
Where medical systems are installed for hyperbaric use, the hyperbaric medical air MUST be a separate zone. (NFPA 99, 2012; 14.2.1.6.1)		PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
Hyperbaric chamber MUST have a shut off valve installed at the entry point of the room. (NFPA 99, 2012; 14.2.1.3.2)		PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
Area and master alarms are NOT required in non-acute care areas.		Not Applicable
Proper labeling and accessibility of main control and source valves. (NFPA 99, 2012; 5.1.11, 5.1.11.2.1)		PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
Annual testing of piped systems.		PE.04.01.01 EP 2 482.41(d)(2) HAP 485.623(b)(1) CAH
Fire Protection		
Fire extinguisher is located within the space housing the hyperbaric chamber.		PE.03.01.01 EP 3 482.41(b)(1)(i) HAP 485.623(c)(1)(i) CAH
Electrical switches, valves, and electrical monitoring equipment associated with fire detection and extinguishment shall be visually inspected before each chamber pressurization. (NFPA 99, 2012; 14.3.6.3.1) This inspection shall be documented.		PE.04.01.01 EP 2 482.41(d)(2) HAP 485.623(b)(1) CAH
The deluge and handline systems shall be functionally tested at least semiannually per 14.2.5.2.7 for deluge systems and 14.2.5.3.7 for handline systems.		PE.04.01.01 EP 2 482.41(d)(2) HAP 485.623(b)(1) CAH
The fire response plan did not include procedures for both fires within and outside the hyperbaric chamber. (NFPA 101 2012 18/19.7.1; 7.2)		PE.03.01.01 EP 4 482.41(b)(5) HAP 485.625(d)(1)(i)

• Class “A” (Multiple patients in one chamber). Trailer or vehicle-mounted facilities that are NOT contiguous to a health care facility MUST conform to one of the following (NFPA 99, 2012; 14.2.5.1.4.1): ○ Have a fire alarm signaling device at the chamber operator’s control console for contacting the emergency operations center of the facility which is using the equipment. ○ Have a means for immediately contacting the local fire department directly.	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
• Emergency procedures and fire training drills must be conducted annually and documented by the safety director. (NFPA 99, 2012; 14.3.1.4.5) Note: <u>Reference NFPA 99, 2012: B.14.2 and 3 for suggested procedures to follow in event of fire.</u>	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
• The time required to evacuate all persons from a hyperbaric area with a full complement of chamber occupants all at treatment pressure shall be measured annually during the fire training drill required by 14.3.1.4.5. (NFPA 99, 2012: 14.2.4.5.4)	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
• Class “B” (Single-occupancy chamber). ○ MUST have signs prohibiting flammable liquids and/or gases at the entrance(s) to the chamber. (NFPA 99, 2012; 14.2.6.1) ○ MUST have a local fire alarm device within the room housing the chamber(s). (NFPA 99, 2012; 14.2.6.2) ○ Trailer or vehicle-mounted facilities that are NOT contiguous to a health care facility MUST conform to one of the following (NFPA 99, 2012; 14.2.6.2.1): 1. Have a fire alarm device within the room housing the chamber(s) connected to building fire alarm system. 2. Have a means for immediately contacting the fire department directly. ○ Emergency procedures and fire training drills must be conducted annually and documented by the safety director. (NFPA 99, 2012; 14.3.1.4.5) Note: <u>Reference NFPA 99, 2012: B.14.2 and 3 for suggested procedures to follow in event of fire.</u>	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
Furniture containing rubber	
• Any furniture containing rubber shall be inspected as part of the routine maintenance program of the facility, especially at points of kinking. (NFPA 99, 2012; 14.3.6.2.3) Note: A.14.3.6.2.3 reads: “<i>materials containing rubber deteriorate rapidly in oxygen-enriched atmospheres.</i>”	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
Housekeeping/Textiles	
• A housekeeping program shall be implemented, whether the facility is in regular use or not. (NFPA 99, 2012; 14.3.6.4)	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
• Housekeeping personnel MUST be trained in the following (NFPA 99, 2012; 14.3.6.4.1): ○ Potential damage to equipment from cleaning procedures. ○ Potential personal injury. ○ Specific cleaning procedures. ○ What equipment needs to be cleaned. Note: A.14.3.6.4 reads: “<i>it is absolutely essential that all areas of, and components associated with, the hyperbaric chamber be kept meticulously free of grease, lint, dirt, and dust.</i>”	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH
• Silk, wool, or synthetic textile materials, or any combination thereof, shall be prohibited in Class A or Class B chambers. (NFPA 99, 2012; 14.3.1.5.4.1) Note exception: “<i>Garments fabricated of 100 percent cotton or a blend of cotton and polyester fabric shall be permitted in Class A chambers equipped with fire protection as specified in 14.2.5 and in Class B chambers.</i>” (NFPA 99 2012; 14.3.1.5.4.2)	PE.04.01.01 EP 1 482.41(c) HAP 485.623(d) CAH

HAP/CAH Business Occupancy Building Tour Guidance

This guidance is intended for the following types of occupancies/settings:

- Business occupancy locations***
- Ambulatory Surgical Centers (ASC's) that are not deemed and have less than 4 patients that are incapable of self-preservation

***This guidance does not apply to deemed ASCs and free-standing emergency departments.

New Occupancy: Building design approved after July 5, 2016.

Existing Occupancy: Building design approved before July 5, 2016

Topic	Notes	Business Occupancy Scoring Location
Facility Orientation		
Fire Alarm System	If building has fire alarm system, check that it is functioning.	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Sprinkler System/Fire Pump	If building has fire pump, check that it is functioning or ready to operate. If no fire pump, ensure sprinkler valves are open.	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Means of Egress		
Locked exits	Look for exit doors that are locked or delayed that would impact exiting the building. If there is delayed egress, test the delayed egress hardware to ensure it releases in time frame posted on the door (no more than 30 seconds max).	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Illumination	- Continuous when occupied -Is the path of egress well lit, including outside the building at the point of discharge and to the public way?	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Emergency Lighting	39.2.9 Existing: Emergency Lighting. 39.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9 in any building where any one of the following conditions exists: (1) The building is three or more stories in height. (2) The occupancy is subject to 100 or more occupants above or below the level of exit discharge. (3) The occupancy is subject to 1000 or more total occupants.	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH

Topic	Notes	Business Occupancy Scoring Location
	38.2.9 New: Emergency Lighting. 38.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9 in any building where any one of the following conditions exists: (1) The building is three or more stories in height. (2) The occupancy is subject to 50 or more occupants above or below the level of exit discharge. (3) The occupancy is subject to 300 or more total occupants. 38.2.9.2 Emergency lighting in accordance with Section 7.9 shall be provided for all underground and limited access structures, as defined in 3.3.271.11 and 3.3.271.3, respectively *Note: 7.9 requires that emergency lighting provide illumination for at least 90 minutes.	
Battery back-up	If battery back-up lights exist, are they functional and being tested on monthly/ annual basis? Note: Refer to NFPA 101-2012 for battery powered emergency egress testing requirements.	PE.04.01.01, EP 1 482.41(c) HAP or 485.623(d) CAH
Corridor widths	The clear width of any corridor or passageway serving an occupant load of 50 or more shall be not less than 44 in.	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Visible exit signs	Look to see there are exit signs that are visible to direct occupants out of the building. Exit signs should be located at any egress point where the egress path is uncertain.	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Utilities		
Junction Boxes	Observe open ceiling areas, such as electrical closets and mechanical spaces for open electrical junction boxes that have the cover removed.	PE.04.01.01, EP 2 482.41(d)(2) HAP or 485.623(b)(1) CAH

Topic	Notes	Business Occupancy Scoring Location
Electrical Outlets	Ground fault circuit interrupters (GFCI) should be installed in kitchens, bathrooms, and any electrical outlets located within 6 ft of sinks.	PE.04.01.01, EP 2 482.41(d)(2) HAP or 485.623(b)(1) CAH
Electrical Panel	Electrical panels should be protected from unauthorized access (examples include, locking, environmental controls, or staff observation).	PE.04.01.01, EP 1 482.41(c) HAP or 485.623(d) CAH
	Verify that panel legends are accurate and circuit breakers in panels are identified on the panel legend. Spare breakers should be in the “off” position.	PE.04.01.01, EP 1 482.41(c) HAP or 485.623(d) CAH
Medical Equipment	- Review medical equipment inventory - Has the equipment on the inventory been identified as high risk or non-high risk? - Is equipment maintenance being performed using manufacturer instructions for use (IFU) or alternative equipment maintenance (AEM) program If AEM is being used, refer to section 482.41(d)(2) in the Physical Environment Module for 482.41. -Is the organization performing inspection, testing, and maintenance per IFU or AEM?	PE.04.01.01, EP 2 482.41(d)(2) HAP or 485.623(b)(1) CAH
Ventilation	Evaluate high risk ventilation areas only: Operating Rooms, isolation rooms, sterile Processing Clean and Decon areas for pressure only.	PE.04.01.01, EP3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Fire Extinguishers		
Inspection	Verify that fire extinguishers are inspected monthly and maintained annually. This is documented on the tag or electronically.	PE.04.01.01, EP 2 482.41(d)(2) HAP or 485.623(b)(1) CAH
Mounting and Visibility	Verify that fire extinguishers are: - Properly mounted at a height between 4” and 60” off the floor - Extinguishers must be clearly visible in the path of egress or be identified by signage. If	PE. 03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH

Topic	Notes	Business Occupancy Scoring Location
	located in concealed cabinets, there must be signage. - Extinguishers should be accessible within 75 feet of any location	
MRI	In MRI locations, verify that a non-ferrous fire extinguisher is installed in the area.	PE. 03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Hazardous Areas/Materials		
Biohazardous and Pharmaceutical Waste	- Ensure that biohazard waste is stored in proper containers with proper labeling - Ensure that sharps containers are locked and not overfilled - Ensure that biohazard and pharmaceutical waste is stored so the public cannot access while awaiting pickup.	PE.02.01.01, EP 4 No CoP PE.02.01.01, EP 6 No CoP
Alcohol-based hand rub (ABHR) Dispensers	Verify the following: - ABHR dispensers are not directly over outlets - Corridor width of 44 inches is not compromised by dispensers - ABHR does not exceed 95% alcohol - Maximum individual dispenser capacity is 0.32 gallon of fluid (0.53 gallon in suites or rooms separated from corridors) or 18 ounces of NFPA Level 1–classified aerosols - Dispensers have a minimum of four feet of horizontal spacing between them - Dispensers are not installed within one inch of an ignition source - Operation must comply with the manufacturer’s instructions for use. - ABHR is protected against inappropriate access - Not more than an aggregate of 10 gallons of fluid or 135 ounces of aerosol are used on a single story or in a single fire compartment outside a storage cabinet, excluding one individual dispenser per room	PE.03.01.01, EP 7 For ABHR installation and location issues, score: PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH For inappropriate access issues, score: PE.03.01.01, EP 7 482.41(b)(7) HAP or 485.623(c)(5) CAH

Topic	Notes	Business Occupancy Scoring Location
	- Storing more than five gallons of fluid on a single story or in a single fire compartment complies with NFPA 30	
Safety Data Sheets (SDS)	Does the organization have an inventory of their hazardous materials (chemicals, medications, cleaning materials, etc.)? Do staff have access to SDS for any hazardous chemicals on their inventory? If the organization uses electronic SDS, is there a way for employees to access SDS during computer downtime?	For no inventory, score: PE.02.01.01, EP 1 No CoP For no SDS sheets or access, score PE.02.01.01, EP 2 No CoP
Eye Wash Stations	-Are there chemicals being used that require eye wash per SDS? -Is there a mixing valve on the eye wash station if need to maintain tepid temperature 60 – 100 degrees? -Can the eye wash be reached within 10 secs (approximately 55 feet) without going through a doorway? -Is there eye wash testing documentation?	PE.02.01.01, EP 4 No CoP
Storage Rooms	Any rooms used for general storage, furnaces, boilers, and maintenance rooms must be protected by one of the following: - – A one-hour fire barrier, Or - Sprinklers <i>*For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited on these doors.</i>	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Medical Gas Cylinders		
Cylinder Storage	- Are cylinders secured? - For rooms with storage of more than 300 cubic feet (12 E oxygen cylinders or more),	PE.04.01.01, EP 1 482.41(c) HAP or 485.623(d) CAH

Topic	Notes	Business Occupancy Scoring Location
	the room needs to secure and be of non-or limited-combustible construction. (do not count cylinders in use/mounted to equipment) - Rooms with more than 300 cubic feet of medical gases must have signage per NFPA 99-2012.	
Sprinklers		
Sprinkler Heads/ System	Make sure sprinkler heads are not obstructed by items suspended from the ceiling or mounted to the floor. See NFPA Chapter 8 guidance for additional information. Ensure curtains mounted to the ceiling have at least 18” of curtain mesh. Sprinkler heads are not obstructed (18” rule) Sprinkler heads are not damaged/dirty, escutcheon plates are installed	PE.03.01.01, EP 3 482.41(c) HAP or 485.623(d) CAH
Fire Drills		
Fire Drills	Documentation of annual fire drill The fire drill does not require activation of the fire alarm or inclusion of all patients and visitors.	PE.03.01.01, EP 3 482.41(b)(1)(i) HAP or 485.623(c)(1)(i) CAH
Security		
Security Access	Can the public enter parts of the facility without authorization? Backdoors unsecured etc. Has the organization determined which areas are security sensitive? How is the organization controlling identified security sensitive areas?	NPG.11.01.01, EP 1 The hospital controls access to and from areas it identifies as security sensitive. No CoP

HAP/CAH Infection Prevention and Control Program Assessment Tool

Required Documents and Data

- Assessment of infection risks

Note: Performed at least annually, the format is determined by the hospital.

- Results of infection control surveillance

Note: Infection control surveillance includes surveillance of healthcare-associated infections (HAIs), such as data submitted to the National Healthcare Safety Network (NHSN) for Centers for Medicare & Medicaid (CMS) or State requirements, and data on any epidemiologically important organisms or infectious diseases that have impacted the hospital during the preceding 12 months.

- Infection prevention and control policies and procedures that guide program activities and methods (in electronic or paper form)
- Documentation of completed job-specific staff education, training, and competencies on infection control and prevention
- Program documents demonstrating that the problems identified by the infection prevention and control program have been reviewed and addressed in collaboration with the hospital's quality assessment and performance improvement leaders and other leaders (for example, the medical director, nurse executive, and administrative leaders).

Note: The format of this documentation is determined by the hospital. Examples may include relevant committee meeting agendas and minutes, presentations, reports, planning documents.

- Documentation demonstrating the governing body's oversight of the program implementation and performance (for example, governing body minutes)

Table: Elements of Compliance and Scoring Guidance

Elements of Compliance	Standard(s)/EP(s)
Infection Prevention and Control Program & Leader(s)	
1. An infection preventionist(s) or infection control professional(s) has been appointed by the hospital governing body, based on the recommendation of the medical staff and nursing leaders, and is qualified through education, training, experience, or certification.	NPG.12.01.01 EP 12
2. The hospital defines the qualifications for the infection preventionist(s) or infection control professional(s), which may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).	HR.11.02.01 EP 1
3. The infection preventionist(s)/infection control professional(s) perform the following activities in collaboration with all departments, programs, and areas involved in infection prevention and control activities: a. Development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to law and regulation and nationally recognized guidelines b. Documentation of the infection prevention and control program and its surveillance, prevention, and control activities c. Competency-based training and education of hospital staff, including medical staff and, as applicable, personnel providing contracted services on infection prevention and control policies and procedures and their application	IC.04.01.01 EP 2

d. The prevention and control of healthcare-associated infections and other infectious diseases, including auditing staff adherence to infection prevention and control policies and procedures Note: Auditing tasks may be delegated to the appropriate staff (for example, unit-based liaisons or leaders); however, if delegation occurs, the infection preventionist(s) or infection control professional(s) must be updated on the results of auditing activities e. Communication and collaboration with all components of the hospital involved in infection prevention and control activities, including but not limited to the antibiotic stewardship program, sterile processing department, and the water management program f. Communication and collaboration with the hospital's quality assessment and performance improvement program to address infection prevention and control issues Note: The outcome of competency-based training is the staff's ability to demonstrate the skills and tasks specific to their roles and responsibilities. Examples of competencies may include donning/doffing of personal protective equipment and the ability to correctly perform the processes for high-level disinfection (HLD). (For more information on competency requirements, refer to HR.11.04.01 EP 1)	
4. The infection prevention and control program reflects the scope and complexity of the hospital's services provided by addressing all locations, patient populations, and staff as evidenced by the following: a. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all staff providing patient care, treatment, or services. b. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all inpatient and outpatient care locations. c. The program's policies and procedures; prevention, control, and auditing activities; and job-specific competency-based training activities apply to all care, treatment, and services (for example, hemodialysis, HLD/sterilization, respiratory therapy, wound care, dietary services, and laundry services). d. The scope of surveillance is consistent with infection control standards of practice and the scope and complexity of the hospital's services. e. Policies and procedures address the special populations served by the hospital (for example, pediatric patients, patients undergoing bone marrow transplant, hemodialysis, etc.) f. New hospital locations, services, and areas (for example, new ambulatory sites) are incorporated into the infection prevention and control program activities.	IC.04.01.01 EP 5
Hospital Leadership Responsibility & Program Resources	

1. The governing body, or responsible individual, ensures that the infection prevention and control program is operational and resourced to carry out and track its activities through the following: a. Resources must be adequate to accomplish the tasks required for the infection prevention and control program. This includes the following: i. Allocating human resources to mitigate infection risks and prevent transmission of infections (for example, nursing and environmental services staffing must be adequate to carry out infection prevention and control activities). ii. Allocating material resources to mitigate infection risks and prevent transmission of infections, such as information technology, laboratory services, equipment, and supplies. iii. Allocating sufficient information resources to guide program activities, such as access to local, state, and federal public health authorities' advisories and alerts (for example, the CDC's Health Alert Network [HAN]; FDA alerts); access to manufacturers' instructions for use; access to any standards and guidelines required by applicable regulation and the guidelines and consensus standards chosen by the hospital to inform policies and procedures (for example, guidelines and standards from ASHRAE, FGI, SHEA, AAMI, AORN, APIC Text, etc.) b. The governing body, or responsible individual, is ultimately accountable for the implementation, success, and sustainability of the program activities, while the medical director, nurse executive, and administrative leaders provide additional leadership support for the program. c. Hospital policies address the roles and responsibilities for infection prevention and control program within the hospital and how the various hospital committees and departments interface with the infection prevention and control program (for example, how to report infectious/communicable disease issues to the infection prevention and control program).	IC.05.01.01 EP 1
2. The hospital's governing body ensures that the problems identified by the infection prevention and control program are addressed in collaboration with the hospital's quality assessment and performance improvement (QAPI) leaders, and other leaders (for example, the medical director, nurse executive, and administrative leaders) as evidenced by the following: a. The hospital's QAPI program addresses problems identified by the infection control leader(s). b. The hospital leaders, including the CEO, the medical staff leader, and the nurse executive, monitor adherence to corrective action plans, assess the effectiveness of actions taken, and verify the implementation of revised corrective actions as needed. c. The hospital's governing body, the medical staff leader, the nurse executive, and administrative leaders must ensure that staff in-service training programs address problems identified through the infection prevention and control program.	IC.05.01.01 EP 2

3. For hospitals that use Joint Commission accreditation for deemed status purposes: If a hospital is part of a hospital system consisting of separately certified hospitals using a system governing body that is legally responsible for the conduct of two or more hospitals, the system governing body can elect to have unified and integrated infection prevention and control and antibiotic stewardship programs for all of its member hospitals after determining that such a decision is in accordance with applicable law and regulation. The system governing body is responsible and accountable for making certain that each of its separately certified hospitals meet all of the requirements at 42 CFR 482.42(d). Each separately certified hospital subject to the system governing body demonstrates that the unified and integrated infection prevention and control program and the antibiotic stewardship program have the following characteristics: - Structured in a manner that accounts for each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital - Establish and implement policies and procedures to make certain that the needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration - Have mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed - A qualified individual(s) with expertise in infection prevention and control and in antibiotic stewardship has been designated at the hospital as responsible for communicating with the unified infection prevention and control and antibiotic stewardship programs, implementing and maintaining the policies and procedures governing infection prevention and control and antibiotic stewardship (as directed by the unified infection prevention and control and antibiotic stewardship programs), and providing education and training on the practical applications of infection prevention and control and antibiotic stewardship to hospital staff	LD.11.01.01 EP 10
Program Policies and Procedures	
1. The hospital's infection prevention and control program has written policies and procedures to guide its activities and methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings. The policies and procedures are in accordance with the following hierarchy of references: - Applicable law and regulation. Note: Relevant federal, state, and local law and regulations include but are not limited to the Centers for Medicare & Medicaid Services Conditions of Participation, the Food and Drug Administration (FDA) regulations for reprocessing single-use medical devices; Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard 29 CFR 1910.1030, Personal Protective Equipment Standard 29 CFR 1910.132, and Respiratory Protection Standard 29 CFR	IC.04.01.01 EP 3

1910.134; health care worker vaccination laws; state and local public health authorities' requirements for reporting of communicable diseases and outbreaks; and state and local regulatory requirements for biohazardous or regulated medical waste generators. - Manufacturers' instructions for use. - Nationally recognized evidence-based guidelines and standards of practice, including The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, or, in the absence of such guidelines, expert consensus or best practices. The guidelines are documented within the policies and procedures. Note 1: For full details on CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, refer to https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html. Note 2: The hospital determines which evidence-based guidelines, expert recommendations, or best practices, or a combination thereof, it adopts in its policies and procedures.	
2. The hospital's policies and procedures for cleaning, disinfection, and sterilization of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and sterilization of reusable medical and surgical devices in accordance with the Spaulding classification system and manufacturers' instructions Note: The Spaulding classification system classifies medical and surgical devices as critical, semi critical, or noncritical based on risk to the patient from contamination on a device and establishes the levels of germicidal activity (sterilization, high-level disinfection, intermediate and low-level disinfection) to be used for the three classes of devices. - The use of EPA-registered disinfectants for noncritical devices and equipment according to the directions on the product labeling, including, but not limited to, indication, specified use-dilution, contact time, and method of application - The use of FDA-approved liquid sterilants for the processing of critical devices and high-level disinfectants for the processing of semi critical devices in accordance with the FDA-cleared label and device manufacturers' instructions - Required documentation for device reprocessing cycles, including but not limited to sterilizer cycle logs, the frequency of chemical and biological testing, and the results of testing for appropriate concentration for chemicals used in high-level disinfection - Resolution of conflicts or discrepancies between a medical device manufacturer's instructions and manufacturers' instructions for automated high-level disinfection or sterilization equipment - Criteria and the process for the use of immediate-use steam sterilization - Actions to take in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up.	IC.04.01.01 EP 4
Risk Assessment	

1. The hospital identifies risks for infection, contamination, and exposure that pose a risk to patients and staff to prioritize program activities, including the following: a. The hospital includes risks from organisms with a propensity for transmission within health care facilities based on published reports and the occurrence of clusters of patients (for example, norovirus, respiratory syncytial virus ([RSV]), influenza, measles, and organisms with antimicrobial resistance such as Carbapenem-resistant Enterobacteriales ([CRE]), <i>Candida auris</i>). b. The hospital evaluates risk based on the geographical location and population it serves, for example, risk for exposure to tuberculosis (TB). c. The hospital includes community data in its risk assessment, for example, community-onset cases of multi-drug resistant organisms. d. The hospital evaluates risk based on the care, treatment, and services it provides, for example, the types of procedures, medical equipment, devices, and supplies used. e. The hospital examines the risk of potential exposure to infectious materials, blood, body fluids, secretions, or excretions to make sure PPE is appropriate and available based on the tasks performed. f. The hospital uses the information from local, state, and federal public health authorities' advisories and alerts, such as CDC's Health Alert Network (HAN) and FDA alerts, to identify infection control risks. Note: The hospital determines how it keeps current on epidemiological risks or changes.	NPG.05.01.01 EP 1
2. As reflected in the water management program documentation, the hospital includes a hospital risk assessment to identify where <i>Legionella</i> and other opportunistic waterborne pathogens (for example, <i>Pseudomonas</i>, <i>Acinetobacter</i>, <i>Burkholderia</i>, <i>Stenotrophomonas</i>, nontuberculous mycobacteria, and fungi) could grow and spread in the hospital water system.	PE.04.01.05 EP 2
3. As part of its infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, the hospital requires an infection control risk assessment (ICRA) to define the scope of infection risk for the project and the need for barrier measures before a project gets underway.	PE.01.01.01 EP 1
4. The hospital reviews identified risks at least annually or whenever significant changes in risk occur.	NPG.05.01.01 EP 2
Surveillance	
1. The hospital performs and documents surveillance activities to prevent and control healthcare-associated infections (HAIs). Note: The hospital conducts surveillance and reporting in accordance with law and regulation, its risk assessment, and in accordance with recognized surveillance practices, such as those set forth by the CDC's National Healthcare Safety Network (NHSN).	IC.06.01.01 EP 3
2. Surveillance of infections and infection prevention and control activities is conducted on a hospital wide basis. Note: This does not imply surveillance is always conducted in all areas and locations of the hospital. The expectation is that the hospital must have reliable sampling or other mechanisms in place to permit identifying and monitoring infections and communicable diseases occurring throughout the hospital's various locations or departments	IC.06.01.01 EP 3

Education, Training, and Competency Assessment	
1. The hospital provides job-specific training and education on infection prevention and control. The staff's records confirm completion of education and training. Note 1: Job-specific means that education and training are consistent with or tailored to the performed roles and responsibilities. For example, environmental services staff must be trained in the methods and procedures for surface disinfection. Note 2: The training and education must include the practical applications of infection prevention and control guidelines, policies, and procedures.	HR.11.03.01 EP 1
2. The hospital provides training to staff expected to have contact with blood or other potentially infectious material on the blood borne pathogen standards upon hire, at regular intervals, and as needed.	HR.11.03.01 EP 1
3. The hospital staff receive training in the following: a. When personal protective equipment (PPE) is necessary b. What PPE is necessary c. How to properly don, doff, adjust, and wear PPE	HR.11.03.01 EP 1
4. The hospital defines and assesses staff competency in infection prevention and control. Note: Competency-based training must be job-specific. For example, the staff in the sterile processing department must demonstrate competencies in the methods and procedures of sterilization, and the staff in areas that perform high-level disinfection must demonstrate competencies in the methods and procedures for high-level disinfection.	HR.11.04.01 EP 1
5. The hospital develops and implements education and training and assesses competencies for the staff who will implement protocols for high-consequence infectious diseases or special pathogens.	NPG.05.02.01, EP 2
Outbreak Management	
1. There is a process in place for reporting to public health authorities when the transmission of infection occurs; this process is consistent with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks.	IC.06.01.01 EP 4
2. The hospital implements its policies and procedures for infectious disease outbreaks, including the following: - Implementing infection prevention and control activities when an outbreak is first recognized by internal surveillance or public health authorities - Reporting an outbreak in accordance with state and local public health authorities' requirements - Implementing outbreak investigation - Communicating information necessary to prevent further transmission of the infection among patients, visitors, and staff, as appropriate	IC.06.01.01 EP 4
Standard Precautions: Hand Hygiene	
Note: The hospital policies and procedures on hand hygiene are in accordance with either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines, including the following:	
1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines.	NPG.05.03.01 EP 1
2. Set goals for improving compliance with hand hygiene guidelines.	NPG.05.03.01 EP 1
3. Improve compliance with hand hygiene guidelines based on established goals.	NPG.05.03.01 EP 1

4. Supplies necessary for adherence to hand hygiene (such as alcohol-based hand rub, soap, water, and a sink) are readily accessible in all areas where patient care is being delivered including but not limited to patient care areas and food and medication preparation areas.	IC.06.01.01 EP 3
5. Alcohol-based hand rub is readily accessible and placed in appropriate locations where it can be accessed by the staff, patients, and visitors. The locations may include the following: a. Entrances to patient rooms b. At the bedside c. Staff workstations d. Other convenient locations	IC.06.01.01 EP 3
6. Hospital staff use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (for example, placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal	IC.06.01.01 EP 3
7. Hospital staff perform hand hygiene using soap and water when hands are visibly soiled (for example, blood, body fluids) or after caring for a patient with known or suspected <i>C. difficile</i> or norovirus during an outbreak. Note: In all other situations, alcohol-based hand rub is preferred.	IC.06.01.01 EP 3
8. Hospital staff do not wear artificial fingernails and/or extenders when having direct contact with patients in accordance with hospital policy. Note: If following the <i>CDC Guideline for Hand Hygiene in Health-Care Settings</i> : when having direct contact with patients at high risk of infection (for example, those in intensive care units or ORs). If following the <i>WHO Guidelines on Hand Hygiene</i> : when having direct contact with patients.	IC.06.01.01 EP 3
Standard Precautions: Environmental Cleaning and Disinfection Note: Environmental cleaning and disinfection is performed in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. The hospital implements routine and targeted cleaning of environmental surfaces as indicated by the level of patient contact and degree of soiling, including the following: a. Surfaces in the patient care environment and areas are cleaned and disinfected on a regular basis, using an EPA- registered disinfectant. Note: High-touch surfaces (for example, bed rails, over-bed table, bedside commode, lavatory surfaces in patient bathrooms) are cleaned and disinfected more frequently than minimal-touch surfaces. b. Spills of blood or other potentially infectious materials are promptly cleaned and decontaminated, using appropriate EPA-registered hospital disinfectants.	IC.06.01.01 EP 3
2. Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturers' instructions (for example, dilution, storage, shelf-life, contact time).	IC.06.01.01 EP 3
3. Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (for example, following manufacturers' instructions when laundering microfiber items).	IC.06.01.01 EP 3

4. The hospital has established and follows a schedule for areas/equipment (for example, refrigerators, ice machines, eye wash stations, scrub sinks) to be cleaned regularly.	IC.06.01.01 EP 3
5. After a patient vacates a room and before the bed linens and towels are replaced, all potentially contaminated surfaces in the room are thoroughly cleaned and disinfected.	IC.06.01.01 EP 3
6. Undamaged hospital bed mattress covers are cleaned and disinfected according to manufacturers' instructions. Any damaged, worn, or visibly stained hospital bed mattress or mattress covers are removed from service and cleaned, disinfected, refurbished, or discarded in accordance with manufacturers' instructions and hospital procedures.	IC.06.01.01 EP 3
Standard Precautions: Injection and Sharps Safety Note: Injection practices and sharps safety and disposal are performed in accordance with The Centers for Disease Control and Prevention (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Injections are prepared using aseptic technique in an area that has been cleaned and separated from potential sources of contamination (for example, visible blood, body fluids, sinks or other water sources).	IC.06.01.01 EP 3
2. Single-dose or single-use vials, ampules, bags or bottles of parenteral solution, fluid infusion or administration sets (for example, intravenous tubing) are used for one patient only.	IC.06.01.01 EP 3
3. Diaphragms of medication vials are disinfected before inserting a device into the vial.	IC.06.01.01 EP 3
4. Needles and syringes are used for one patient only (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	IC.06.01.01 EP 3
5. The same lancing/fingerstick device is <u>not</u> used for more than one individual, even if the lancet is changed.	IC.06.01.01 EP 3
6. If multidose vials are used for more than one patient, medication vials do not enter the immediate patient treatment area (for example, operating room, patient room, anesthesia carts). Note: If multi-dose vials enter the immediate patient treatment area, they must be dedicated for single patient use and discarded immediately after use.	IC.06.01.01 EP 3
7. Immediately or as soon as possible after use, contaminated sharps are discarded in puncture-resistant, leakproof (on the sides and bottom) sharps containers, and sharps containers are replaced when the fill line is reached.	IC.06.01.01 EP 3
Standard Precautions: Risk Assessment with Appropriate Use of Personal Protective Equipment Note: Appropriate personal protective equipment (PPE) is used in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. Staff have immediate access to PPE and are able to select, put on, remove, and dispose of PPE in a manner that protects themselves, the patient, and others.	IC.06.01.01 EP 3
2. Gloves are worn when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment could occur. The staff change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	IC.06.01.01 EP 3
3. A gown is worn that is appropriate to the task to protect skin and prevent soiling of clothing during procedures and activities that could cause contact with blood, body fluids, secretions, or excretions.	IC.06.01.01 EP 3

4. Protective eyewear and a mask or a face shield are worn to protect the mucous membranes of the eyes, nose and mouth during procedures and activities that could generate splashes or sprays of blood, body fluids, secretions, and excretions. Note: Masks, goggles, face shields, and combinations of each are selected according to the need anticipated by the task performed.	IC.06.01.01 EP 3
5. PPE removal and disposal: PPE, other than respirators, are removed and discarded upon completing a task before leaving the patient's room or care area. If a respirator is used, it should be removed and discarded (or reprocessed if reusable) after leaving the patient room or care area and closing the door. Disposable gloves are removed and discarded upon completion of a task or when soiled during the process of care.	IC.06.01.01 EP 3
6. Face masks (procedure or surgical) are worn by staff who are placing a catheter or injecting materials into the epidural or subdural space (for example, during myelogram, epidural, or spinal anesthesia).	IC.06.01.01 EP 3
Standard Precautions: Minimizing Potential Exposures. Preparedness for High-Consequence Infectious Diseases or Special Pathogens.	
1. Respiratory hygiene and cough etiquette instructional signage or handouts are posted and tissues, masks, and hand hygiene supplies available at the points of entry to minimize potential exposures to or transmission of respiratory infection. Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics	IC.06.01.01 EP 3
2. The hospital has developed and implemented protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following: - Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens Note: Points of entry may include the emergency department, urgent care, and ambulatory clinics. - Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls Note: See the Glossary for a definition of hierarchy of controls. - Procedures for waste management and cleaning and disinfecting patient care spaces, surfaces, and equipment	NPG.05.02.01, EP 1
Standard Precautions: Reprocessing of Reusable Medical Equipment Note: Reprocessing of reusable medical equipment is performed in accordance with the Spaulding classification system, manufacturers' instructions, and hospital policies and procedures.	

1. Only devices labeled as reusable are reprocessed directly by the hospital onsite or offsite via a reprocessing vendor. If the hospital elects to reuse any devices labeled for single use by the manufacturer, these devices are reprocessed by an entity that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital has documentation from the third-party reprocessor confirming this is the case.	IC.06.01.01 EP 3
2. Manufacturers' instructions for medical devices and equipment are available to the staff performing reprocessing. The hospital may use posters or other condensed methods to provide critical information to staff performing reprocessing to ensure reprocessing consistent with the instructions for use.	IC.05.01.01 EP 1
3. Reusable non-critical medical equipment (for example, blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes) are cleaned and disinfected according to manufacturers' instructions after each use or when visibly soiled.	IC.06.01.01 EP 3
4. Hydrotherapy equipment (for example, Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturers' instructions after each patient use.	IC.06.01.01 EP 3
5. Responsibility for cleaning and disinfection of reusable noncritical patient-care equipment and devices is clearly designated.	IC.06.01.01 EP 3
High-level disinfection:	
6. All reusable semi-critical items receive at least high-level disinfection prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
7. Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
8. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to high-level disinfection. For instruments with lumens (for example, endoscopes), pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
9. Manufacturers' instructions are followed for the following: a. Enzymatic cleaners or detergents b. Reusable cleaning brushes c. Chemicals used in high-level disinfection, including instructions for preparation, testing for appropriate concentration, and replacement (for example, prior to expiration) Note: The results of testing for appropriate concentration are documented to ensure minimal effective concentration of the active ingredient. d. Disinfection temperatures and length of time e. Device rinsing following high-level disinfection f. If automated reprocessing equipment is used, manufacturers' recommended connectors are used to assure that all endoscope channels are appropriately disinfected.	IC.06.01.01 EP 3
10. Devices are dried thoroughly prior to storage/reuse in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
11. After high-level disinfection, devices are stored in a manner that protects them from damage or contamination.	IC.06.01.01 EP 3
12. The hospital has a system in place to identify which endoscope was used on a patient for each procedure.	IC.06.01.01 EP 3
Sterilization:	

13. All reusable critical items are sterilized prior to reuse, in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
14. Items are thoroughly pre-cleaned according to manufacturers' instructions and visually inspected for residual soil prior to sterilization. Note: For instruments with lumens, pre-cleaning of devices must include all channels using cleaning brushes of appropriate size.	IC.06.01.01 EP 3
15. Enzymatic cleaner or detergent is used and discarded according to manufacturers' instructions.	IC.06.01.01 EP 3
16. Cleaning brushes are single-use, disposable items or, if reusable, cleaned and either high-level disinfected or sterilized (per manufacturers' instructions) at least daily.	IC.06.01.01 EP 3
17. After pre-cleaning, items are appropriately wrapped-packaged for sterilization (for example, the package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	IC.06.01.01 EP 3
18. The sterilization process is monitored by using a combination of mechanical, chemical, and biological indicators to ensure the effectiveness of the sterilization process. Indicators are used in accordance with the sterilizer or sterilizer accessory (pouch, casket, tray, etc.) manufacturers' instructions.	IC.06.01.01 EP 3
19. For dynamic air removal-type sterilizers (for example, prevacuum steam sterilizers), an air removal test (Bowie-Dick test) is performed each day the sterilizer is used to verify efficacy of air removal in accordance with manufacturers' instructions.	IC.06.01.01 EP 3
20. Sterile packs are labeled with the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.	IC.06.01.01 EP 3
21. Logs for each sterilizer cycle are current and include results from each load, in accordance with the hospital policies and procedures.	IC.06.01.01 EP 3
Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	
22. After sterilization, medical devices and instruments are stored so that sterility is not compromised.	IC.06.01.01 EP 3
23. Sterile packages are inspected for integrity, and compromised packages are repackaged and reprocessed prior to use.	IC.06.01.01 EP 3
24. If immediate use* steam sterilization (IUSS) is performed, all of the following criteria are met: a. Work practices ensure proper cleaning and decontamination, inspection, and arrangement of the instruments into the recommended sterilizing trays or other containment devices before sterilization. b. Once clean, the item is placed within a container intended for immediate use. c. The sterilizer cycle and parameters used are selected according to the manufacturers' instructions for use for the device, container, and sterilizer. d. The sterilizer function is monitored with mechanical monitors and chemical and biologic indicators that are validated for use with the sterilization cycle and in accordance with the device and sterilizer manufacturers' instructions. e. The processed item must be transferred immediately*, using aseptic technique, from the sterilizer to the actual point of use, the sterile field in an ongoing surgical procedure. *“Immediate use” is defined as the shortest possible time between a sterilized item’s removal from the sterilizer and its aseptic transfer to the sterile field. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another.	IC.06.01.01 EP 3

25. Immediate-use steam sterilization is not performed on the following devices: a. Implants (except in documented emergency situations when no other option is available) Note: If IUSS must be used for an implantable device, the name of the patient/patient's unique identifier and any other information needed to accurately link the instrument processed using IUSS back to the patient must be recorded. b. Post-procedure decontamination of instruments used on patients who may have Creutzfeldt-Jakob disease or similar disorders c. Devices that have not been validated with the specific cycle employed d. Single-use devices that are sold sterile	IC.06.01.01 EP 3
26. Staff follow hospital policies and procedures in the event of a reprocessing error or failure identified either prior to the release of the reprocessed item(s) or after the reprocessed item(s) was used or stored for later use. Note: Depending on the nature of the incident, examples of actions may include quarantine of the sterilizer, recall of item(s), stakeholder notification, patient notification, surveillance, and follow-up. Note: For the absence of policies and procedures, score IC.04.01.01 EP 4.	IC.06.01.01 EP 3
Transmission-Based Precautions Note: Transmission-based precautions are applied in accordance with hospital policies and procedures to maximize prevention of infection and communicable disease including the following:	
1. The hospital implements transmission-based precautions based on the patient's clinical presentation and likely infection diagnoses (for example, syndromes suggestive of transmissible infections such as diarrhea, meningitis, fever and rash, respiratory infection) and adjusts or discontinues precaution per policies and procedures and clinical information. Note: Implementation of transmission-based precautions may differ based on the patient care settings (inpatient, outpatient, long-term care), facility design characteristics, and the type of patient interaction.	IC.06.01.01 EP 3
2. Personal protective equipment and supplies are available and located near point of use.	IC.06.01.01 EP 3
3. Personal protective equipment is put on/donned and removed/doffed properly.	IC.06.01.01 EP 3
4. Signs indicating that a patient is on transmission-based precautions are clear and visible.	IC.06.01.01 EP 3
5. If a patient is on transmission-based precautions and must leave their room for medically necessary purposes, there are methods and processes in place to communicate that patient's status and to prevent transmission of infectious disease.	IC.06.01.01 EP 3
6. A NIOSH-approved particulate respirator (N95 or higher) is worn by staff when entering the airborne infection isolation room (AIIR) for patients with confirmed or suspected TB. Hospital policies are followed for other pathogens requiring AIIR.	IC.06.01.01 EP 3
Temporary Invasive Medical Devices for Clinical Management	
1. Staff adhere to invasive medical devices insertion, maintenance, and discontinuation practices, in accordance with hospital policies and procedures. Note: Examples of invasive medical devices include vascular catheters, indwelling urinary catheter, ventilator.	IC.06.01.01 EP 3
2. The hospital follows its policies and procedures for appropriate indications for urinary catheters.	IC.06.01.01 EP 3

3. The hospital promptly removes any intravascular catheter that is no longer essential, in accordance with its policies and procedures.	IC.06.01.01 EP 3
Note: For the absence of policies and procedures, score IC.04.01.01 EP 3.	

Occupational Health

1. The hospital implements policies and procedures to minimize the risk of communicable disease exposure and acquisition among its staff, in accordance with law and regulation. The policies and procedures address the following: - Screening and medical evaluations for infectious diseases - Immunizations - Staff education and training - Management of staff with potentially infectious exposures or communicable illnesses	IC.06.01.01 EP 5
Note: For the absence of policies and procedures, score IC.04.01.01 EP 3.	
2. The hospital has a respiratory protection program that details required worksite-specific procedures and elements for required respirator use.	IC.06.01.01 EP 5
3. Fit testing is provided at regular intervals to staff at risk.	IC.06.01.01 EP 5
4. Following an exposure incident, post-exposure evaluation and follow-up, including prophylaxis as appropriate, is available to the individual and performed by or under the supervision of a practitioner.	IC.06.01.01 EP 5
Note: An exposure incident refers to a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an individual's duties.	
5. Hospital policies and procedures are followed for management of staff with potentially infectious exposures or communicable illnesses (for example, regarding contact with patients or food preparation and handling).	IC.06.01.01 EP 5

Hemodialysis

Note: Infection prevention practices during hemodialysis procedure are performed in accordance with hospital policies and procedures including the following:

1. Staff wear appropriate PPE (gloves, gowns, face, and eye protection) and perform hand hygiene throughout the procedure.	IC.06.01.01 EP 3
2. Staff perform appropriate central line care, including preparing catheter hubs prior to accessing for hemodialysis, connecting, and disconnecting from bloodlines after the procedure.	IC.06.01.01 EP 3
3. During the priming process, blood lines do not come into contact with contaminated prime waste.	IC.06.01.01 EP 3
4. For tasks requiring aseptic technique, the staff avoid contamination of gloves and other clean/sterile items, for example avoiding touching contaminated surfaces.	IC.06.01.01 EP 3
5. Environmental surface disinfection is performed, when no patient is present, including the following: a. The dialysis station b. Priming buckets c. Reusable equipment	IC.06.01.01 EP 3
6. Disposable supplies are discarded after the patient has departed the dialysis station in accordance with the local regulated medical waste law and regulation.	IC.06.01.01 EP 3

7. The hospital adheres to the policies and procedures to determine and document the hepatitis status of a dialysis patient.	IC.06.01.01 EP 3
Note: For the absence of policies and procedures, score IC.04.01.01 EP 3	
8. The hospital adheres to manufacturers' instructions and hospital policies and procedures for cleaning and disinfection of the dialysis machine used for the treatment of a patient with hepatitis B.	IC.06.01.01 EP 3
Note: For the absence of policies and procedures, score IC.04.01.01 EP 4	

Laundry & Linen

Note: Laundry is processed in a manner consistent with law and regulation and hospital policies and procedures to maximize prevention of infection and communicable disease including the following:

1. Soiled textiles/laundry are handled with minimum agitation to avoid contamination of air, surfaces, and persons.	IC.06.01.01 EP 3
2. Soiled laundry is contained in leak-proof bags or containers at the point of use. Note: Hamper covers are not required in patient care areas.	IC.06.01.01 EP 3
3. Healthcare textiles are protected from environmental contamination during transport and storage.	IC.06.01.01 EP 3
Note: Textiles/linens are covered if stored in a clean area in the inpatient unit or may be uncovered if stored in a dedicated clean storage area.	
4. The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas of the laundry in accordance with FGI construction standards in effect during the time of facility construction.	PE.04.01.01 EP 3

Dietary Services/Kitchen

Note: Practices for the prevention of foodborne infections and diseases are performed in accordance with the federal, state, and local codes, law and regulation on food operations, and hospital policies and procedures.

1. The hospital has written policies and procedures on sanitary and hand hygiene practices for its dietary services and kitchen staff.	IC.04.01.01 EP 3
2. The hospital provides a clean and sanitary environment in food storage, preparation, serving, and dishware storage areas, consistent with law, regulation, and food sanitation code. Note: Examples may include: a. Cutting boards, prep surfaces, work areas, trays and equipment are cleaned properly to avoid contamination and sanitized between uses. b. Different cutting boards/prep surfaces are used for meat, vegetables, and other food items. c. Handwashing sinks are available. d. Sinks are clear of items that can be contaminated by splashes. e. Raw food and ingredients are prepared and stored in a manner that prevents cross contamination with other foods (for example, to avoid dripping, liquid pooling, splashing). f. Dishes and utensils are air dried and stored in a manner that prevents cross contamination. g. Food carts are sanitized after every meal. h. Wet wiping cloths are stored in an approved sanitizing solution and washed daily.	IC.06.01.01 EP 3
3. The dietary services and kitchen staff comply with hand hygiene practices.	IC.06.01.01 EP 3

4. The hospital prepares food and nutrition products using proper sanitation and temperature, including the following: a. Food service staff wear hair or beard coverings, in accordance with hospital policies and procedures, b. Food service staff adhere to hand hygiene in accordance with hospital policies and procedures. c. The hospital monitors the food's temperature for hot and cold items during meal service. d. The hospital maintains proper temperature of refrigerated or warmed foods during preparation. e. The hospital follows the proper process for thawing of foods. f. The hospital monitors final cooking temperatures.	CAH NPG.11.04.01 EP 1 HAP NPG.12.01.01 EP 8
5. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation: a. Food is protected from contamination during storage. b. Food storage areas such as a refrigerator, cupboards, drawers, and bins are not soiled and protected from splashes and free of odors.	CAH NPG.11.04.01 EP 1 HAP NPG.12.01.01 EP 8
6. The hospital manages foodborne outbreak(s) and reports outbreak(s) to public health authorities, in accordance with law and regulation and hospital policies and procedures.	IC.06.01.01 EP 4
Surgical Services	
Note: Surgical services are performed in accordance with hospital policies and procedures including the following:	
1. Staff perform a surgical scrub before donning sterile gloves for surgical procedures using either an antimicrobial surgical scrub agent or an FDA-approved alcohol-based antiseptic surgical hand rub. After surgical scrub, hands and arms are dried with a sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	LD.13.03.01 EP 1
2. Staff in the surgical area adhere to aseptic and sterile technique.	LD.13.03.01 EP 1
3. Staff and visitors wear surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair in semi-restricted and restricted areas. Note: Restricted areas include ORs, procedure rooms, and the clean core (sterile supply) area. The semi restricted areas include the peripheral support areas of the surgical suite.	LD.13.03.01 EP 1
4. Surgical masks are worn fully covering the mouth and nose by all staff in restricted areas where open sterile supplies or scrubbed staff are located.	LD.13.03.01 EP 1
5. The sterile field is maintained, including the following: • Items used within the sterile field are sterile. • Items introduced into the sterile field are opened, dispensed, and transferred in a manner to maintain sterility. • The sterile field is prepared in the location where it will be used and as close as possible to time of use. • Movement in or around sterile field is done in a manner to maintain sterility.	LD.13.03.01 EP 1
6. Traffic in and out of the OR is kept to a minimum and limited to essential staff.	LD.13.03.01 EP 1
7. All horizontal surfaces (for example, furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and an EPA-registered hospital detergent/disinfectant.	LD.13.03.01 EP 1
8. High-touch environmental surfaces are cleaned and disinfected between patients.	LD.13.03.01 EP 1
9. ORs are terminally cleaned after the last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping the floor with an EPA-registered disinfectant.	LD.13.03.01 EP 1
10. Anesthesia equipment surfaces that are touched by staff while providing patient care or while handling contaminated items are cleaned and low-level disinfected between use on patients according to manufacturers' instructions.	LD.13.03.01 EP 1
11. Exterior surfaces of anesthesia equipment that are not knowingly contaminated during patient care are terminally low-level disinfected at the end of the day according to manufacturers' instructions.	LD.13.03.01 EP 1
12. Internal components of the anesthesia machine breathing circuit are cleaned per manufacturers' instructions and hospital policies and procedures.	LD.13.03.01 EP 1

13. Reusable noncritical items (for example, blood pressure cuffs, ECG leads, tourniquets, oximeter probes) are cleaned and disinfected between patients.	LD.13.03.01 EP 1
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Imaging Document Review Guide

The following documents and data need to be made available to the surveyor for review, based on the imaging modalities provided by your organization. Note: It is not necessary for you to copy these documents for the surveyor, just ensure that they are available for review. This document will assist you with compiling those documents.

1. Facilities and Equipment:

- ☐ Equipment quality control (QC) and performance maintenance (PM) activities for CT, MRI, PET, and NM equipment, with the dates completed (last 12 months) (NPG.13.03.01 EP 4)
- ☐ CT annual equipment performance evaluation: NPG.13.03.01 EP 5
Must be documented, done by medical physicist, and include:
 - Image uniformity
 - Slice thickness accuracy
 - Alignment light accuracy
 - Table travel accuracy
 - Radiation beam width
 - High contrast resolution
 - Low contrast resolution
 - Geometric or distance accuracy
 - CT number accuracy and uniformity
 - Artifact evaluation
- ☐ MRI annual equipment performance evaluation: NPG.13.03.01 EP 6
Must be documented, done by medical physicist or MRI scientist, and include
 - Image uniformity for all coils used clinically
 - Signal to noise ratio (SNR) for all coils used clinically
 - Slice thickness accuracy
 - Slice position accuracy
 - Alignment light accuracy
 - High contrast resolution
 - Low contrast resolution
 - Geometric or distance accuracy
 - Magnetic field homogeneity
 - Artifact evaluation
- ☐ NM annual equipment performance evaluation: PE.05.01.01 EP 1
Must be documented, done by medical physicist or nuclear medicine physicist, and include
 - Image uniformity / system uniformity
 - High contrast resolution / system spatial resolution
 - Artifact evaluation
 - Sensitivity
 - Energy resolution
 - Count rate performance
- ☐ PET annual equipment performance evaluation: PE.05.01.01 EP 2
Must be documented, done by medical physicist or nuclear medicine physicist, and include
 - Image uniformity / system uniformity
 - High contrast resolution / system spatial resolution
 - Low contrast resolution or detectability
 - Artifact evaluation

- ☐ Image Acquisition Display Monitor Performance Evaluations for CT, MRI, NM, PET-PE.05.01.01 EP 3
 Must be performed as part of annual equipment performance evaluations and include:
 - Maximum and minimum luminance
 - Luminance uniformity
 - Resolution
 - Spatial accuracy
 Often documented in the CT, MRI, NM, PET, and Fluoro annual equipment performance evaluation
 - ☐ CT Dose Verification NPG.13.03.01 EP 5
 - Annual report from medical physicist on the CTDI vol for adult and pediatric brain and abdomen protocols for each diagnostic CT imaging system
 - ☐ Lead Apron Assessment PE.02.01.01, EP 4
 - Inventory and inspection for cracks, tears, integrity
2. Radiation Protection and Radiopharmaceutical Management
 Radiation Protection and Radiopharmaceutical Management
 - Records of radiopharmaceutical receipt and disposition MM.13.1.1 EP 6
 3. Clinical Policies and Protocols
 - Critical Tests: Written procedures or protocols, and data collected on the timeliness of reporting critical results of tests and diagnostic procedures NPG.01.02.01 EP 1
 - CT Protocols: Protocols must be based on current standards of practice and address clinical indication, contrast administration, pediatric or adult, patient size and body habitus, expected radiation dose range. Must include input from interpreting physician, lead imaging technologist, and medical physicist and be reviewed at timeframes established by hospital NPG.13.2.1 EP 3
 - MRI Safety: Policies address: claustrophobia, noise protection, metal detection, patient emergencies while in scanner, restricting access to scanner for all people not trained in MRI safety NPG.12.03.01 EP 2 and EP 3
 4. Reporting and Performance Improvement
 - Data collected on thermal injuries during MRI NPG.13.04.01 EP 1
 - Data collected on incidents and injuries where ferromagnetic objects unintentionally entered MRI scan room NPG.13.04.01 EP 1
 - Data collected on incidents where radiation dose (CTDIvol, DLP, SSDE) exceeded the expected range Identified in the imaging protocol NPG.13.04.01 EP 2
 5. Staff Competencies
 - Credential files for all diagnostic medical physicists who work with CT. NPG.13.1.1 EP 2
 - Credential files including certification and annual training on dose optimization for CT techs NPG.13.1.1 EP 3
 - Credential files including annual training for all MRI techs on safe MRI practices NPG.13.1.1 EP 4
 6. Leadership
 - Documentation / Radiology Director: must be a qualified MD or DO. MS.17.01.03, EP 5
 - Documentation / Nuclear Medicine: must be a qualified MD or DO. LD.13.1.7 EP 3
 - Documentation / Radiation Safety Officer: must be designated. NPG.13.2.1 EP 1
 - Documentation of Medical Staff Approval (usually at Med Exec Comm Meeting) for:
 Qualifications of radiology staff who use equipment and administer procedures MS.16.01.01, EP11

Nuclear Medicine Director's specifications for the qualifications, training, functions, of nuclear medicine staff MS.16.01.01, EP 12

7. Medical Records:

- Reports, including medical record number, documenting radiopharmaceutical dose received for 5 recent inpatients. RC.12.01.01, EP 2
- Reports, including medical record number, documenting contrast dose and radiation dose for 5 recent inpatients. RC.12.01.01, EP 2
- Reports, including medical record number, documenting fluoroscopy radiation dose for 5 recent inpatients. RC.12.01.01 EP 2

Performance Improvement Evaluation Tool

Use this tool as a checklist to verify that data is being collected on the items below. This review should be performed prior to conducting the Organization Quality and Performance Improvement group interview. Surveyor(s) will inform the hospital staff of the specific PI activities, projects, and proactive monitoring activities that will be discussed during the interview.

QAPI Program Attributes					
Evaluation of	Compliance Met/Not Met Notes	JC HAP	JC CAH	HAP CoP	CAH CoP
☐ Quality assurance/performance improvement (QAPI) program documents to verify the program meets the following requirements: - Includes processes for systematically examining the quality of care delivered and implementing specific improvement projects on an ongoing basis - Facilitates the continuous study and improvement of processes and service delivery - Takes a proactive approach to improve their performance (for example, the hospital analyzes risks and near misses, and focuses on prevention and reduction of future errors or adverse events) - Is based on, and reflects, the size and complexity of the organization and services - Is hospital wide (including services		LD.11.01.01, EP 8 LD.12.01.01, EP 1 PI.14.01.01, EP 1	LD.12.01.01, EP 1 LD.11.01.01, EP 8 PI.11.01.01, EP 1	482.21	485.641(a) 485.641(b)(1) 485.641(b)(2) 485.641(b)(3) 485.641(b)(4) 485.641(b)(5) 485.641(c)

under contract or arrangement) ▪ All hospital departments and services are included in the QAPI program ▪ Documentation shows participation by all contracted services ▪ Written contracts include QAPI requirements and roles and responsibilities of the contractor ☐ Is data driven ▪ Documentation indicates which data are used to make QAPI program decisions ☐ Focuses on quality indicators or measures related to improved health outcomes, as well as the prevention and reduction of medical errors ○ Does the program focus on nonclinical measures, such as employee satisfaction data, as opposed to clinical measures, such as infection control incidence rates and/or nationally recognized quality indicators? ☐ Evidence of continuous data collection (or collection of data on an ongoing basis), data analysis (with identified					
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areas for improvement), and implementation of changes, including ongoing monitoring of changes for effectiveness. ☐ Evidence that the governing body is engaged in oversight of QAPI program ☐ Evidence of services provided under an arrangement or contract are included in its QAPI program.					

Data Collection & Analysis					
Evaluation of	Compliance Met/Not Met Notes	JC HAP	JC CAH	HAP CoP	CAH CoP
☐ Ask QAPI staff to provide a list of the quality indicators they are currently tracking. Verify that the - List includes the tracking of adverse events. - Quality indicator data include patient care data and other relevant data, such as that received from Medicare quality reporting (hospital readmissions and hospital-acquired conditions) and performance programs. - Quality indicators are reflective of the hospital's patient population. ☐ Ask QAPI staff to provide evidence (measurement data) of measurable improvements in the quality indicators it has selected for its program. - Verify that improvements are ongoing (several data analyses showing improvement over time) and not just one-time events. - If the evaluation did not show improvements or sustained improvements, is there evidence that the hospital implemented a revised or new solution? ☐ Ask to see evidence that the governing body has specified		LD.12.01.01, EP 2 PI.11.01.01, EP 2 PI.12.01.01, EP 3	LD.12.01.01, EP 2 PI.11.01.01, EP 2 PI.14.01.01, EP 1	482.21(a) 482.21(b) 482.21(b)(1) 482.21(b)(2) 482.21(b)(3)(i) 482.21(b)(3)	485.641(d)(1) 485.641(d)(2) 485.641(d)(3) 485.641(e)

the frequency and detail of QAPI program data collection. ○ Look at governing body meeting minutes. ○ Do QAPI program reviews include this information? □ Verify that the hospital is using the data being collected to monitor the safety and quality of care. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to explain how the collection of the particular data is used to monitor quality and safety. □ Verify that the hospital is using the data being collected to identify opportunities for improvement. ○ Select a sample of data being collected and ask the governing body or other appropriate leaders to give examples of how the specific data has identified opportunities for improvement. ○ Ask to see documented evidence of the opportunities the hospital has identified for improvement based on the collection of data.					
Quality Improvement Activities					
Evaluation of	Compliance Met/Not Met Notes	JC HAP	JC CAH	HAP CoP	CAH CoP

□ A list of current or recent performance improvement activities. ○ Ask about the actions taken, post action measurement to determine improvement, and measurement to determine sustained improvement. ○ Evidence that the hospital tracks data for the identified indicators, which may include but are not limited to blood product transfusion reactions, drug reactions, errors in medication administration, and infection control–related errors and events. □ Ask the governing body or the leaders who oversee the QAPI program to provide evidence ○ That its improvement activities are focused on high-risk, high-volume, or problem-prone areas. ○ Does it have any data (either derived from its own QAPI data collection or public data) on incidence, prevalence, or severity to support its choices? ○ Does it have evidence that the activities affect health outcomes through improving quality of care or patient safety?		LD.12.01.0 1, EP 2 PI.12.01.0 1, EP 4 PI.14.01.0 1, EP 1	LD.12.01.0 1, EP 2 LD.11.01.0 1 EP 8	482.21(b)(2) 482.21(b)(2)(ii) 482.21(c)(1) 482.21(c)(3)	485.641(d)(1) 485.641(d)(2) 485.641(d)(3) 485.641(e) 485.641(c)
Patient Safety, Medical Errors & Adverse Events					
Evaluation of . . .	Compliance Met/Not Met Notes	JC HAP	JC CAH	HAP CoP	CAH CoP

□ Verify that the hospital has a medical error and adverse patient event reporting policy. □ Select a sample of several (at least three) adverse events or errors the hospital has tracked and ask to see written evidence showing that it has used a systematic approach (for example, root cause analysis) to ○ Analyze the cause of the events and errors, ○ Implement changes based on the identified causes to prevent further events or errors, ○ Conduct periodic data collection to verify if the changes resulted in improvements, and ○ Analyze the post-implementation data to assess whether the improvement (if there was an improvement) was sustained over time. □ Ask QAPI staff for a demonstration of the system and explain how the system is able to organize the reported data for meaningful analysis. ○ Can the system organize the data by type of error or adverse event, and by actual or near misses? ○ Can the system organize the data by dates to show trends over time? ○ Can the system organize the data by shift, by unit where the error occurred, and so on?		PI.11.01.0 1, EP 2 PI.12.01.0 1, EP 1 PI.12.01.0 1, EP 3 LD.12.01.0 1, EP 3		482.21(a)(1)) 482.21(a)(2)) 482.21(c)(2)) 482.21(e)(3))	
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<i>During inpatient/outpatient tracer activities:</i> □ Look for evidence of the medical error/adverse event reporting system. <i>During HR/Competency/MedStaff Review</i> □ Look for evidence of hospital-wide staff education and training regarding what errors and adverse events must be reported and how to report them. Review the materials used for education and training. ○ Are there records to show staff received the training? *Please refer to SPG Module 482.21 for <i>Prospective hospitals applying for initial certification in Medicare</i>					
Performance Improvement Projects					
Evaluation of	Compliance Met/Not Met Notes	JC HAP	JC CAH	HAP CoP	CAH CoP
□ Ask QAPI leader and staff to provide a list of distinct performance improvement projects it is currently conducting and has conducted within the last three years to verify that the hospital is conducting annual QAPI projects. □ Ask to see documentation showing why each project was conducted and evidence to support the progress being made on each project. □ Ask the governing body or responsible leaders to explain		PI.11.01.0 1, EP 3 PI.12.01.0 1, EP 2 PI.14.01.0 1, EP 1		§482.21(d)	

how the selection (number and scope) of the specific projects is in alignment with the hospital's complexity and the scope of services it provides. ☐ Consider the size of the facility and the intensity of its services, such as critical care services/units, complex surgeries, transplant services, maternal/child health services, and oncology services, including radiation and chemotherapy.					
Executive Responsibilities					
Evaluation of	Compliance Met/Not Met Notes	JC HAP	JC CAH	HAP CoP	CAH CoP
Ask to see evidence that the governing body, hospital CEO, medical staff (or its executive committee), and other administrative officials are providing oversight for the QAPI program. ○ Are there QAPI meeting minutes that document their attendance? ○ Do the governing body meeting agendas provide evidence that the QAPI program has been addressed? ○ Do the governing body meeting minutes include evidence of QAPI discussions? ○ Are there documents such as annual QAPI program reviews that include signatures from the governing body? ☐ Ask to see evidence that the governing body, medical staff (or its executive committee), and		LD.12.01.0 1, EP 3 PI.14.01.0 1, EP 1	LD.11.01.0 1 EP 8	\$482.21(e)	485.641(c)

administrative officials do the following: ○ Approve the number of distinct QAPI projects to be conducted annually. ○ Review the results of QAPI data collection, analyses, activities, and projects and make decisions based on such review. ☐ For those services the hospital provides under arrangement or contract, ask to see evidence that the contractor is actively involved in the QAPI program. ○ Do the governing body, medical staff, and administrative officials periodically receive and review quality data from the contractor? ○ Is the contracted service involved in any current or past hospital QAPI projects? ○ Does the contract or agreement include the hospital's expectations regarding the contractor's roles and responsibilities for QAPI? ○ Does the data from the contractor demonstrate positive outcomes related to the services provided? <i>During inpatient/outpatient tracer activities:</i> ☐ Ask staff if they are aware of the hospital's expectations for safety and how they learned about these. ○ Do they know their roles and responsibilities in quality assessment					
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and performance improvement?					
Providing Adequate Resources					
Evaluation of	Compliance Met/Not Met Notes	JC HAP	JC CAH	HAP CoP	CAH CoP
Document Review General ☐ Ask QAPI leader and staff to see detailed evidence of the resources (for example, staff, staff time, education, information systems) that are provided to support required QAPI functions. ☐ For QAPI services provided under contract, ask to see evidence that contracted services have been incorporated into the QAPI program and that there is governing body oversight of these services and the QAPI program. Personnel/Credential File ☐ Ask to see evidence that staff are qualified to engage in their respective QAPI responsibilities. ○ Have all staff been educated and trained on how to report errors and adverse events? ○ Have staff who are required to conduct data collection and analysis received training or possess experience in these functions?		LD.12.01.01, EP 3		482.21(e)	
Unified and integrated QAPI program for multi-hospital systems					
Evaluation of	Compliance Met/Not Met	JC HAP	JC CAH	HAP CoP	CAH CoP

	Notes				
<i>If the hospital is part of a multihospital system:</i> □ Ask if there are any descriptions of the unified and integrated QAPI program. ○ Does the program include governing body expectations for each certified hospital? ○ Does it take into account each member hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital? □ Ask to see policies and procedures that guide the unified and integrated QAPI program to ensure that the following requirements are met: ○ The needs and concerns of each separately certified hospital, regardless of practice or location, are given due consideration. ○ The unified and integrated QAPI program has procedures in place to ensure that issues localized to particular hospitals are duly considered and addressed. □ Ask to see reports provided to the governing body about QAPI performance. ○ Do such reports reveal the performance of each certified hospital?		LD.11.01.01, EP 9	LD.11.01.01, EP 9	482.21(f) 482.21(f)(1) 482.21(f)(2)	485.641 (f)

☐ Ask staff if their system governing body has elected to have a unified and integrated QAPI program. ☐ Did the system check state and local laws to determine if a unified program was acceptable? ☐ Ask leaders and QAPI staff at each individual hospital how they participate in the unified and integrated program and if it addresses their unique circumstances.					
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Emergency Management (EM) Discussion Tool

This EM Discussion Tool complements the EM Documentation Review tool and is intended to provide an overview of EM-discussion and related topics

Introduction of EM Leadership & other Team Members

Interview

- ☐ Ask participants to introduce themselves and briefly describe their role in emergency planning and preparedness and their role in incident command (if applicable). **(not scored)**
- ☐ Ask who has **authority and oversight of the EM program** and ask them to describe how they support the EM program and program lead. **(NPG.03.01.01, EP 1)**
- ☐ Ask leaders to describe how the **EM (or similar) committee** is defined and represented **(NPG.03.01.01, EP 3)** and how the committee plans, evaluates, and maintains the EM program **(NPG.03.01.01, EP 4)**

Personnel/Credential File

- ☐ Review the EM program lead's job description, qualifications, and responsibilities **(NPG.03.01.01, EP 2)**

Part 1: EM Program and Hazard Vulnerability Analysis (HVA)

CMS CoP 482.625 & 482.625 (a) 1-2

Interview

- ☐ Ask leaders to describe the hospital's **emergency preparedness program** and how the hospital used an all-hazards approach when developing its program. **(EM.09.01.01, EP 1)**
- ☐ Ask leaders to **identify the hazards** (for example, natural, human-made, facility, geographic) that were identified in the hospital's **risk assessment** and how the risk assessment was conducted. **(EM.11.01.01, EP 2)**

Document Review

- ☐ See Part 1 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 2: Emergency Operations Plan (EOP)

CMS CoP 482.625 (a) 3-4

Interview

- ☐ Ask leaders to describe plans for the following:
 - The **patient populations** that would be at risk during an emergency event **(EM.12.01.01, EP 2)**
 - **Services they will continue to provide**, services that cannot be provided, and plans for continued operations during an emergency or disaster incident. **(EM.13.01.01, EP 1)**
 - **Succession plans** **(EM.13.01.01, EP 3)** and process for **delegating authority** **(EM.13.01.01, EP 4)**
- ☐ Ask leaders to describe their process for **cooperation and collaboration** with local, tribal, regional, state, and federal emergency preparedness officials **(EM.12.01.01, EP 6)**
- ☐ Ask leaders to describe the **incident command structure** **(NPG.03.02.01, EP 1)**
 - Activation procedures **(NPG.03.02.01, EP 2)**
 - Primary and alternate command sites **(NPG.03.02.01, EP 3).**

Document Review

- ☐ See Part 2 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 3: EM Policies and Procedures

CMS CoP 482.625 (b) & 482.625 (b) 1-8

Interview

- ☐ Ask leaders to describe policies/procedures for the following:
 - Providing **subsistence needs** for staff and patients (food, water, medical, pharmaceutical supplies) (**EM.12.01.01, EP 4**)
 - How they **monitor and track resources** needed during an emergency (**EM.12.02.09, EP 1**) and how the plan to replenish or conserve resources during an emergency (**EM.12.02.09, EP 2**)
- ☐ Ask leaders to describe policies/procedures for the following:
 - **Shelter in place and evacuation** procedures (**EM.12.01.01, EP 3**)
 - **Coordinating care/transferring** to other hospitals (transportation arrangements, care considerations, staff responsibilities, evacuation locations). (**EM.12.02.05, EP 1**)
 - Role in providing care at **alternate care sites (1135 waiver)** (**EM.12.01.01, EP 7**)
 - **Tracking systems** used to locate patients and staff. (**EM.12.02.07, EP 2**)
- ☐ Ask leaders to describe staffing strategies:
 - Use of **volunteers or emergency staffing** agencies for surge events? (**EM.12.02.03, EP 1**)
 - Procedures for reporting in, **roles and responsibilities**, integration of staffing agencies (**EM.12.02.03, EP 2**)
 - Managing **volunteer licensed practitioners (NPG.03.02.03)**
 - Documenting/ verifying and licensure primary source verification (**EP 1**)
 - Granting disaster privileges to disaster volunteer physicians (**EP 2**)
 - **Supporting staff needs** (housing, transportation, family support needs, mental health and wellness) (**NPG.03.02.03, EP 3**)
- ☐ Ask leaders to describe policies/procedures for the following:
 - **Managing non-ill & non-injured persons** presenting during a disaster (**NPG.03.02.04, EP 1**)
 - Coordination with local mortuaries/medical examiners **surge of unidentified or deceased** patients. (**NPG.03.02.04, EP 2**)
 - Coordinating and planning **safety and security** during an emergency (**NPG.03.02.05, EP 1**)
 - Planning for **96-hour sustainability** of resources and assets (**NPG.03.02.06, EP 1**)
 - Planning for **disaster recovery** assessments and restoration (**NPG.03.03.01, EP 1**)
 - **Family reunification** procedures (**NPG.03.03.01, EP 2**)

Document Review

- ☐ See Part 3 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 4: Communications Plan

CMS CoP 482.625 (c) & 482.625 (c) 1-7

Interview

- ☐ Ask leaders to describe communications plan and procedures as follows:
 - How they maintain **contact lists** (**EM.12.02.01, EP 1**)
 - How they **communicate with relevant authorities** & provide occupancy (**EM.12.02.01, EP 3**)
 - Methods for **sharing / releasing** patient information (**EM.12.02.01, EP 4**)
 - **Primary and alternate** methods for communicating (**EM.12.02.01, EP 5**)
 - Providing coordinated messages to staff, patients, external stakeholders (**NPG.03.02.02, EP 1**)

- Use of warning and notifications procedures specific to emergencies or disaster incidents (**NPG.03.02.02, EP 2**)

Document Review

- See Part 4 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 5: EM Training and Testing (Exercises)

CMS CoP 482.625 (d) & 482.625 (d) 1-2

Interview

- Ask the following related to the education and training program:
 - Ask leaders to describe the EM education and training program (**EM.15.01.01, EP 1**)
 - Ask various staff about the hospital's **initial education & training received**-verify staff knowledge (**EM.15.01.01, EP 2**)
 - Ask various staff about **ongoing education & training received** (at least every 2 years) (**EM.15.01.01, EP 3**)
 - Ask leaders with **incident command** responsibilities to describe **education and training** they have received (**NPG.03.04.01, EP 1**)
- Ask the following related to emergency preparedness exercises:
 - Ask leaders to describe the annual exercises they are **planning** to conduct, why they were selected, and how staff and management are involved (**EM.16.01.01, EP 1**)
 - Discuss the previously documented **annual exercises** (at least 2 exercises per year) (**EM.16.01.01, EP 2**); **and**
 - Discuss exercises conducted at the freestanding outpatient care buildings (if applicable)
 - Note: one exercise per year is required to test staff roles/responsibilities at these sites (**NPG.03.05.01, EP 1**)
- In response to an emergency or disaster incident (real or simulated), ask leaders to describe their role in **evaluating after-action reports**, identified opportunities for improvement, and recommendations needed to improve the EM Program (**NPG.03.06.01, EP 1**)

Document Review

- See Part 5 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Personnel/Credential File

- Review a sample of staff training files to verify that staff have received initial and subsequent (at least every 2 years) emergency preparedness training. Note: For ease of demonstrating compliance that the hospital has updated its training program at least every 2 years, hospitals should retain, at a minimum, the past 2 cycles (generally 4 years) of emergency training documentation for both training and exercises.

Part 6: Emergency Generator and Fuel

CMS CoP 482.625 (e) & 482.625 (e) 1-3

Interview

- Ask hospital or facility leaders to describe how they determined the **emergency power and stand-by systems** based on their risk assessment /HVA. (**EM.12.02.11, EP 1**)
- Ask hospital or facility leaders to describe

- How they monitor and track **onsite fuel sources (EM.12.02.09, EP 1)** to power emergency generators and how they will **replenish** fuel sources **(EM.12.02.09, EP 2)**
- Plans for how they will **keep emergency power systems operational (EM.12.02.11, EP 3)** during the duration of emergencies, unless it evacuates.
- Providing **alternate sources of energy** to maintain temperatures, emergency lighting, fire detection systems and sewage/waste disposal **(EM.12.02.11, EP 4)**

Document Review

- ☐ See Part 6 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Part 7: Integrated Healthcare Systems (if applicable)

CMS CoP 482.625 (f) & 482.625 (f) 1-4

Interview

- ☐ Verify if the hospital has opted to be part of its health care system's unified and integrated emergency preparedness program **(EM.09.01.01, EP 2)**
- ☐ Ask leaders to describe how the program is updated (at least every 2 years) based on changes within the health care system **(EM.17.01.01, EP 3)**

Document Review

- ☐ See Part 7 - required written documentation in the Documentation Review Tool to assess compliance with EPs

Emergency Management (EM) Documentation Review Tool – HAP/CAH

This EM Documentation Review Tool complements the EM Discussion Tool and is intended to provide a checklist of required written documentation

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
Part 1: Emergency Management Program				
☐ Written emergency management program (may be incorporated with EOP or other policies and procedures) (See listed items to ensure comprehensive program requirements)	All hospitals and CAHs	EM.09.01.01, EPs 1 & 3	HAP 482.15 CAH485.625	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No
Part 1: Hazard Vulnerability Analysis (HVA)				
☐ Written all-hazards HVA that include: ☐ Facility-based and community-based risk assessment ☐ Strategies for addressing events identified by the risks ☐ HVA includes All-hazards: - Natural hazards - Human-caused hazards - Technological hazards - Hazardous materials - Emerging infectious diseases	All hospitals and CAHs	EM.11.01.01, EPs 1-4	HAP 482.15 (a)(1) - (a)(2) CAH485.625 (a)(1) - (a)(2)	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No
Part 2: Emergency Operations Plan (EOP)				
☐ Written EOP that include: - Addresses patient population & persons at-risk - Type of services provided in an emergency - Continuity of operations - Delegation of authority - Leadership succession - Cooperation and collaboration with external authorities	All hospitals and CAHs	EM.12.01.01, EPs 1 -2 & 6 EM.13.01.01, EPs 1-4	HAP 482.15 (a), (a)(3) - (a)(4) CAH485.625 (a), (a)(3) - (a)(4)	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No
Part 3: EM Policies and Procedures				
☐ Written Policies & Procedures that include: ☐ Provision of subsistence needs for staff and patients - food, water, medical and pharmaceutical supplies ☐ Alternate sources of energy to maintain: - temperatures to protect patient health & safety & safe and sanitary storage of provisions - emergency lighting,	All hospitals and CAHs	EM.12.01.01, EPs 1, 3, 4 & 7 EM.12.02.01, EP 5 EM.12.02.03, EPs 1 & 2 EM.12.02.05,	HAP 482.15 (b), (b)(1) – (b)(8) CAH485.625 (b), (b)(1) - (b)(8)	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
• fire detection, extinguishing and alarm systems ☐ Sewage and waste disposal ☐ System to track location of on-duty staff and sheltered patients ☐ Safe evacuation from the hospital (needs of evacuees, staff responsibilities, transportation, evacuation location(s)) ☐ Means to shelter in place ☐ System of medical documentation to preserve PHI ☐ Use of volunteers and other staffing strategies ☐ Arrangements and/or agreements with other hospitals and providers to receive patients if needed ☐ Role of the hospital in providing care and treatment at alternate care sites under an 1135 waiver		EP 1 EM.12.02.07, EP 2 EM.12.02.11, EP 4 IM.11.01.01, EP 1 PE.03.01.01, EP 4		
Part 4: Communications plan				
☐ Written communication plan that includes: ☐ Names & contact information for: • Staff • Entities providing services under arrangement • Patient physicians • Other hospitals • Volunteers ☐ Contact information for: • Federal, state, tribal agencies • Other sources of assistance ☐ Primary and alternate means for communicating with: • Hospital staff • Federal, state, tribal agencies ☐ Method for sharing information & medical documentation with other healthcare providers ☐ Means of providing/releasing information under 45 CFR 164.510(b)(1)(ii) ☐ Means of providing information about occupancy needs and ability to provide assistance	All hospitals and CAHs	EM.09.01.01, EP 3 EM.12.01.01, EP 1 EM.17.01.01, EP 3 EM.12.02.01, EPs 1, 3 - 5 EM.12.02.05, EP 1	HAP 482.15 (c), (c)(1) – (c)(7) CAH485.625 (c), (c)(1) - (c)(7)	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No
Part 5: EM Education & Training				
☐ Written education and training program Documented education & training occurs:	All hospitals and CAHs	EM.15.01.01, EPs 1, 2, 3	HAP 482.15	Current Review Date:

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
☐ Initially to all new/existing staff, those providing services under contract, volunteers ☐ At least every 2 years ☐ Staff demonstrate knowledge in EM procedures ☐ Conducts training when: - When roles & responsibilities change - When significant revisions are made to P&Ps - When procedural changes are made during an event		EM.16.01.01, EP 1	(d), (d)(1) - (d)(1)(v) CAH485.625 (d), (d)(1) - (d)(1)(v)	Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No
Part 5: EM Testing (Exercises)				
☐ Two annual emergency exercises are documented and conducted as follows: ☐ Participation in one operational-based exercise (full-scale community (if avail) or a functional facility-based) and ☐ One additional exercise of choice operations-based or discussion-based ☐ Has exemption from conducting its next operations-based exercise due to a real event in which the EOP was activated	Applies to all hospitals and CAHs	EM.16.01.01, EP 2	HAP 482.15 (d)(2) - (d)(2)(ii)(C) CAH485.625 (d)(2) - (d)(2)(ii)(C)	Exercise Date(s) #1 Exercise Date(s) #2 Additional Exercise Date(s):
Part 5: EM Program Evaluation				
☐ Documents and reviews of all emergency exercises, emergency or disaster incidents (After-action reports) ☐ Documentation, review, & update of improvement plans, actions taken, and any revisions made to plans/policies and procedures	Applies to all hospitals and CAHs	EM.17.01.01, EP 1	HAP 482.15 (d)(2)(iii) CAH485.625 (d)(2)(iii)	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No
Part 6: Emergency & Standby Power Systems (may be incorporated with LS document review/LS building tour)				
☐ A written plan for managing essential or critical utilities during an emergency that includes: - Emergency & standby power systems - Emergency generator location	Applies to all hospitals and CAHs	EM.12.02.09, EPs 1 - 2 EM.12.02.11, EPs 1--3 PE.03.01.01,	HAP 482.15 (e)(1) - (e)(3) CAH485.625 (e)(1) - (e)(3)	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3)

Assessment Item	Applicability	Joint Commission Standards	CMS CoP	Comments
- Emergency generator inspection & testing - Emergency generator fuel source		EP 3 PE.04.01.01, EP 1 PE.04.01.03, EP 3		Yes No
Part 7: Unified and Integrated EM Program (if applicable)				
If hospital is part of health care system and chooses to participate in a unified and integrated emergency management program: ☐ Program accounts for the hospital's unique circumstances, patient population, and services offered ☐ Documented community-based & individual facility-based risk assessment ☐ Unified and integrated EOP ☐ Integrated P&Ps ☐ Coordinated communication plan ☐ Training and testing program ☐ Reviews and evaluates exercises and emergency events ☐ Documentation of improvement plans, actions taken, revisions to plans/policies and procedures	Applies to Hospitals and CAHs that are part of a system that has a unified and integrated EM program	EM.09.01.01, EPs 2-3 EM.11.01.01, EPs 3-4 EM.12.01.01, EPs 1, 2 & 6 EM.13.01.01, EPs 1-4 EM.15.01.01, EP 1 EM.16.01.01, EP 1	HAP482.15 (f), (f)(1) - (f)(5) CAH485.625 (f), (f)(1) - (f)(5)	Current Review Date: Updated at least every 2 years? (EM.17.01.01, EP 3) Yes No

Program Specific Tracer – Suicide Prevention, including Ligature and Other Safety Risks Assessment

Applies to: Critical Access Hospital accreditation program, including psychiatric distinct part units

Duration

60 minutes (takes place as part of an individual tracer)

Participants

Clinical surveyors
Life Safety Code Surveyor

Organization:

- Staff who have been involved in the individual's care, treatment, or services
- Facility manager(s)
- Safety Management Coordinator
- Nurse Leader or chief nursing officer
- Medical Director or chief medical officer

See revised elements of performance at NPG.08.01.01

Rationale:

The rate of suicide is increasing in America.¹ Now the 11th leading cause of death,² suicide claims more lives than traffic accidents³ and more than twice as many as homicides.⁴ At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,⁵ usually for reasons unrelated to suicide or mental health.⁶⁻⁷ Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.⁸

Objectives-

The surveyor will do the following:

- Evaluate the effectiveness of the organization's suicide prevention strategy.
- Identify process and system level issues contributing to suicide attempts and/or death by suicide.
- Evaluate the effectiveness of the organization's processes for designing and maintaining buildings and the patient care environment in a manner to prevent suicides and self-harm behaviors.
- Evaluate the effectiveness of the organization's processes for identifying, assessing, and resolving or mitigating ligature, suicide, and self-harm risks present in the environment.
- Assess the organization's ability to implement and maintain activities to mitigate against environmental risks, through clinical program activities such as suicide risk assessment, precautions, one-to-one monitoring when appropriate, contraband searches, patient observation checks, etc.
- Educate the organization on potential actions to take to address any identified ligature or suicide and self-harm vulnerabilities. All JC resources can be found at www.jointcommission.org, Knowledge Library> Resource Centers > Suicide Prevention.

Before

- Determine where patients are being treated for psychiatric conditions or may be at risk for suicide or self-harm within the hospital.
 - Dedicated spaces are those used only for psychiatric care, this includes locked, Psychiatric Inpatient Units, and may include temporary housing in the Emergency Department or other inpatient care areas that are dedicated for use for psychiatric care as determined by the organization.
 - Non-dedicated spaces include all other units/areas that may treat or house a patient at high risk for suicide.
- The following items are needed for this activity:
 - Risk assessment(s) for environment and existing mitigation plans for any dedicated space. Plan/process to remove non-essential items for non-dedicated spaces.
 - Related policies on patient safety and suicide risk assessment and treatment
 - Any state or national guidelines they are using in the risk assessment process
- Together, identify any questions the team needs answers to, based on review of the risk assessment(s), mitigation plans, policies on patient safety and suicide risk assessment, and state or national guidelines the organization is using. Determine a strategy to gather the needed information.

- Plan interaction and communication with the entire team during survey to review any ligature, suicide, or self-harm issues or unusual observations identified.

During

Life Safety and clinical surveyors will determine how to best explore these issues, either as a team or by splitting up, to perform individual tracers and continuing the building tour.

Life Safety Surveyor

- **Dedicated Spaces:** Assess ligature (patient rooms/bathrooms), and other suicide and self-harm safety risks (all areas accessible to patients) during the building tour activity. Trace their presence back through the organization's environmental risk assessment.
- **Non-dedicated spaces:** Assess plan/process to prepare a room or space for a high-risk suicidal patient, including who is responsible, what items should be removed and resources available to guide staff. Validate compliance.

Clinical Surveyor

- Select a patient who:
 - Currently receiving services AND
 - is identified as a high risk for suicide OR
 - had a previous attempt at suicide
- Review the patient record to attain an understanding of services provided and patient specific issues.
- Interview the clinical staff working with the patient and explore the following issues:
 - Triage process – trace this patient from the time the organization is first involved with the patient.
 - Initial Screen and Assessment process –comprehensively trace from the initial risk screening and assessment through to treatment planning with a focus on mitigation strategies.
 - Reassessment process – trace the triggers for and frequency of reassessment of the risk for suicide as defined in policy and implementation of same.
 - Care planning process – trace from the assessment through to the individualization of care planning, including mitigation strategies relative to suicide risk and preventative care.
 - Continuum of care – evaluate the communication and coordination process with other staff, family, and significant others involved with care relative to the patient's level of suicide risk.
 - Education - evaluate education provided to the patient and family about ongoing care with respect to the suicide risk, including information for crisis situations.
 - Human Resource components – evaluate orientation, training and competency assessment of staff who care for patients at risk for suicide based on job duties and responsibilities.
- Interview other staff, (e.g. security, counselors) and ask about their training and processes related to caring for suicidal patients.

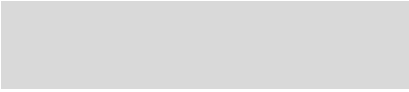
- Staffing – trace from staffing levels through to implementation of the organization’s safety observations to evaluate adequacy of staffing patterns to support mitigation plans.

After

- Consider the pervasiveness of identified issues and evaluate possible systems issues.
- Trace specific aspects of care, treatment and services for other patients/individuals served, as applicable, to evaluate extensiveness of identified problems
- Seek additional information, such as assessments of other high-risk patients, the organization’s history of patient safety events and the process for root cause analysis, or the process for monitoring compliance with its own policies, if necessary, during an Issue Resolution session.
- Discuss findings with the organization at the conclusion of the tracer activity and/or at the next daily briefing.

Documentation Instructions

- For dedicated spaces, the surveyor will document observations of ligature risks identified in patient rooms or bathrooms if they have not been identified on the risk assessment or self-harm or safety risks if they have not been identified on the risk assessment at NPG.08.01.01 and CoP 482.13 following the standard procedure using quantification, precise description, and all required elements of documentation.
- Clinical and Life Safety surveyors will collaborate on an analysis of ligature, suicide, and self-harm risks observed during the survey. Note: This analysis must be completed while the team is present on-site.
 - Evaluate existing plans the facility has for removing these risks.
 - Evaluate the organization’s environmental risk assessment process.
- If the organization attempts to correct findings during the survey, the review of the corrective action must include:
 - The actions taken to remove risks in total, or
 - The mitigation plan the organization is implementing.
- Findings of ligature, suicide, or self-harm will be evaluated according to the SAFER rating methodology in terms of Likelihood to Harm and Scope.
 - Risks have been identified, but not yet mitigated, and what actions have been implemented to operationally mitigate the risk.
 - Stratify level of risk based on identifying high, moderate, and low hazardous areas, such as private rooms, and out of sight areas such as stair enclosures, and places where patients may be alone, versus common use areas where staff are present.
- The survey team and organization will discuss all the mitigating efforts available and determine which will be implemented until the deficiency has been resolved. **This plan for mitigation of the risks on an interim basis must be documented as part of the requirement for improvement (RFI).**
- **Condition-Level Deficiencies: Level of deficiency is evaluated based on manner (prevalence) and degree (level of risk) of both environmental and clinical deficiencies.**
- **Immediate Threat to Life Consideration:** If the survey team has concerns about the organization’s ability to put effective clinical or



environmental mitigation in place, then the process for evaluating an ITHS should be initiated (contact SIG on call).

Workplace Violence Evaluation Tool

This is a guide to addressing the Workplace Violence Prevention requirements during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

Standard NPG.02.04.01: The critical access hospital has a workplace violence prevention program

EP 3: The critical access hospital conducts an annual worksite analysis related to its workplace violence prevention program. The critical access hospital takes actions to mitigate or resolve the workplace violence safety and security risks based on findings from the analysis.

Note: A worksite analysis includes a proactive analysis of the worksite, an investigation of the critical access hospital's workplace violence incidents, and an analysis of how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations.

JC Process:

The worksite analysis is an assessment of the environmental factors along with the procedures and operations that occur within that workspace to identify hazards, conditions, operations, and situations that could lead to potential violence based on a proactive assessment as well as events that have occurred.

Explore during interviews with leadership and/or LSC Building Tour:

- Is there evidence of multidisciplinary team input to complete the worksite analysis?
- Is mitigation/correction included in the analysis?

Resource: This is **NOT REQUIRED** but provides a good example: Occupational Safety and Health Administration, United States Department of Labor. (2016). "OSHA 3148-06R 2016: Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers." <https://www.osha.gov/Publications/osh3148.pdf>

Explore during individual tracers and staff/leadership interviews:

- Is there evidence the hospital personnel are aware of the workplace violence prevention program and actions taken to address identified risks?

Surveyor notes:

Standard NPG.11.01.01: The critical access hospital manages security risks.

EP 3: The critical access hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following:

- Injuries to patients or others within the critical access hospital's facilities and grounds

- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others
- Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures
- Medical or laboratory equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors.

Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.

Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, and to prevent similar incidents, are not lost as a result of following the legal process.

JC Process:

During interviews with leadership or Organization Quality and Performance Improvement session (can be completed during the Safety Culture assessment discussion or when reviewing hospital data to inform PI):

- Are workplace violence incidents, per our WPV definition, included in the hospital's safety/security incident reporting system?
- Does the organization have an established investigation process for WPV events?
 - **PLEASE NOTE:** The level of investigation is based upon the magnitude of events and organization processes. A root cause analysis is **NOT** required by JC for each event. See Sentinel Events (SE) chapter of the manual.

Explore during individual tracers and staff/leadership interviews:

Is there evidence that hospital personnel are aware of the process for internally reporting workplace violence incidents? Can they describe what happens after an incident is reported? Have relevant report data been shared with them? (See also HR.11.03.01, EP 5)

Surveyor notes:

Standard NPG.02.04.01: The critical access hospital has a workplace violence prevention program.

EP 2: As part of its workplace violence prevention program, the critical access hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention

program) to leaders, staff, and licensed practitioners. The critical access hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:

- What constitutes workplace violence
- Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement
- Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
- The reporting process for workplace violence incidents

JC Process:

During competency and medical staff credentialing activity and staff interviews during tracers:

- Are leadership, staff, and licensed practitioners educated regarding the events that need to be reported per the JC definition?
- Are they aware of their roles/responsibilities during/after event?
- Does staff know how to report an incident? Ease of access of reporting system?
- Evaluate that training and education was completed per the organization's policy/plan.

Surveyor notes:

NPG.02.04.01: The critical access hospital has a workplace violence prevention program.

EP 1: The critical access hospital has a workplace violence prevention program led by a designated individual and developed by a multidisciplinary team that includes the following:

- Policies and procedures to prevent and respond to workplace violence
- A process to report incidents in order to analyze incidents and trends
- A process for follow up and support to victims and witnesses affected by workplace violence, including trauma and psychological counseling, if necessary
- Reporting of workplace violence incidents to the governing body

JC Process:

Can be incorporated in the Leadership Session when safety culture assessment is discussed:

- Is there a designated individual to ensure that key components of the WPV program are in place?
 - Policies and procedures
 - Reporting system/structure (including the governing body)
 - Response/action plans based upon risks identified in worksite analysis and reported events

Surveyor notes:

Excellent Health Outcomes for All Evaluation Tool (HAP/CAH)

This is a guide to addressing the requirements for excellent health outcomes for all during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

JC Process:

Organizations need established leaders and standardized structures and processes in place to identify opportunities to achieve the optimal delivery of care, treatment and services for all. These efforts should be fully integrated with existing quality improvement activities within the organization.

Explore during interviews with leadership:

- Discuss how the organization has prioritized improving health outcomes for all as a quality and safety issue.

Explore during Individual Tracers and staff/leadership interviews:

- Is there evidence the hospital personnel are aware of the efforts to improve health outcomes for all?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

EP 1: The hospital designates an individual(s) to lead activities to improve health outcomes for all the hospital's patients.

Note: Leading the hospital's activities to improve health outcomes for all may be an individual's primary role or part of a broader set of responsibilities.

JC Process:

Explore during interviews with leadership:

- Identify the designated individual that is leading the organization's efforts to improve health outcomes for all.
- How was the individual selected?
- What is the scope of the individual's responsibilities?
- If the individual oversees improving health outcomes for all at multiple locations, how do they coordinate the efforts to address specific health outcome issues at each location?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

EP 2: The hospital assesses the patient's health-related social needs (HRSNs) and provides information about community resources and support services.

Note 1: Hospitals determine which HRSNs to include in the patient assessment. Examples of a patient's HRSNs may include the following:

- Access to transportation
- Difficulty paying for prescriptions or medical bills
- Education and literacy
- Food insecurity
- Housing insecurity

Note 2: HRSNs may be identified for a representative sample of the hospital's patients or for all the hospital's patients.

JC Process:

Explore during interviews with leadership:

- Discuss how the organization assesses patients' health-related social needs.
 - Which patients are asked about their health-related social needs? How did the organization identify which patients to assess for health-related social needs (for example, OB, pediatrics, specific diagnosis)?
 - Which health-related social needs are being assessed?
- How has the organization identified community resources and services that address the health-related social needs of its patients?
- How does the organization provide information about community resources and services to patients with health-related social needs?

Explore during Individual Tracers and staff/leadership interviews:

- Determine whether the patient's health-related social needs were assessed.
 - Are health-related social needs being assessed for the subpopulation identified by the organization?
- If a health-related social need was identified, ask whether the patient was given information on available resources to address the health-related social need.
 - Verify that resource information was provided to the patient.

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

EP 3: The hospital identifies differences in the care provided to its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.

Note 1: Hospitals may focus on areas with known differences across populations identified in the scientific literature (for example, organ transplantation, maternal care, diabetes management) or select measures that affect all patients (for example, experience of care and communication).

Note 2: Hospitals determine which sociodemographic characteristics to use for stratification analyses. Examples of sociodemographic characteristics may include the following:

- Age
- Gender
- Preferred language
- Race and ethnicity
- Veterans
- Patients in rural communities
- Physical, mental, and cognitive disabilities

JC Process:

Explore during the Organization Quality and Performance Improvement session

Note: this process mirrors that for other requirements related to data collection, trending, action planning (LD, PI chapters).

- Review the organization's stratified quality measures.
- How did the organization determine which quality measures to focus on and which sociodemographic characteristics to use in their analysis?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

EP 4: The hospital develops a written action plan that describes how it will improve health outcomes for all by addressing at least one of differences identified in the care provided to its patient population.

JC Process:

Explore during the combined Organization Quality and Performance Improvement session:

Note: this process mirrors that for other requirements related to data collection, trending, action planning (LD, PI chapters).

- Review the organization's written action plan for improving health outcomes for all.
 - How did the organization identify which difference (or differences) to address?
 - Verify written action plan for at least 1 of the differences identified.

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

EP 5: The hospital acts when it does not achieve or sustain the goal(s) in its action plan to improve health outcomes for all.

JC Process:

Explore during the combined Organization Quality and Performance Improvement session:

Note: this process mirrors that for other requirements related to data collection, trending, action planning (LD, PI chapters).

- Review the revisions to the written action plan if the organization's goal(s) to improve health outcomes for all is not achieved or sustained.
- How did the organization determine which area(s) to improve?

Surveyor notes:

Standard NPG.04.01.01: Improving health outcomes for all the hospital's patients is a quality and safety priority.

EP 6: At least annually, the hospital informs key stakeholders, including leaders, licensed practitioners, and staff, about its progress to improve health outcomes for all.

JC Process:

Explore during interviews with leadership:

- Discuss how information about the organization's activities to improve health outcomes for all is disseminated within the organization (for example, quarterly meetings, newsletters, web page).

Explore during Individual Tracers and staff/leadership interviews:

- Ask staff how they receive information about the organization's progress to improve health outcomes for all its patients. How frequently is the information disseminated?

Surveyor notes:

Antibiotic Stewardship Evaluation Tool (HAP/CAH)

This is a guide to addressing the Antibiotic Stewardship requirements during the survey.

PRE-SURVEY: Gather and Review

Review all pertinent documents submitted or provided by the organization.

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

JC Process:

Optimizing the use of antibiotics is a patient safety priority, and antibiotic stewardship programs play a critical role in supporting appropriate antibiotic prescribing practices and reducing antibiotic resistance. The revisions to Standard MM.09.01.01 include a combination of updates to align with federal regulations and recommendations from scientific and professional organizations, editorial changes, additional notes to clarify expectations, and EPs that will now apply to all accredited hospitals (deeming lead-in statements have been deleted).

Explore during interviews with leadership:

- Discuss how the organization supports its antibiotic stewardship program.

Explore during Individual Tracers and staff and leadership interviews:

- Is there evidence the hospital personnel are aware of the antibiotic stewardship program and its efforts to reduce antibiotic resistance?

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

EP 1: The antibiotic stewardship program reflects the scope and complexity of the critical access hospital services provided.

JC Process:

Explore during interviews with antibiotic stewardship program leadership:

- The scope of the antibiotic stewardship program.
- How does the leader ensure that the program covers the complexity of the hospital's services?
- What evidence is available to demonstrate the program is suitable for the scope and complexity of the services provided by the hospital?

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

EP 2: The critical access hospital demonstrates that an individual (or individuals), who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship, is appointed by the governing body as the leader(s) of the antibiotic stewardship program and that the appointment is based on the recommendations of medical staff leadership and pharmacy leadership.

JC Process:

Explore during interviews with hospital leadership and the program leader:

- *Identify the leader(s) of the antibiotic stewardship program.*
- *How does the organization determine the individual(s) is qualified to lead the antibiotic stewardship program?*
- *If Board members are present during the session, ask how they are involved in decisions about the leader(s) of the antibiotic stewardship program.*
- *Ask the program leader(s) about their qualifications to oversee antibiotic stewardship for the hospital.*

During the Competency Assessment Session:

- Request the antibiotic stewardship program leader(s) personnel file for review to determine whether they are qualified through ongoing education, training, experience, or certification to oversee the antibiotic stewardship program.
- Ask to see the policies and procedures that govern the antibiotic stewardship program to determine they address the roles and responsibilities for antibiotic stewardship and use within the hospital, how the various hospital committees and departments interface with the program, and how to optimize antibiotic use.
- Review the criteria the hospital used to determine the resources necessary to operate effectively and ensure the resource allocation matches the determined needs.

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

EP 3: The leader(s) of the antibiotic stewardship program is responsible for the following:

- Developing and implementing a critical access hospitalwide antibiotic stewardship program that is based on nationally recognized guidelines to monitor and improve the use of antibiotics
- Documenting antibiotic stewardship activities, including any new or sustained improvements
- Communicating and collaborating with the medical staff, nursing leadership, and pharmacy leadership, as well as with the critical access hospital's infection prevention and control and quality assessment and performance improvement programs on antibiotic use issues
- Providing competency-based training and education for critical access hospital personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the critical access hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures

JC Process:

Explore during the combined Organization Quality and Performance Improvement session or medication safety individual tracer:

- Review the organization's guidelines about appropriate antibiotic prescribing practices.
- Ask about how medical/nursing/pharmacy staff are involved in the antibiotic stewardship program.

Explore during the Competency and Medical Staff Credentialing and Staff Interviews:

- Review the competency-based training addressing the organization's antibiotic stewardship guidelines, policies, and procedures.

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

EP 4: The governing body ensures all antibiotic use issues identified by the antibiotic stewardship program are addressed in collaboration with the critical access hospital's QAPI leadership.

JC Process:

Explore during the Organization Quality and Performance Improvement session or Leadership Session:

- Interview program leader(s) to confirm that the hospital's infection control program and antibiotic stewardship program are being coordinated with their QAPI leadership, medical staff, nursing services, and pharmacy services.
- Determine through interview if identified infection control and antibiotic use problems are reported to the hospital's leadership.
- Verify that hospital leaders take steps to assure that corrective actions are implemented and successful.
- If the antibiotic stewardship program's data analysis shows improvements are needed, verify that an action plan is in place.

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

EP 5: The critical access hospitalwide antibiotic stewardship program:

- Demonstrates coordination among all components of the critical access hospital responsible for antibiotic use and resistance, including, but not limited to, the infection prevention and control program, the quality assessment and performance improvement program, the medical staff, nursing services, and pharmacy services.
- Documents the evidence-based use of antibiotics in all departments and services of the critical access hospital.
- Documents any improvements, including sustained improvements, in proper antibiotic use.

JC Process:

Explore during Individual Tracer Activity through interviews:

- *Ask staff that work in various departments and services who prescribe antibiotics about the antibiotic stewardship program and if they are aware of any improvements that have been made to the hospital's antibiotic prescribing practices.*
- *Ask staff that work in various departments and services who prescribe antibiotics how the hospital promotes the evidence-based use of antibiotics.*

Explore during the Organization Quality and Performance Improvement session or medication safety individual tracer:

- *Review the hospital's antibiotic stewardship policies and procedures for evidence that the hospital has a process in place for coordination among all components of the hospital responsible for antibiotic use and resistance, including, but not limited to, the antibiotic stewardship program, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services.*
- *Ask about any improvements in proper antibiotic use that have been achieved and sustained.*

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

EP 6: The antibiotic stewardship program adheres to nationally recognized guidelines, as well as best practices, for improving antibiotic use.

JC Process:

Explore during the Organization Quality and Performance Improvement session or individual tracer activity:

- Ask staff who prescribe antibiotics about the nationally recognized guidelines that have been implemented as part of the hospitalwide antibiotic stewardship program.
- Verify that core elements of best practices have been included within the hospitalwide antibiotic stewardship program, including hospital leadership commitment, accountability, pharmacy expertise, tracking, reporting, education, and appropriate interventions or actions being taken to improve antibiotic use to reduce adverse events, prevent emergence of resistance, and ensure better outcomes for patients in this setting.

Surveyor notes:

Standard MM.18.01.01: The critical access hospital establishes antibiotic stewardship as an organizational priority through support of its antibiotic stewardship program.

EP 7: The governing body ensures that systems are in place and operational for the tracking of all antibiotic use activities in order to demonstrate the implementation, success, and sustainability of such activities.

JC Process:

Explore during the Organization Quality and Performance Improvement session or Leadership Session:

- Interview program leaders to confirm that the hospital's infection control program and antibiotic stewardship program are being coordinated with their QAPI leadership, medical staff, nursing services, and pharmacy services.
- Review the hospital policies and governing body meeting minutes for record of support for the infection control and antibiotic stewardship programs.
- Verify that the hospital policies are being followed for the tracking of all infection surveillance, prevention and control, and the monitoring of hospital antibiotic use activities.

Surveyor notes:

Standard NPG.14.06.01: The critical access hospital has an active antibiotic stewardship program.

EP 1: The critical access hospital has a multidisciplinary committee that oversees the antibiotic stewardship program.

Note 1: The committee may be composed of representatives from the medical staff, pharmaceutical services, the infection prevention and control program, nursing services, microbiology, information technology, and the quality assessment and performance improvement program.

Note 2: The committee may include part-time or consultant staff. Participation may occur on site or remotely.

JC Process:

Explore during the Organization Quality and Performance Improvement session or Medication Safety Individual Tracer:

- *How does the multidisciplinary committee oversee the antibiotic stewardship program?*
- *Which disciplines are represented on the multidisciplinary committee (the composition is determined by the hospital)?*
- *What is the scope of the multidisciplinary committee's oversight?*
- *What is the frequency of committee meetings?*

Surveyor notes:

Standard NPG.14.06.01: The critical access hospital has an active antibiotic stewardship program.

EP 2: The antibiotic stewardship program monitors the critical access hospital's antibiotic use by analyzing data on days of therapy per 1000 days present or 1000 patient days, or by reporting antibiotic use data to the National Healthcare Safety Network's Antimicrobial Use Option of the Antimicrobial Use and Resistance Module.

JC Process:

Explore during the Organization Quality and Performance Improvement session or Medication Safety Individual Tracer:

- *Verify that data about the hospital's antibiotic use is collected and monitored.*

Surveyor notes:

Critical Access Hospital National Performance Goals Evaluation Module

This is a guide to surveying selected National Performance Goals that are not already addressed in other topic-specific survey tools (for example, Antibiotic Stewardship Evaluation Tool, Excellent Health Outcomes for All Evaluation Tool, Workplace Violence Prevention Tool).

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.01.01.01 The hospital has a process in place to correctly identify patients when providing care, treatment, and services. NPG.01.01.01, EP 1 The hospital has a process in place to correctly identify patients when providing care, treatment, and services. This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier. Note: Examples of patient identifiers may include but are not limited to the following: - Assigned identification number (for example, medical record number) - Telephone number or another person-specific identifier - Electronic identification technology coding, such as bar coding or RFID, that includes two or more person-specific identifiers This includes using at least two patient identifiers. The hospital does not use the patient's room number or physical location as an identifier. NPG.01.01.01, EP 2 The hospital labels containers used for blood and other specimens in the presence of the patient. NPG.01.01.01, EP 3 The hospital uses distinct methods of identification for newborn patients. Note: <u>Examples of methods to prevent misidentification may include:</u> - Distinct naming systems that are based on established patient naming guidelines or frameworks, and use the mother's first and last names preceded by the newborn's sex, or "baby" if sex is unknown (for example, if single birth: GirlKatherine Miller-Smith, for multiple births: Boy1Katherine Miller-Smith and Girl2Katherine Miller-Smith; for newborns with identical mother's first and last name: BOYMariaGomes, BOY MariaSueGomez). - Standardized practices for identification banding, such as two body sites	Interview ☐ Interview staff in areas where care and treatment is provided to ascertain the processes surrounding two patient identifiers. ☐ Interview patients if possible, in these areas as well, to determine if adherence to hospital policy is followed. Determine if patients are educated to this process for understanding and safety. Document Review ☐ Review hospital policy and procedures. Determine if data is collected and if there are any PI activities associated with internal reporting of events. Observation ☐ Observe care processes to determine if staff are adhering to requirements.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
and/or bar coding. - Staff communication tools, such as visual alerts or signage for newborns with similar names. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example: "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples). - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification). - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).	
NPG.01.02.01 The hospital reports critical results of tests and diagnostic procedures on a timely basis. NPG.01.02.01, EP 1 The hospital develops and implements written procedures for managing the critical results of tests and diagnostic procedures that address the following: - The definition of critical results of tests and diagnostic procedures - By whom and to whom critical results of tests and diagnostic procedures are reported - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures NPG.01.02.01, EP 2 The hospital evaluates the timeliness of reporting the critical results of tests and diagnostic procedures.	Interview ☐ Ask the responsible staff about the process for critical results to determine knowledge of processes. Document Review ☐ Review policy and procedures related to reporting of critical results of tests and diagnostic procedures. ☐ Review data collected and any PI to ascertain the activities of the hospital. ☐ Review required documentation within patient medical records, according to hospital policy.
NPG.01.04.01 The hospital has a process for hand-off communication. NPG.01.04.01, EP 1. The hospital follows a process to receive or share patient information when the patient is referred to internal providers of care, treatment, and services.	Interview ☐ Ask staff about the patient hand-off process and what information is shared between the giver and receiver. ☐ Ask staff who the hand-off process applies to internally.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.01.04.01, EP 2. The hospital's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. Note: Such information may include the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.	
NPG.01.05.01 The hospital improves the safety of clinical alarm systems. NPG.01.05.01, EP 1 Identify the most important alarm signals to manage based on the following: - Input from the medical staff and clinical departments - Risk to patients if the alarm signal is not attended to or if it malfunctions - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue - Potential for patient harm based on internal incident history - Published best practices and guidelines NPG.01.05.01, EP 2 Establish policies and procedures for managing the alarms identified in NPG.01.05.01, EP 1 above that, at a minimum, address the following: - Clinically appropriate settings for alarm signals - When alarm signals can be disabled - When alarm parameters can be changed - Who in the organization has the authority to set alarm parameters - Who in the organization has the authority to change alarm parameters - Who in the organization has the authority to set alarm parameters to “off” - Monitoring and responding to alarm signals - Checking individual alarm signals for accurate settings, proper operation, and detectability.	Purpose Make improvements to ensure that alarms on medical equipment are heard and responded to on time. Interview ☐ Interview CEO, CMO, CNO, and other formal leaders such as board members to understand the process taken to establish hospital priorities, including risk analysis and recommendations from medical staff and clinical departments in determining alarm system safety as a hospital priority. ☐ Interview patients to identify if alarm signals are answered and are timely. Document Review ☐ Review board meeting minutes to determine hospital priorities. ☐ Review policy and procedures that were analyzed from EP 2. • Is there evidence that medical staff and clinical departments had input. • What risks were identified if alarm signal is not attended or it malfunctions • Were specific alarm signals reviewed for unnecessary noise or contribute to alarm fatigue • What published best practices and guidelines were used in the review for policy and procedures ☐ Request internal list of incident reports that were associated to alarm signals, noise and fatigue; has the hospital made changes if incidents were associated with alarms?

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
	Observation □ During survey activities in patient care areas, listen for alarms and signals. Are staff and providers responding according to risks both clinically and environmentally.
NPG.01.05.02 The hospital recognizes and responds to changes in a patient's condition. Note: Hospitals are not required to create rapid response teams or medical emergency teams in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved. NPG.01.05.02, EP 1 The hospital develops and implements written criteria describing early warning signs of a change or deterioration in a patient's condition and the appropriate action to take.	Interview □ Ask staff about the available criteria and guidance that describe early warning signs of a change or deterioration in a patient's condition and how they should respond. □ Ask staff about the education and training they have received about the early warning signs of changes in patient condition and how to respond. Document Review Review the written criteria that describes early warning signs of a change or deterioration in patient condition in the form that is available to staff. Observation Ask staff to demonstrate how they access the change in patient condition early warning signs criteria and guidance.
NPG.01.05.03 Resuscitative services are available throughout the hospital. NPG.01.05.03, EP 1 The hospital provides resuscitative services based on national standards of care, guidelines, and the hospital's policies, procedures, or protocols. NPG.01.05.03, EP 2 Resuscitation equipment is available for use based on the needs of the population served. Note: For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. NPG.01.05.03, EP 3 The hospital provides education and training to staff involved in the provision of resuscitative services. The hospital determines which staff complete this education and training based on their job	Interview □ Ask staff members about their responsibilities during resuscitation and about the education and training on resuscitation that the hospital has provided. Ask how frequently education and training on resuscitation are provided. □ Ask staff if patient population appropriate resuscitation equipment is available and accessible when needed. Observation □ Verify resuscitation equipment is available, properly maintained, and staff responsible in the use of the equipment are competent

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
responsibilities and hospital policies and procedures. The education and training are provided at the following intervals: - At orientation - A periodic basis thereafter, as determined by the hospital - When staff responsibilities change Note 1: Topics may cover resuscitation procedures or protocols; use of cardiopulmonary resuscitation techniques, devices, or equipment; and roles and responsibilities during resuscitation events. Note 2: The hospital determines the format and content of education and training (for example, a skills day, a mock code).	Document Review Personnel Files Review personnel files of staff who per hospital policy should have resuscitative services education and training for evidence of completion at the required intervals.
NPG.01.05.04 The hospital develops and implements processes for post-resuscitation care. NPG.01.05.04, EP 1 The hospital develops and implements policies, procedures, or protocols based on current scientific literature for interdisciplinary post-cardiac arrest care. Note 1: Post-cardiac arrest care is aimed at identifying, treating, and mitigating acute pathophysiological processes after cardiac arrest and includes evaluation for targeted temperature management and other aspects of critical care management. Note 2: This requirement does not apply to hospitals that do not provide post-cardiac arrest care. NPG.01.05.04, EP 2 The hospital develops and implements policies, procedures, or protocols based on current scientific literature to determine the neurological prognosis for patients who remain comatose after cardiac arrest. Note 1: Because any single method of neuroprognostication has an intrinsic error rate, current guidelines recommend that multiple testing modalities be incorporated into the hospital's routine procedures and protocols to improve decision-making accuracy.	Interview ☐ Ask staff if they are aware of any hospital policies, procedures, or protocols for interdisciplinary post-cardiac arrest care. ☐ Ask staff if the hospital has policies, procedures, or protocols on determining the neurological prognosis for patients who remain comatose after cardiac arrest. Document Review Confirm the hospital has post cardiac arrest care policies, procedures, or protocols available.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
Note 2: This requirement does not apply to hospitals that do not provide post-cardiac arrest care.	
NPG.01.05.05 The hospital reviews resuscitation cases to identify opportunities for improvement. NPG.01.05.05, EP 1 An interdisciplinary committee reviews cases and data to identify and suggest practice and system improvements in resuscitation performance. Note 1: Review examples could include the following: - How often early warning signs of clinical deterioration were present prior to in-hospital cardiac arrest in patients in nonmonitored or non-critical care units - Timeliness of staff's response to a cardiac arrest - Quality of cardiopulmonary resuscitation (CPR) - Post-cardiac arrest care processes - Outcomes following cardiac arrest Note 2: The review functions may be designated to an existing interdisciplinary committee.	Interview ☐ Clinical leaders to determine if there is an interdisciplinary committee review of resuscitation cases. ☐ Ask about the data being collected and analyzed and if any improvements have been made in resuscitation performance as a result.
NPG.01.06.01 The hospital conducts a preprocedure verification process. NPG.01.06.01, EP 1 The hospital implements a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. Note: The patient is involved in the verification process when possible. NPG.01.06.01, EP 2 The hospital identifies the items that must be available for the procedure and uses a standardized list to verify their availability. At a minimum, these items include the following: - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment) - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed	Interview ☐ In procedural areas, inquire with staff and licensed practitioners if there is a preprocedure verification process. • Can staff describe the steps and who is involved in the verification process? • Are they able to articulate their own responsibilities in the process? • What happens if the described process does not occur? Are they encouraged or feel safe to speak up? • If possible, interview a patient to determine if they were involved in the process. Document Review

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Any required blood products, implants, devices, and/or special equipment for the procedure Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.	☐ Review documents related to procedural services and care of the patient. This may include but is NOT limited to anesthesia policies, surgical services procedures, medical staff bylaws. ☐ Review patient medical records for those requirements as determined by the organization. Observation ☐ Observe patient care service in procedural areas to verify hospital processes related to preprocedure verification.
NPG.01.06.02 The hospital marks the procedure site. NPG.01.06.02, EP 1 The hospital identifies those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety. Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level. NPG.01.06.02, EP 2 The procedure site is marked before the procedure is performed and, if possible, with the patient involved. NPG.01.06.02, EP 3 The procedure site is marked by a licensed practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications: - An individual in a medical postgraduate education program who is being supervised by the licensed practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed	Interview ☐ In procedural areas, inquire with staff and licensed practitioners about the site marking processes established by the hospital and what their role is within the procedure. • Can they identify what procedures require marking and those that do not? • What happens if a patient refuses site marking? Document Review ☐ Review documents related to procedural services and care of the patient. This may include but is NOT limited to: anesthesia policies, surgical services procedures, medical staff bylaws. ☐ Review patient medical records for those requirements as determined by the organization. Observation ☐ Observe patient care in procedural areas to verify hospital processes related to procedural site marking.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed. Note: The hospital's leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications. NPG.01.06.02, EP 4 The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital. Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site. NPG.01.06.02, EP 5 A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum). Note: Examples of other situations that involve alternative processes include the following: - Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice - Teeth - Premature infants, for whom the mark may cause a permanent tattoo	
NPG.01.06.03 The hospital performs a time-out before the procedure. NPG.01.06.03, EP 1 The hospital conducts a time-out immediately before starting the invasive procedure or making the incision. NPG.01.06.03, EP 2 The time-out has the following characteristics: - It is standardized, as defined by the hospital. - It is initiated by a designated member of the team.	Interview ☐ In procedural areas, inquire with staff and licensed practitioners about the time out process • Who leads the time out? • What happens when the process is not followed according to hospital policy and procedure? Document Review

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning. NPG.01.06.03, EP 3 When two or more procedures are being performed on the same patient, and the person performing the procedure changes, the hospital performs a time-out before each procedure is initiated. NPG.01.06.03, EP 4 During the time-out, the team members agree, at a minimum, on the following: - Correct patient identity - The correct site - The procedure to be done NPG.01.06.03, EP 5 The hospital documents the completion of the time-out. Note: The hospital determines the amount and type of documentation.	☐ Review documents related to procedural services and care of the patient. This may include but is NOT limited to: anesthesia policies, surgical services procedures, medical staff bylaws. ☐ Review patient medical records for those requirements as determined by the organization. Observation ☐ Observe patient care in procedural areas to verify hospital processes related to the time out process. Note: The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure. A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.
NPG.02.01.01 The mission, vision, and goals guide the hospital's actions. NPG.02.01.01, EP 1 The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals, which guide the leaders' actions. The mission, vision, and goals are communicated to staff and the population(s) served.	Interview ☐ Ask senior leaders about the creation of the organization's current mission, vision, and goals. Determine who was involved in the creation. ☐ Ask leaders and staff at all levels of the organization about how the mission, vision and goals influence day-to-day activity throughout the organization.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
	Observation ☐ Look for evidence that the organization’s mission, vision, and goals are being communicated throughout the organization.
NPG.02.02.01 The hospital addresses conflicts of interest and ethics. NPG.02.02.01, EP 1 The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest that could affect safety and quality of care, treatment, and services. NPG.02.02.01, EP 2 The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflicts of interest will be addressed. NPG.02.02.01, EP 3 Conflicts of interest are disclosed as defined by the hospital. NPG.02.02.01, EP 4 Senior managers and leaders of the organized medical staff work with the governing body to develop and implement an ongoing process for managing conflict among leadership groups that has the potential to adversely affect patient safety or quality of care. NPG.02.02.01, EP 5 The hospital develops and implements a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.	Interview ☐ Ask leaders about the organization’s policy and process for managing conflicts of interest among leadership groups. ☐ Ask leaders about the organization’s process for staff, patients, and families to raise ethical issues and issues prone to conflict. Document Review ☐ Review the organization’s written description of conflicts of interest that could affect safety and quality of care, treatment, and services. ☐ Review the organization’s written policy on how conflicts of interest will be addressed.
NPG.02.03.01 The hospital’s leaders design work processes to focus individuals on safety and quality issues. NPG.02.03.01, EP 1 The leaders implement a hospitalwide patient safety program as follows: - One or more qualified individuals or an interdisciplinary group manage the safety program. - All departments, programs, and services within the hospital participate in the safety program.	Interview ☐ Discuss the Safety Culture in the organization including: • How well the leaders understand the assessment tool, scope of assessment in the organization, response rates, and reported results. • Does the organization have benchmarks? Are these Internal and/or external benchmarks • What quality improvement projects have been undertaken to improve your scores on safety culture?

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events. NPG.02.03.01, EP 2 The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. Note: Examples of voluntary programs include Joint Commission’s Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. NPG.02.03.01, EP 3 As part of the safety program, the leaders create procedures for responding to system or process failures. Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis. NPG.02.03.01, EP 4 The leaders provide and encourage the use of systems for internal reporting of a system or process failure, or the results of a proactive risk assessment, without the risk of retaliation. Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for errors due to negligence. NPG.02.03.01, EP 5 The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Event Policy" (SE) chapter of this manual. NPG.02.03.01, EP 6 The leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that health care workers who are involved in sentinel events may be negatively affected by the event and require support. Support systems provide staff with help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.	• Does the Board set expectations for improving safety culture? • Does the organization include safety culture improvement goals in performance expectations for leaders and middle management? □ Discuss the code of conduct that leaders developed and adopted for physicians and staff. • Is it the same for everyone? • Describe your policy and procedures for dealing with intimidating behaviors, especially by physicians. • What has been done to try to eradicate intimidating behavior? • How do staff report intimidating behavior? • How widespread is disrespectful behavior in your organization? ▪ Does the organization measure it? ▪ How do you deal with serial violators? ▪ Do you use the same process for all caregivers? ▪ Are your disciplinary procedures equitable and transparent? • How do you decide if discipline should be used in evaluating errors? ▪ Did the individual depart from agreed and available safe practices or protocols (foresight test)? ▪ Were there mitigating circumstances? • Would another person from the same professional group, with similar training and experience, behave in the same way in similar circumstances (substitution test)?

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.02.03.01, EP 7 At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter. HospitNPG.02.03.01, EP 8 To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. NPG.02.03.01, EP 9 Communication processes are effective in doing the following: - Fostering the safety of the patient and their quality of care - Supporting a culture of safety and quality - Meeting the needs of internal and external users - Informing those who work in the hospital of changes in the environment - Disseminating lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and proactive risk assessments to all affected staff. NPG.02.03.01, EP 10 Leaders evaluate the effectiveness of communication methods. NPG.02.03.01, EP 11 Leaders regularly evaluate the culture of safety and quality using valid and reliable tools. Possible issues are identified by the culture of safety evaluation. Proposed improvements are prioritized and implemented. NPG.02.03.01, EP 12 Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety. NPG.02.03.01, EP 13 Leaders create and implement a process for managing behaviors that undermine a culture of safety.	▪ Were there deficiencies in training, experience or supervision? ▪ Were there mitigating circumstances? ☐ In the event an error occurs, and a patient is harmed: • Do you have a process in place to determine whether this was a system error or whether the person responsible should be held accountable? • How do you separate blameless errors (for learning) from blameworthy errors (for discipline, equitably applied to all groups)? • What process do you have in place for reporting a “close call” or an error that occurred but did not reach the patient? ▪ How often is this used? ▪ Can you give me a recent example? • Do you conduct root cause analyses of all “near misses?” Document Review ☐ Process/tool used to conduct a safety culture assessment ☐ Current and past results of the safety culture assessment; changes made based on results
NPG.05.02.01 The hospital implements processes to support preparedness for high-consequence infectious diseases or special pathogens.	Interview ☐ Interview staff in the emergency department, urgent care settings about the hospital process for screening for fever,

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.05.02.01 EP 1 The hospital develops and implements protocols for high-consequence infectious diseases or special pathogens. The protocols are readily available for use at the point of care and address the following: - Identify: Procedures for screening at the points of entry to the hospital for respiratory symptoms, fever, rash, and travel history to identify or initiate evaluation for high-consequence infectious diseases or special pathogens - Isolate: Procedures for transmission-based precautions - Inform: Procedures for informing public health authorities and key hospital staff - Required personal protective equipment and proper donning and doffing techniques - Infection control procedures to support continued and safe provision of care while the patient is in isolation and to reduce exposure among staff, patients, and visitors using the hierarchy of controls - Procedures for managing waste and cleaning and disinfecting patient care spaces, surfaces, and equipment Note 1: Points of entry may include the emergency department, urgent care, and ambulatory clinics. Note 2: See the Glossary for a definition of hierarchy of controls. NPG.05.02.01 EP 2 The hospital develops and implements education and training and assesses competencies for staff who will implement protocols for high-consequence infectious diseases or special pathogens.	respiratory symptoms, rash, and travel history (the hospital may utilize active and/or passive screening processes, such as staff at the point of entry asking specific questions, posting visual alerts at the entrances of clinics on signs and symptoms that patients/visitors should report to staff when they first register for care, etc.) ☐ Ask who receives education and training on high-consequence infectious diseases or special pathogens and how frequently education and training are provided. ☐ Ask staff members in the intake or triage areas about their responsibilities for screening and education and training that the hospital has provided. Document Review ☐ Review hospital protocols for high-consequence infectious diseases or special pathogens and whether the protocols address the required elements.
NPG.05.03.01 The hospital complies with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the current World Health Organization (WHO) hand hygiene guidelines. NPG.05.03.01, EP 1 The hospital implements a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. The program sets goals for improving compliance with hand hygiene based on established goals.	Interview ☐ Discuss with staff and providers in all areas of patient care and services the hand hygiene guidelines established in the organization. • Include activities they have identified within the area of survey activities. • Discuss scenarios where safety culture may be identified. For example, hospital staff entering patient rooms- do staff

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
	AND patients feel safe to speak up if hand hygiene is not performed? ☐ Interview patients and ask if they observe hand hygiene procedures being performed, if so ask when? Document Review ☐ Request and review documents related to the hand hygiene program. These may include but are not all inclusive, hand hygiene-- policy, data and PI activities, Infection Control Plan and Risk assessment and goals. Observation ☐ Observe care being provided in all areas of the organization, are staff and providers following hand hygiene procedures adopted by the organization?
NPG.06.01.01 Pain assessment and pain management, including safe opioid prescribing, are identified as an organizational priority. NPG.06.01.01, EP 1 The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing, as well as developing and monitoring performance improvement activities. NPG.06.01.01, EP 2 The hospital provides nonpharmacologic pain treatment modalities. NPG.06.01.01, EP 3 The hospital provides staff with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population. NPG.06.01.01, EP 4 The hospital provides information to staff on available services for consultation and referral of patients with complex pain management needs. NPG.06.01.01, EP 5 The hospital identifies opioid treatment programs that can be used for patient referrals.	Interview ☐ Ask leaders how they have made pain assessment, pain management, and safe opioid prescribing an organizational priority ☐ Ask leaders how they provide staff with educational resources to improve pain assessment, pain management, and the safe use of opioids Ask staff about: ☐ Hospital processes for collecting patient-level data on pain assessment, pain management and safe-opioid prescribing such as: • Hospital process for identifying patients at high risk for adverse outcomes related to opioid treatment. • Hospital process for monitoring patients identified as high risk when receiving opioids.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.06.01.01, EP 6 The hospital facilitates licensed practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids. NPG.06.01.01, EP 7 Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment.	• How they screen, assess, and reassess patients for pain, non-pharmacologic approaches they offer. Ask physicians and other licensed practitioners about: ☐ Knowledge of pain assessment, pain management, and safe opioid prescribing initiatives by the hospital and any resources that have been made available. • Has the hospital provided access to and criteria that prompts accessing the Patient Drug Monitoring Database? • What non-pharmacologic modalities are available to patients and how were these modalities determined? • What information has leadership provided on available services for consultation and referral of patients with complex pain management needs? • What opioid treatment programs are available for patient referrals? Document Review ☐ Review documentation that demonstrates leadership making pain assessment, pain management, and safe opioid prescribing an organizational priority. Examples may include budget items or plans, strategic plans and performance improvement plans
NPG.06.02.01 The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment. NPG.06.02.01, EP 1 The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand. NPG.06.02.01, EP 2 The hospital screens patients for pain during emergency department visits and at the time of admission.	Interview Ask staff about: ☐ Hospital processes for collecting patient-level data on pain assessment, pain management and safe-opioid prescribing such as: • Hospital process for identifying patients at high risk for adverse outcomes related to opioid treatment. • Hospital process for monitoring patients identified as high risk when receiving opioids.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.06.02.01, EP 3 The hospital treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches. NPG.06.02.01, EP 4 The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals. NPG.06.02.01, EP 5 The hospital involves the patient in the pain management treatment planning process through the following: - Developing realistic expectations and measurable goals that the patient understands for the degree, duration, and reduction of pain - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function) - Providing education on pain management, treatment options, and safe use of opioid and nonopioid medications when prescribed NPG.06.02.01, EP 6 The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment. NPG.06.02.01, EP 7 The hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals, including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment NPG.06.02.01, EP 8 The hospital educates the patient and family on discharge plans related to pain management, including the following: - Pain management plan of care	• How they screen, assess, and reassess patients for pain, non-pharmacologic approaches they offer. Ask patients and when appropriate, family members about: ☐ How the staff involved them in their pain management, plan of care, what their pain management plan of care includes (non-pharmacologic, pharmacologic or a combination of approaches). ☐ Their level of understanding of discharge instructions related to the pain management plan of care including side effects of pain management treatment, activities of daily living in the home environment that may exacerbate pain including strategies to address these issues. Document Review ☐ Review patient clinical records for: • Screening, assessments, and reassessments of the patient's pain. • A pain treatment plan and involvement of the patient in the planning process. • Documentation of patient monitoring for pain and their response to pain management interventions, including effectiveness, side effects and risk factors for adverse events caused by the treatment. • Documentation of any patient and family education related to pain management throughout the stay and at the time of discharge.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Side effects of pain management treatment - Daily living activities, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care and strategies to address these issues - Safe use, storage, and disposal of opioids when prescribed	
NPG.06.03.01 The hospital collects data on pain assessment and management. NPG.06.03.01, EP 1 The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.	Interview ☐ Discuss with staff, as appropriate, at the unit level: • Data collection processes and responsibilities (for example but not limited to: medication management, blood and blood product use, resuscitation, restraints and seclusion, pain assessment, pain management, other) ☐ Ask leaders and staff responsible for the organization's quality assessment and performance improvement activities about the patient safety-related data monitoring that is taking place. Determine if pain assessment, pain management, including non-pharmacologic approaches, and safe opioid use are being monitored.
NPG.07.01.01 The hospital respects the patient's right to receive information in a manner the patient understands. NPG.07.01.01, EP 1 The hospital respects the patient's right to and need for effective communication. NPG.07.01.01, EP 2 The hospital provides interpreting and translation services, as necessary. Note: For hospitals that elect Joint Commission's Primary Care Medical Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated, and the languages into which they are translated, are dependent on the primary care medical home's patient population.	Interview ☐ Ask staff about the availability of tools and resources to assist with patient communication, such as: Access to language interpreters, access to translated documents, the potential for involvement of interpreter on care team Observation ☐ Look for staff use of available tools and resources to identify and address patient communication needs, such as language identification tools, language interpreter services, communication boards, use of teach back techniques to address health literacy needs, patient access to the nurse call button.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.07.01.01, EP 3 The hospital communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient's needs.	
NPG.07.02.01 The hospital honors the patient's right to give or withhold informed consent. NPG.07.02.01, EP 1 The hospital develops and implements a written policy on informed consent that describes the following: - Specific care, treatment, and services that require informed consent. - Circumstances that would allow for exceptions to obtaining informed consent. - Process used to obtain informed consent. - Physicians or other licensed practitioners permitted to conduct the informed consent discussion in accordance with law and regulation. - How informed consent is documented in the patient record. Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record. - When a surrogate decision-maker may give informed consent. NPG.07.02.01, EP 2 The informed consent process includes a discussion about the following: - Patient's proposed care, treatment, and services. - Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving their goals; and any potential problems that might occur during recuperation. - Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.	Interview ☐ Ask staff, including physicians and other practitioners about the process they follow when a patient's care, treatment, and services requires informed consent. • What do they explain and discuss with the patient? • How do they document informed consent in the patient's medical record? • What happens when a patient is unable to provide informed consent? ☐ Ask a patient who is scheduled for a procedure about the process they experienced when they were asked to consent to the procedure. Document Review General ☐ Confirm that the hospital has a written policy on patient informed consent and that it addresses all the EP requirements. Patient Clinical Record Patient informed consent documented per hospital policy

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.07.03.01 The hospital assesses the patient who may be a victim of possible abuse, neglect, and exploitation. NPG.07.03.01, EP 1 The hospital uses written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, elder or child abuse, neglect, and exploitation. Patients are evaluated upon entry into the hospital and on an ongoing basis. Note: Criteria can be based on age, sex, and circumstance. NPG.07.03.01, EP 2 To assist with referrals of possible victims of abuse, neglect, and exploitation, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care. NPG.07.03.01, EP 3 The hospital educates staff about how to recognize signs of possible abuse, neglect, and exploitation and about their roles in follow-up. NPG.07.03.01, EP 4 The hospital internally reports cases of possible abuse, neglect, and exploitation. NPG.07.03.01, EP 5 When the hospital serves a population of patients that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the patient's needs for such services.	Interview ☐ Ask staff about the criteria that guides them in identifying potential victims of abuse, neglect, and exploitation. • How do they access these criteria and guidance? • Has the organization offered staff education on how to recognize signs of possible abuse, neglect and exploitation and how to follow-up? • What resources and information does the organization have available for staff to offer possible victims? • What process does staff follow when they suspect a patient may be a victim of abuse, neglect, and exploitation? Document Review Review the organization's policy and procedures on patient abuse, neglect and exploitation.
NPG.07.04.01 The hospital treats the patient in a dignified and respectful manner. NPG.07.04.01, EP 1 The hospital respects the patient's cultural and personal values, beliefs, and preferences. NPG.07.04.01, EP 2 The hospital accommodates the patient's right to religious and other spiritual services.	Interview ☐ Ask patients or family members how the organization identified and addressed oral and written communication needs with them and, if necessary, how language services were provided ☐ Ask patients or family members if staff inquired about their race and ethnicity and informed them of their rights to religious and other spiritual services. ☐ Ask staff about organization expectations for treatment of patients and observance of patient rights. Observation During tracer activity throughout the organization, observe and listen to how staff interact with and care for patients.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.09.01.01 The hospital uses standardized procedures for managing tissues. NPG.09.01.01, EP 1 The hospital develops and implements standardized written procedures for the acquisition, receipt, storage, and issuance of tissues. NPG.09.01.01, EP 2 The hospital confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required. Note 1: This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA. Note 2: The supplier's FDA registration status may also be checked annually by using the FDA's online database: https://www.fda.gov/vaccines-blood-biologics/biologics-establishment-registration/findtissueestablishment. NPG.09.01.01, EP 3 The hospital follows the tissue suppliers' or manufacturers' written directions for transporting, handling, storing, and using tissue. NPG.09.01.01, EP 4 The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage. Note 2: Tissues requiring no greater control than "ambient temperature" (defined as the temperature of the immediate environment) for storage would not require temperature monitoring. NPG.09.01.01, EP 5 The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues. Note 1: Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems.	Interview ☐ Interview laboratory personnel to discuss: • Process for ensuring that the source facility is licensed (state) and/or registered (federal) (EP 2) • Coordination of tissue ordering, receipt, storage, handling and issuance – validate that these processes are being done according to manufacturer or source facility written directions (EP 3) • Physical Environment (EPs 4-6) ○ Storage – continuous temperature (refrigerator and freezer, not room or ambient storage), functional alarms, emergency backups ○ Documentation of tissue temperatures ○ Acceptance of tissue from source: ▪ Process for ensuring package integrity ▪ Transportation temperature • No thermometer needed but do need to know if shipping containers were validated. Document Review ☐ Daily records for tissue storage temperatures ☐ Temperature monitoring logs for tissue storage equipment

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
Note 2: For tissue stored at room temperature, continuous temperature monitoring is not required. NPG.09.01.01, EP 6 Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency backup plan. Note: For tissue stored at room temperature, alarm systems are not required. NPG.09.01.01, EP 7 In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or whose death is imminent is done according to procedures approved by the respective agency.	
NPG.09.02.01 The hospital traces all tissues bi-directionally. NPG.09.02.01, EP 1 The hospital's records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier. NPG.09.02.01, EP 2 The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.	Document Review ☐ Record keeping on tissues • Donor/source facility to final disposition (discarded, returned to source facility or transplanted/implanted to recipient) traceability and vice versa. ○ Source facility information ○ Pre-transplant/implant documentation ○ Post transplant/implant documentation ○ Return information to source facility
NPG.09.03.01 The hospital investigates adverse events related to tissue use or donor infections. NPG.09.03.01, EP 1 The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue. The procedure includes the following at a minimum: - Investigating disease transmission or other complications that are suspected of being directly related to the use of tissue - Reporting of a post-transplant infection or adverse event related to the use of tissue to the tissue supplier as soon as the hospital becomes aware	Interview ☐ Ask laboratory staff responsible for tissue storage and issuance about adverse events investigation and implementation of procedures for: • Tracking and investigation of tissue transplant infections • Reporting of infections to source • Sequestering other associated tissue, if contamination is suspected • Identification and notification to recipients of suspected infections Document Review

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Sequestering of tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection - Identifying and informing tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue.	Confirm that the organization has written procedures to investigate tissue adverse events and that it includes at a minimum those elements identified in the EP.
NPG.10.01.01 Policies and procedures for waived tests are established, current, approved, and readily available. NPG.10.01.01, EP 1 The person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following: - Clinical usage and limitations of the test methodology - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test) - Specimen type, collection, and identification, and required labeling - Specimen preservation, if applicable - Instrument maintenance and function checks, such as calibration - Storage conditions for test components - Reagent use, including not using a reagent after its expiration date - Quality control (including frequency and type) and corrective action when quality control is unacceptable - Test performance - Result reporting, including not reporting individual patient results unless quality control is acceptable - Equipment performance evaluation	Interview ☐ Interview the waived testing director or supervisor whose name appears on the CLIA certificate, or a qualified designee about • Policies and procedures for waived testing ○ Do they reflect manufacturers' instructions for use and include specific operational policies? • How these policies and procedures are made available to testing personnel. Document Review Confirm that waived testing policies and procedures address all the required items from the EP.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
Note 1: Policies and procedures for waived testing are made available to testing personnel. Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed. NPG.10.01.01, EP 2 Policies or procedures for each waived test are consistent with manufacturers' instructions for use and include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).	
NPG.10.02.01 Staff performing waived tests are competent. NPG.10.02.01, EP 1 Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented. Note: This includes training on the use and maintenance of instruments. NPG.10.02.01, EP 2 Competence for waived testing is assessed according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. Competency is assessed using at least two of the following methods per person per test: - Performance of a test on a blind specimen - Periodic observation of routine work by the supervisor or qualified designee - Monitoring of each user's quality control performance - Use of a written test specific to the test assessed This competency is documented. Note 1: When a licensed practitioner performs waived testing that does not involve an instrument and the test falls within their specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual privileges include the specific waived tests appropriate to the scope of practice that they are authorized to perform. At the discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA	Interview ☐ Ask staff who are performing waived testing about their orientation and training as well as their competency assessment for performing the specific test(s). • How often is their competency in performing waived testing assessed? Document Review Personnel Files ☐ Confirm through documentation that staff who perform waived testing have been trained for each test they perform. ☐ Confirm through documentation that staff competence for waived testing has been assessed according to hospital policy at defined intervals, but at least at orientation and annually thereafter. • Does documentation reflect that staff competency was assessed using at least two of the methods presented in the EP?

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
'88) certificate or according to hospital policy, more stringent competency requirements may be implemented. Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.	
NPG.11.01.01 The hospital manages security risks. NPG.11.01.01, EP 1 The hospital controls access to and from areas it identifies as security sensitive. NPG.11.01.01, EP 2 The hospital develops and implements written policies and procedures to follow in the event of a security incident, including an infant or pediatric abduction. NPG.11.01.01, EP 3 The hospital develops and implements a process(es) for continually monitoring, internally reporting, and investigating the following: - Injuries to patients or others within the hospital's facilities and grounds - Occupational illnesses and staff injuries - Incidents of damage to its property or the property of others - Safety and security incidents involving patients, staff, or others within its facilities, including those related to workplace violence - Hazardous materials and waste spills and exposures - Fire safety management problems, deficiencies, and failures - Medical or laboratory equipment management problems, failures, and use errors - Utility systems management problems, failures, or use errors Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities. Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment,	Interview ☐ Ask organization staff about the areas that are considered security sensitive and require controlled access. ☐ Ask about the methods of controlled access that are being used throughout the organization and the effectiveness. ☐ Ask about the organization's internal safety and security reporting process. • How accessible (ease of locating and use) is the reporting process to staff? • Is staff encouraged to report both actual and potential for safety and security issues? ☐ Ask leaders and staff to describe: • How they monitor safety and security throughout the organization (e.g., unit-, department-, building/site-level) and with what frequency. • The process that is followed to investigate and address safety and security incident reports. ☐ Ask leaders and staff about the processes that are followed when the organization is providing care to patients under legal or correctional restrictions. How does the organization coordinate administrative and clinical decisions for these patients? Document Review Review organization written policies and procedures related to security incidents, including infant or pediatric patient abduction. Observation During individual tracer and other building tour activity, visit areas that are subject to controlled access to observe the security measures that are in place.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
and services, or to prevent similar incidents, are not lost as a result of following the legal process. NPG.11.01.01, EP 4 The hospital coordinates administrative and clinical decisions for patients under legal or correctional restrictions on the following: - Use of seclusion and restraint for nonclinical purposes - Imposition of disciplinary restrictions - Restriction of rights - Plan for discharge and continuing care, treatment, and services - Length of stay.	
NPG.11.02.01 The hospital assesses and manages the patient's risks for falls. NPG.11.02.01, EP 1 The hospital implements fall risk reduction interventions based on the patient population, setting, and individual patient's assessed risks.	Interview ☐ Ask staff about the assessment process for determining if a patient is at risk for falls. • Describe the types of interventions the organization has available for staff to use with patients that are at risk for falls. ☐ If possible, interview a patient or patients that have been identified as at risk for falls. Ask if they are aware of this assessment and how staff are working with them to reduce their risk for a fall. Document Review Patient Clinical Record Review the clinical records of patients who were identified as fall risks to see if documentation reflects the interventions that are being used to mitigate the risk of falls and avoid injuries due to a fall. Observation Try to observe a patient or patients who have been assessed as being at risk for falls to see what risk reduction interventions are in place and how staff are working with these patients.
NPG.11.03.01 The hospital manages utility systems.	Interview

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.11.03.01, EP 1 The hospital develops and implements written procedures for responding to utility system disruptions. The procedures include but are not limited to shutting off a malfunctioning system and notifying staff in the affected areas. NPG.11.03.01, EP 2 The hospital develops and implements a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed. NPG.11.03.01, EP 3 The hospital develops and implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers. Note: Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.	☐ Facilities staff about utility systems and the procedures that are followed if there be a disruption in operations. ☐ Ask facilities staff about the emergency back-up systems that are in place in case of a malfunctioning utility system. Document Review ☐ Confirm that there are written procedures for responding to utility system disruptions. ☐ Confirm that the organization has policies for providing utility system emergency backup to essential medication dispensing equipment and essential medication refrigeration and freezer units.
NPG.11.04.01 The critical access hospital safely prepares and stores food and nutrition products. NPG.11.04.01, EP 1: The critical access hospital prepares and stores food and nutrition products (including those brought in by patients or their families) using proper sanitation.	Interview ☐ Ask leaders and staff to describe the food services offered by the organization. ☐ Determine who is responsible for these services and ask them to describe the safety measures in place for food preparation and storage. ☐ Ask staff on units about how the monitor any food and nutrition products brought in by patients or their families. Observation Visit areas where food is prepared and stored and determine who oversees and maintains these areas and monitors them for safety.
Note: NPG.12.01.01 through NPG.12.03.01 are addressed in the Survey Process Guide (SPG). Refer to the SPG for applicable requirements and survey processes.	
NPG.12.04.01 The hospital verifies that staff complete all requirements for employment and practice within their scope of practice.	Interview

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.12.04.01, EP 1: The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented. NPG.12.04.01, EP 2: Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented. NPG.12.04.01, EP 3: Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration, in accordance with law and regulation.	Ask clinical leaders how they monitor staff to determine that they are providing patient care, treatment and services within their scope of practice. Document Review Personnel Files ☐ Verify criminal background checks are obtained on applicants per law and regulation or hospital policy. ☐ Verify through review of a sample of employee health files any documentation that staff has undergone required health screenings. Observation Observe clinical staff throughout the organization providing care, treatment and services to patients.
NPG.12.05.01 The hospital provides education and training and evaluates staff competence. NPG.12.05.01, EP 1: The hospital orients staff on the following: - Relevant hospitalwide and unit-specific policies and procedures - Their specific job duties, including those related to infection prevention and control and assessing and managing pain - Sensitivity to the needs of all populations based on their job duties and responsibilities - Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities. Completion of this orientation is documented. NPG.12.05.01, EP 2: The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. Staff are evaluated based on performance expectations that reflect their job responsibilities. This evaluation is documented.	Interview ☐ Ask staff responsible for the human resources functions in the organization to describe the orientation process for new staff to the organization, job responsibilities, and/or clinical responsibilities. Ask about the topics that are included in the curriculum for all staff and all clinical staff. ☐ Ask human resources staff what they know about department and job-level orientation processes and content. ☐ Ask human resources staff about the conduct of staff performance evaluations. Is there a common process used throughout the organization? Anything unique to clinical staff? What is the frequency of such evaluations? Document Review General ☐ Review staff orientation curriculum to determine what hospital policies and procedures are covered; make a note to validate with staff encountered during individual patient tracers.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
	Personnel Files ☐ Review personnel files for documentation of staff member orientation completion and any performance evaluations. Check that each are based on job responsibilities.
NPG.12.06.01 The hospital evaluates staffing during performance improvement activities. NPG.12.06.01, EP 1: When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to workflow; competency assessment; credentialing; supervision of staff; and orientation, training, and education. Note 2: Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues. NPG.12.06.01, EP 2: When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as addressed at NPG.02.03.01, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s). NPG.12.06.01, EP 3: At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems.	Interview ☐ Ask leaders and staff responsible for organization quality and performance improvement: • When staffing adequacy is considered or evaluated in association with a quality or safety issue that is in need of correction or improvement. • How are organization leaders responsible for the organization-wide patient safety program informed of analyses that reveal staffing adequacy problems and actions taken to resolve the problems. • How frequently are the leaders of the organization wide safety program presented with the results of staffing adequacy analyses and actions taken to resolve problems. • If any information is shared with governance about staffing adequacy analyses? Document Review Review any written reports related to staffing adequacy analyses that are provided to safety program leaders and governance.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.12.06.01, EP 4: At least once a year, the leaders provide governance with written reports that include results of the analyses related to the adequacy of staffing.	
NPG.13.01.01 The hospital defines and verifies qualifications and education requirements for imaging services staff. NPG.13.01.01, EP 1: Technologists who perform diagnostic computed tomography (CT) exams have advanced-level certification by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) in computed tomography or have one of the following qualifications: - State licensure that permits them to perform diagnostic CT exams and documented training on the provision of diagnostic CT exams - Registration and certification in radiography by ARRT and documented training on the provision of diagnostic CT exams - Certification in nuclear medicine technology by ARRT or NMTCB and documented training on the provision of diagnostic CT exams Note 1: This element of performance does not apply to CT exams performed for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. NPG.13.01.01, EP 2: The hospital verifies and documents that diagnostic medical physicists who support computed tomography (CT) services have board certification in diagnostic radiologic physics or radiologic physics by the American	Document Review Personnel and Credentials Files ☐ Review the personnel and credentials files and job descriptions of specific staff and other credentialed practitioners. For example, the director of dietary services, pharmacist responsible for pharmacy services, radiology and nuclear medicine, and therapy staff. ☐ Verify that the medical staff determines the qualifications of the radiology staff and approves the nuclear services director's specifications for qualifications of the nuclear medical staff. ☐ Review the personnel and credentials files of the medical physicist(s) supporting CT and fluoroscopy services ☐ Review personnel files of technologists responsible for performing diagnostic CT exams. Verify whether they have obtained any certification(s) or licensure that would indicate they are qualified to perform diagnostic CT exams ☐ Check for documentation indicating that CT technologists have received training in the provision of diagnostic CT exams.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
Board of Radiology, or in diagnostic imaging physics by the American Board of Medical Physics, or in diagnostic radiological physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements: - A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university - College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics - Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. NPG.13.01.01, EP 3: The hospital verifies and documents that individuals who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following: - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns - Safe procedures for operation of the types of CT equipment they will use Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at https://www.imagegently.org and https://www.imagewisely.org, respectively. Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery or for calculating attenuation coefficients for nuclear medicine studies.	

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. NPG.13.01.01, EP 4: The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education, including annual training on safe MRI practices in the MRI environment that addresses the following: - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF) - Proper patient and equipment positioning activities to avoid thermal injuries - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional) - MRI safety response procedures for patients who require urgent or emergent medical care - MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures - Patient hearing protection - Management of patients with claustrophobia, anxiety, or emotional distress Note: Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).	
NPG.13.02.01 The hospital's imaging services have a designated leader and follow current safe imaging practices. NPG.13.02.01, EP 1: The hospital designates an individual to serve as the radiation safety officer who is responsible for making certain that radiologic services are provided in accordance with law, regulation, and hospital policy. This individual has the necessary authority and leadership support to do the following:	Interview ☐ Identify who the organization has identified to serve as the radiation safety officer. Ask this individual about their responsibilities and the authority and leadership support they receive to make certain radiologic services are provided in accordance with law, regulation, and hospital policy.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Monitor and verify compliance with established radiation safety practices (including oversight of dosimetry monitoring) - Provide recommendations for improved radiation safety - Intervene as needed to stop unsafe practices - Implement corrective action NPG.13.02.01, EP 2: The hospital provides radiology services that meet safety standards approved by nationally recognized professional organizations. At a minimum, diagnostic radiology services are maintained and available at all times the hospital provides services, including emergency services. Note: If the hospital also provides other radiology services, such as therapeutic radiology, the requirements of this element of performance also apply to those services. NPG.13.02.01, EP 3: The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including the following: - Clinical indication - Contrast administration - Age (to indicate whether the patient is pediatric or an adult) - Patient size and body habitus - Expected radiation dose index range Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. NPG.13.02.01, EP 4: Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For rehabilitation and psychiatric distinct part units in hospitals, refer to MS.17.01.03, EP 5 for supervision of radiologic services) Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting	☐ Ask about the availability of diagnostic radiology services and the availability of therapeutic radiology services if provided by the organization. ☐ Ask radiology services leaders and staff about imaging services protocols and what these are based on, as well as who is involved in the review and update. Document Review Confirm the organization is following diagnostic CT imaging protocols and that they are current with standards of practice.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
the maxillofacial region or to obtain guidance for the treatment of such conditions.	
NPG.13.03.01 The hospital manages imaging safety risks. NPG.13.03.01, EP 1: The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following: - Patients who may experience claustrophobia, anxiety, or emotional distress - Patients who may require urgent or emergent medical care - Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel) - Ferromagnetic objects entering the MRI environment - Acoustic noise NPG.13.03.01, EP 2: The hospital manages magnetic resonance imaging (MRI) safety risks by doing the following: - Restricting access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and the area that immediately precedes the entrance to the MRI scanner room. - Making sure that these restricted areas are controlled by and under the direct supervision of staff trained in MRI safety. - Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system, by its design, can have its magnetic field routinely turned on and off by the operator. NPG.13.03.01, EP 3: For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: - Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. - Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol	Interview ☐ Ask radiology leaders and staff about the safety program they have in place related to imaging services. ☐ Ask for details related to managing MRI safety risks ☐ If provided, ask about dosimetry monitoring for staff who are performing these services and who is providing this monitoring. ☐ When diagnostic CT services are provided ask if the organization is engaging a diagnostic medical physicist to perform the services that are noted in EPs 3-5. Observation ☐ Visit radiology services as part of tracer activity to look for evidence that imaging safety risks are being managed. ☐ Review reports and records that demonstrate the organization is engaging the services of a diagnostic medical physicist or MRI scientist to perform the services noted in EPs 3-5.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
displayed on the CT console. The dates, results, and verifications of these measurements are documented. Note 1: This element of performance is only applicable for systems capable of calculating and displaying radiation doses. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. Note 3: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3) NPG.13.03.01, EP 4: For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity - Scout prescription accuracy - Alignment light accuracy - Table travel accuracy - Radiation beam width - High-contrast resolution - Low-contrast detectability - Geometric or distance accuracy - CT number accuracy and uniformity - Artifact evaluation Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3) NPG.13.03.01, EP 5: At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics: - Image uniformity for all radiofrequency (RF) coils used clinically - Signal-to-noise ratio (SNR) for all coils used clinically - Slice thickness accuracy - Slice position accuracy - Alignment light accuracy - High-contrast resolution - Low-contrast resolution (or contrast-to-noise ratio) - Geometric or distance accuracy - Magnetic field homogeneity - Artifact evaluation Note: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.11.01.03, EP 1; HR.11.02.01, EP 2; NPG.12.04.01, EP 3)	
NPG.13.04.01 The hospital monitors quality improvement projects related to imaging safety. NPG.13.04.01, EP 1: The hospital collects data on the following: - Patient thermal injuries that occur during magnetic resonance imaging (MRI) exams - Incidents where ferromagnetic object unintentionally entered the MRI scanner room	Interview ☐ Ask imaging services leaders and staff about the data being collected to monitor safety of imaging services. ☐ Ask about the frequency of analysis and reporting of the imaging safety data. ☐ Who is monitoring these data and determining if there is any action needed to correct or improve performance.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
- Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room NPG.13.04.01, EP 2: The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks. Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient's radiation dose. Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.	☐ Who is responsible for reviewing and analyzing incidents related to CT and MRI incidents.
NPG.14.01.01 The hospital safely manages pharmaceutical services. NPG.14.01.01, EP 1 When an on-site pharmacy is not open 24 hours a day, 7 days a week, the following occurs: - A health care professional, who the hospital determines is qualified, reviews the medication order in the pharmacist's absence - A pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens NPG.14.01.01, EP 2 When automatic dispensing cabinets (ADCs) are used, the hospital develops and implements a policy that describes the types of	Interview ☐ Ask organization leaders and staff who reviews medication orders in the pharmacist's absence. ☐ Ask the pharmacist about their process for reviewing orders that are received while the pharmacy is closed. ☐ Ask the pharmacist and other clinical leaders about the policy and procedures for automatic dispensing cabinet medication overrides.

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.	
NPG.14.02.01 The hospital selects and procures medications. NPG.14.02.01, EP 1 The hospital standardizes and limits the number of drug concentrations available to meet patient care needs. NPG.14.02.01, EP 2 The hospital follows a process to communicate medication shortages and outages to staff who participate in medication management. NPG.14.02.01, EP 3 The hospital follows written medication substitution protocols to be used in the event of a medication shortage or outage and communicates the medication substitution protocols for shortages or outages to all affected staff.	Interview ☐ Discuss with leaders and staff: • The safeguards the organization has in place to reduce the risk of errors and minimize patient or staff harm related to high alert or hazardous medication(s) and look alike and sound alike medications. • Interventions/solutions the organization/unit has in place to prevent medication errors (standardizing processes). • Process to communicate medication shortages and outages to staff who participate in medication management, and the substitution protocols that will be followed • Medication substitution protocols that are followed in the event of a medication shortage or outage. Document Review ☐ Review organization lists and processes for managing high alert and hazardous medication(s) and look alike and sound alike medications ☐ For hazardous drugs, review organization requirements for drug precaution labeling and appropriate personal protective equipment and observe handling by nursing staff if possible.
NPG.14.03.01 The hospital labels all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins. NPG.14.03.01, EP 1 In perioperative and other procedural settings both on and off the sterile field, the hospital labels medications and solutions that are not immediately administered. This applies even if there is only one medication being used. Note: An immediately administered medication is one that an	Interview ☐ Discuss with staff in procedural areas what procedures are followed for medication safety specific to labeling of medications and containers. Document Review

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. NPG.14.03.01, EP 2 In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container. NPG.14.03.01, EP 3 In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: - Medication or solution name - Strength - Amount of medication or solution containing medication (if not apparent from the container) - Diluent name and volume (if not apparent from the container) - Expiration date and time Note: The date and time are not necessary for short procedures, as defined by the hospital. NPG.14.03.01, EP 4 The hospital verifies all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it. NPG.14.03.01, EP 5 The hospital labels each medication or solution as soon as it is prepared, unless it is immediately administered. Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.	☐ Review any policy or procedures, data collection, PI activities for hospital performance and evaluation. Data collection may also be found with hospital internal reporting systems. Observation ☐ In perioperative and other procedural settings observe actions of staff for medication preparation both on and off the sterile field.
NPG.14.04.01 The hospital reduces the likelihood of patient harm associated with the use of anticoagulant therapy. Note: This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for preventing venous thromboembolism (for example, related to procedures or hospitalization).	Interview ☐ Interview staff about monitoring patients on anticoagulant therapy. Document Review

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
NPG.14.04.01, EP 1 The hospital uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication. NPG.14.04.01, EP 2 The hospital uses approved protocols and evidence-based practice guidelines for perioperative management of all patients on oral anticoagulants. Note: Perioperative management may address the use of bridging medications, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant. NPG.14.04.01, EP 3 The hospital uses only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.	☐ Review hospital approved protocols and evidence based practice guidelines for reversal of anticoagulation management and bleeding events. ☐ Review performance improvement data and discuss any ongoing activities for anticoagulation therapy. ☐ Review medical records of patients on anticoagulant therapy, including those in perioperative areas and management of the pediatric patient.
NPG.14.05.01 The hospital maintains and communicates accurate patient medication information. NPG.14.05.01, EP 1 The hospital obtains information on the medications the patient is currently taking when they are admitted to the hospital or are seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications. Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP. NPG.14.05.01, EP 2 Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings. Note: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings. NPG.14.05.01, EP 3 Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in	Interview ☐ Interview the staff who compares the medication information the patient brought to the hospital with the medications ordered: • How are discrepancies, omissions, duplication, unclear information resolved? • Is this person qualified to do this comparison? Review staff/credential file as appropriate. ☐ Interview patient and family about discharge medications. Determine from review of hospital policy if the patient was provided with any required information upon discharge. Document Review ☐ Review patient medical records for • medication reconciliation in both inpatient and outpatient settings and determine if the documentation is congruent in accordance with defined policy and procedures. • Be sure to determine if the documentation follows the hospital defined types of medication information. For example, name, dose, route, frequency etc. Observation

Joint Commission Standards / EPs	Critical Access Hospital Survey Process
order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. NPG.14.05.01 EP 4 Provide the patient (or family, caregiver, or support person as needed) with written information on the medications the patient should be taking when they are discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose). NPG.14.05.01, EP 5 Explain the importance of managing medication information to the patient when they are discharged from the hospital or at the end of an outpatient encounter. Note: Examples include instructing the patient to give a list to their primary care provider; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.16.01.01, PC.12.02.01, and PC.14.01.01.)	☐ Observe staff discharge process on patient care units. This may also be observed in outpatient areas. Ensure compliance through review of hospital policy and procedures.

Medical Staff-Related Standards Compliance Evaluation Guides

The material presented in this section is representative of what surveyors use when they are evaluating compliance with the medical staff-related standards in the **Hospital** and **Critical Access Hospital** accreditation program. Organizations may find these tools useful for continuous compliance and survey readiness efforts.

1. **Medical Staff Bylaws Review Guide**
2. **Medical Staff and Related Standards Compliance Evaluation Guide**
3. **Professional Graduate Medical Education Program Standard Compliance Evaluation Guide**
4. **Credentials File Review Tool**

Medical Staff Bylaws Review Guide

Medical Staff Bylaws Review Guide	
Notes	Requirement
	MS.14.01.01, EP1 The organized medical staff adopts and enforces bylaws to carry out its responsibilities. The bylaws are approved by the governing body and include the following: - ø Statement of the duties and privileges of each category of medical staff (for example, active, courtesy) - ø Description of the organization of the medical staff, including those members who are eligible to vote - ø Description of the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body - ø Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges, including the process for reprivileging physicians and other licensed practitioners - ø Process for credentialing and recredentialing physicians and other licensed practitioners - ø List of all the officer positions for the medical staff - ø Process by which the organized medical staff selects and/or elects and removes the medical staff officers - ø Process for adopting and amending the medical staff bylaws, medical staff rules and regulations, and policies - ø The qualifications and roles and responsibilities of the department chair, when applicable Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Distant-site physicians and practitioners requesting privileges to provide telemedicine services under an agreement with the hospital are also subject to the requirements in 42 CFR 482.12(a)(8) and (a)(9), and 42 CFR 482.22(a)(3) and (a)(4). CoPs: §482.22(c)(1), §482.22(c)(2), §482.22(c)(3), §482.22(c)(4), §482.22(c)(6)
	MS.14.01.01, EP 2 The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff.

	Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians, as listed at 42 CFR 482.12(c)(1), and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership. CoPs: §482.22(a)
	MS.14.01.01, EP 3 The medical staff bylaws include requirements for the following: - ø Medical history and physical examination for each patient as described in PC.11.02.01, EP 2 - ø Updated patient examinations as described in PC.11.02.01, EP 3 - ø Assessments in lieu of medical history and physical examinations for patients as described in PC.11.02.01, EP 4 Note: The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy. CoPs: §482.22(c)(5)(i), §482.22(c)(5)(ii), §482.22(c)(5)(iii)
	MS.14.01.01, EP 6 (HAP) The medical staff bylaws include the following requirements regarding the medical executive committee: - ø The function, size, and composition, as determined by the organized medical staff and approved by the governing body; - ø The authority delegated to the medical executive committee by the organized medical staff to act on the medical staff's behalf and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.14.02.01.) - ø The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.

	Note: The medical executive committee includes physicians and may include other licensed practitioners.
	MS.14.01.01, EP 7 (HAP) The medical staff bylaws include the following requirements regarding the suspension or termination of a physician's or other licensed practitioner's medical staff membership or privileges: - Indications and process for automatic suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for summary suspension of a physician's or other licensed practitioner's medical staff membership or clinical privileges - Indications and process for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
	MS.14.01.01, EP 8 (HAP) The medical staff bylaws include requirements for the composition of the fair hearing committee.
	MS.14.01.01, EP 9 The medical staff bylaws include the following requirements: • Description of those members of the medical staff who are eligible to vote • Process for credentialing and recredentialing physicians and other licensed practitioners • Process for fair hearings and appeals, which at a minimum, includes the process for scheduling and conducting hearings and appeals
	MS.14.03.01, EP 4 CAH: If a critical access hospital is part of a multihospital system with separately accredited hospitals, critical access hospitals, and/or rural emergency hospitals, and the system chooses to establish a unified and integrated medical staff, the unified and integrated medical staff bylaws, rules, and requirements include the following: - Process for self-governance, appointment, credentialing, privileging, and oversight, as well as its peer review policies and due process rights guarantees - Description of the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective critical access hospital

	CoPs: §482.22(b)(4)(ii), §485.631(e)(2)
	MS.15.01.01, EP 1 (HAP) The structure and function of the medical staff executive committee conforms to the medical staff bylaws.
	MS.15.01.01, EP 4 (HAP) The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on all of the following, at a minimum: - ø Organized medical staff's structure - ø Process used to review credentials and delineate privileges - ø Executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups
	MS.17.01.03, EP 4 The medical staff examines the credentials of all candidates eligible for medical staff membership and makes recommendations to the governing body on the appointment of these candidates, in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is subject to all medical staff bylaws, rules, and regulations. Note: For hospitals that use Joint Commission accreditation for deemed status purposes: A candidate who has been recommended by the medical staff and who has been appointed by the governing body is also subject to 42 CFR 482.22(a). CoPs: §482.22(a)(2)
	MS.17.02.01, EP 5 Completed applications for privileges are acted on within the time period specified in the medical staff bylaws, rules, and regulations, or in policies and procedures.
	MS.17.04.01, EP 1 Temporary privileges are granted to meet an important patient care need for a time period defined in the medical staff bylaws.

	MS.18.04.01, EP 2 (HAP) The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has a mechanism to schedule a hearing of such requests.
	MS.18.04.01, EP 3 (HAP) The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has identified the procedures for the hearing to follow.
	MS.18.04.01, EP 5 (HAP) The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that, with the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws.
Other Medical Staff and Related Standards	
	NPG.03.02.03, EP 2 The hospital identifies the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners and has a process for granting these privileges. This is documented in the medical staff bylaws, rules and regulations, or policies and procedures.

Medical Staff and Related Standards Compliance Evaluation Guide

1- Credentialing Process Discussion			
YES	NO	If no issues found in document review, begin the meeting with the discussion of the credentialing process.	Notes
☐	☐	Ask to discuss the credentialing process – application, processing, role of department chair, cred comm, medical executive committee, governing body. Basic steps must be in bylaws (See also: MS Bylaws Checklist for relevant EPs) Privileges are granted for a period not to exceed 3 years. Physician or other licensed practitioner is notified in writing of the decision regarding appointment, reappointment, privileges. MS.15.01.01, EP 4; MS.17.01.03, EP 4; MS.18.02.03, EP 1	
☐	☐	Discuss how primary source verification (PSV) is performed for licensure, training, competence. Training and competence PSV in writing for privileges requested. Licensure at initial, renewal, and request for new privileges. (PSV for competency and training only on initial appt unless new/additional privileges requested.) MS.17.01.03, EP 3	
☐	☐	Evidence of physician and other licensed practitioner ID verification (Hospital or government-issued picture ID) DEA Registration, when required by MS, hospital, or state. MS.17.01.03, EP 2; LD.13.01.01, EP 1 (Scored only if DEA has expired)	
☐	☐	Are peer recommendations considered; how are "peers" defined and, if yes, did written peer recommendations include information regarding the medical/clinical knowledge, clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism of the physician or other licensed practitioner? MS.18.01.01, EP 1 - 4	
☐	☐	When are the National Practitioner Data Bank (NPDB) queries performed: Must be at least at initial/re-appointment and whenever new privileges are requested. Is there a statement regarding practitioner's health and ability to perform the requested procedures? MS.17.02.01, EP 3, EP 4	
☐	☐	Is there a process for evaluation of identified red flags regarding voluntary or involuntary licensure reductions/termination, reduced/revoked privileges, MS membership terminations, etc. at the same or previous organizations? This should be a credible process that involves MS leaders. MS.17.03.01, EP 3	
☐	☐	Is there an expedited credentialing process? If so, are at least 2 voting board members on the approving committee? Are there established criteria for ineligibility, and do they include an incomplete application and adverse MEC recommendation? MS.17.03.01, EP 1, EP 2	

☐	☐	How are criteria for granting privileges determined and approved (<i>does the governing body approve?</i>) Do the criteria include licensure, training, evidence of current competency, peer recommendations, and information from other organizations, when applicable? MS.17.02.01, EP 1	
☐	☐	Temporary privileges: Time periods must be defined in bylaws. Must be no more than 120 Days. (See also box 3 below - file review) MS.17.04.01, EP 1	
☐	☐	Telemedicine: How are these credentialed? They should all be granted privileges by the originating site but may do so in the usual way -OR- By contractual arrangement to accept the credentialing information from a Joint Commission accredited or CMS certified organization -OR- Joint Commission accredited or CMS certified accept the privilege decision of distant site if all of these are met by the distant site and the privileges to be exercised are granted: - List of privileges at distant site is provided - FPPE, OPPE information is shared - Physician or other licensed practitioner is licensed in the originating site's state MS.20.01.01, EP 1	
☐	☐	CME: Requires that the MS sets priorities for CME topics ☐ Requires CME resources are related to the scope of services of the organization ☐ State CME should be related to outcomes of PI activities ☐ Requires documentation of CME; and ☐ Requires CME to be considered in the credentialing process MS.19.01.01, EP 1 - 4	
2- FPPE/OPPE			
YES	NO	FPPE for all initial or new privileges (MS.18.02.01) EP 2 Implemented for all practitioners in all clinical sites and privilege specific (includes physicians, PAs, APRNs, CRNAs, dietitians granted privileges to write orders, pharmacists with prescriptive authority, telemedicine practitioners, etc., exercised in all settings- inpatient or outpatient-on-site or off-site within the scope of the organization's survey; is a focused direct evaluation of the requested/exercised privileges) EP 1 The process including criteria is approved by the MS (evaluation should be qualitative and not just quantitative). EP 3 The process is clearly defined (<i>i.e., written policy required: criteria for conducting performance monitoring, method for establishing a monitoring plan specific to the requested privilege, method for determining the duration of performance monitoring, circumstances under which monitoring by an external source is required</i>).	
☐	☐	FPPE for Cause (MS.18.02.01) EP 4 Triggers should be defined clearly (<i>i.e., in policy</i>). EP 3 Decisions to initiate FPPE for cause should be based upon objective measures of current performance reflective of quality and/or safety concerns.	

		EP 5 Criteria are developed for type of monitoring to be conducted. EP 6 Measures/actions to address performance issues are defined. EP 7 These measures/actions are consistently implemented.	
☐	☐	OPPE: MS.18.02.03 EP 1 There is a clearly defined process: For example, a written policy, bylaw, or rules and regulations. The organization determines the frequency of the data collection and review, but this may not exceed 12 months. Process includes all physicians and other licensed practitioners in all clinical sites and includes methodology of data collection and who/how the data is reviewed and acted upon. EP 2 The process requires that the data to be collected is approved by the individual departments and the MS (MEC) or just the MEC if there are no departments: - Aggregate (quantitative) or trended quality metrics are encouraged - e.g., SSI rates, complications. - BUT: - Qualitative or chart review data may be used. - The data must be RELEVANT to the specialty or privileges granted. - Review of data that occurs only when triggered by an incident is NOT acceptable. - When there are situations in which there is no other way to collect data or assets, then peer recommendations may be used (<i>low or no volume physicians or other licensed practitioners</i>). - Data must be from the organization except for low volume physicians or other licensed practitioners who have available data from other accredited or CMS certified organizations. However, any data obtained must be supplemental and cannot be used in lieu of a process to attempt to capture 'local' performance data. - Use of quantitative (raw) data may be used; however, it cannot be the only type of data used to evaluate performance EP 3 The data collection, review, and analysis must be used to inform the credentialing process, i.e., it must be used in the process of determining whether to continue, reduce, or otherwise modify a physician's or other licensed practitioner's privileges. This review process should be consistent and documented. This review process should be ongoing, i.e., reports reviewed when they are produced, not just at the time of the 3-year reappointment.	
Other items to review/confirm related to the medical staff.			
YES ☐	NO ☐	Does the medical staff (MEC) approve the dietary manual for the hospital? Frequency: MS approval should be a part of the usual periodic review of the policy and whenever the manual is substantively amended. PC.12.01.09, EP 2	
☐	☐	The medical staff approval by the radiology, nuclear medicine medical director or MEC are acceptable options to approve the qualification of the radiology and nuclear medicine technical staff. Frequency: MS approval should occur initially and be a part of the usual periodic review of job descriptions and qualifications or whenever there is a substantive amendment or change in these qualifications. MS.16.01.01, EP 11 MS.16.01.01, EP 12	
☐	☐	Is there a process for education of licensed practitioners in antibiotic stewardship?	

		Is there a process for education of licensed practitioners in pain management and safe use of opioid medication? <i>(These standards require evidence of process, but do not have to be documented in individual credentialing files.)</i> MM.18.01.01, EP 7 NPG.06.01.01, EP 3	
☐	☐	Disaster Privileges This may be addressed in document review of the disaster privileges policy which must comply with all EPs Note: Bylaws document review should confirm that the individuals who may grant disaster privileges are specified in the bylaws, rules and regulations, or policy and procedures. NPG.03.02.03	

Professional Graduate Medical Education Program Standard Compliance Evaluation Guide

Response (if “no” score standard and EP)		Standard, EP, and Compliance Criteria	Notes
YES	NO	MS.16.02.01 All EPs (1-9)	
☐	☐	MS.16.02.01, EP 1 <i>This EP has a documentation requirement</i> Does the organized medical staff have a document that defines a process for supervision by a physician with appropriate clinical privileges of each program participant while carrying out patient care responsibilities? Note: This information should reside in the rules and regulations or a medical staff approved document.	
☐ If “yes” continue to next item for EP 2	☐ If “no” consider also scoring EP 3	MS.16.02.01, EP 2 <i>This EP has a documentation requirement</i> Does the organization have documentation of written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs? Note: GME trainees have, at various levels of their training, specific functions and skills they may exercise either independently or with supervision. GME programs must develop criteria to determine the competence and level of independence for each trainee as they advance in the program. See EP 3.	
☐	☐	Does the organization provide this information to the organized medical staff and hospital staff? Note: For the resident specific roles and responsibilities to be of use, they must be available to hospital staff in the work centers. The method for making this information available is up to the organization.	
☐	☐	MS.16.02.01, EP 3 The descriptions from EP 2 must include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities.	

☐	☐	MS.16.02.01, EP 4 <i>This EP has a documentation requirement.</i> The organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a supervising physician.	
☐	☐	MS.16.02.01, EP 5 Can the organization demonstrate a mechanism for effective communication between the committee(s) responsible for professional graduate education (which may or may not reside within the organization being surveyed) and the organized medical staff and the governing body of the organization being surveyed? Note: A GME program may reside within the hospital being surveyed and usually has a professional graduate medical education committee (GMEC), or the hospital being surveyed may be an affiliated hospital with a training program residing in another hospital. Affiliated hospitals often have only a coordinator and not a full GMEC, in which case the hospital should demonstrate a method for effective communication with the hospital owning the training program. See EP 6 Note: GMEC minutes or medical staff minutes often have evidence of compliance with this EP. The entire medical staff is rarely briefed, but specific members on the MEC often are.	
☐	☐	MS.16.02.01, EP 6 Can the hospital demonstrate a mechanism for effective communication (whether training occurs at the organization that is responsible for the GME program or in a participating local or community organization or hospital)? If the hospital surveyed has a professional GMEC, how does it communicate to the medical staff and governing body information about: • Safety and quality of patient care, treatment and services by the training program • Related educational and supervisory needs of the training program If the hospital surveyed is a community or local participating hospital or organization hospital, does the person(s) responsible for overseeing the	

		participants from the program communicate to the organized medical staff and its governing body about: • Patient care, treatment, and services provided by the training program • Related educational and supervisory needs of its participants in the GME programs. Note: EP 6 is broad and reflects the overall management of the GME program. The GMEC minutes often have evidence of compliance with this EP. See also EP 8 for information specific to the governing body.	
☐	☐	MS.16.02.01, EP 7 Can the hospital demonstrate a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants? Note: Sometimes GME trainees participate with providers who don't report directly to a GMEC (such as private or community clinics, community based private physicians etc.) and there must be a way for these providers to communicate with the GMEC.	
☐	☐	MS.16.02.01, EP 8 If the hospital sponsors a GME program and has a GMEC, can the hospital demonstrate it specifically informed the governing board about the quality of care, treatment, and services and educational needs? Note: While this EP is like EP 6, it is specific to elements the sponsoring hospital governing board must be informed of. Compliance is often demonstrated in the board or GMEC minutes.	
☐	☐	MS.16.02.01, EP 9 Can the hospital demonstrate how the medical staff demonstrates compliance with residency review committee citations? Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association's Commission on Dental Accreditation are expected to be in compliance with the above requirements; the hospital should be able to	

		demonstrate compliance with any postgraduate education review committee citations related to this standard. Note: AOA programs may now be accredited under the ACGME.	
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Credentials File Review Tool

Practitioner info				PSV Documents						Peer Recommendations						FPPE	OPPE	Administration	
Practitioner Specialty	Application Type	Valid Picture ID (file copy not required)	Current License	Relevant Training	Current Competence	NPDB Review	Health Status	DEA Current? (if required by medical Medical/Clinical Knowledge	Technical/Clinical Skills	Interpersonal Skills	Communication Skills	Professionalism	Was FPPE process used for new applicant or new privileges?	Was OPPE data used for recertifying decision?	Timeliness of decision and < 2 yr term	Board approval and letter to applicant			
Other Medical Staff Standards to Review																			
															Yes	No			
Confirm qualifications of key department leaders—name, license and board certification:																			
Respiratory																			
Radiology																			
Nuclear Medicine																			
Emergency Department																			
Psychiatry (Inpatient)																			
Anesthesia																			
(Refer to the Medical Staff chapter for relevant standards and EPs.)																			

OPTIONAL Primary Care Medical Home (PCMH) Certification Evaluation Guide (Hospital and Critical Access Hospital)

Program Information:

Primary care medical home certification is optional and can be obtained initially through an extension survey (focused only on PCMH-specific requirements) or as part of your triennial accreditation survey. Once certification is obtained, re-certification will always occur at the time of the triennial survey.

If an extension survey is chosen as the route for initially obtaining PCMH certification, then only the unique PCMH accreditation requirements are evaluated during the certification survey.

When PCMH certification is obtained as part of the accreditation survey, all hospital standards as well as the unique PCMH accreditation requirements are evaluated. Surveyors will integrate the evaluation of PCMH requirements into the hospital survey as appropriate to your organization.

Organization Participants

Staff involved in patient care, support staff, and clinic management staff at each PCMH location seeking certification.

Logistical Needs

Hospitals can choose which sites they want to be PCMH certified. During the surveyor planning session, your hospital will need to provide the surveyor with information related to the services provided at those ambulatory care clinics that have been selected for primary care medical home certification, the locations or distance of the clinic from the hospital site, and the individuals who are serving in the role of the primary care clinician at each site. This information will help the surveyor determine which sites will be visited.

Documents for Surveyor Review

- Performance improvement data related to:
 - Disease management outcomes
 - Patient access to care
 - Patient experience and satisfaction related to access to care, treatment, or services, and communication
 - Patient perception of the comprehensiveness, coordination, and continuity of care, treatment, or services
 - Patient perception of the continuity of care

Scope of PCMH Survey

The survey will focus on evaluating the organization's provision of patient-centered care, comprehensive care, coordinated care, and superb access to care. Additionally, the survey will include an evaluation of the organization's system-based approach to quality, that is, the commitment to quality and quality improvement through ongoing engagement in activities such as:

- Using evidence-based medicine and clinical decision support tools,
- Guiding shared decision making with patients and families,
- Engaging in performance measurement and improvement,

- Measuring and responding to patient experiences and patient satisfaction, and
- Practicing population health management.

The site visit to PCMH locations will include evaluation of hospital accreditation standards as well as unique PCMH standards.

Individual tracer activity for unique PCMH requirements will focus on areas such as:

- Information provided to patients related to access to care, treatment and services, as well as primary care clinician information (for example, information related to selection of primary care clinician, how to access clinic staff, make appointments, and obtain specialty care)
- Tracking and follow-up on referrals and test results
- Interdisciplinary team collaboration and communication
- Involvement of patients in establishing treatment goals
- How patients are assessed for health literacy, where this is information documented in the medical record and how do they ensure it is available to all care team members
- The development of self-management goals, when are they developed, and where are they documented in the medical record?
- 24/7 access to prescription renewal requests, test results, clinical advice for urgent health care needs, and appointment availability
- Competence of primary care clinicians and staff
- PI activities related to PCMH

The following standards and EPs directly relate to the **operational characteristics** of the Primary Care Medical Home Model.

Patient-Centered Care	LD.12.01.01, EP 5; NPG.02.03.01, EP 10; NPG.07.01.01, EP 1, EP 2, EP 3; NPG.07.02.01, EP 1, EP 2; NPG.07.04.01, EP 1; PC.11.02.07, EP 1; PC.11.03.01, EP 1, EP 2; PC.12.01.01, EP 5; PC.12.02.01, EP 1, EP 3, EP 4, EP 5, EP 6, EP 7, EP 8; PC.12.03.05, EP 7, EP 9; RC.11.01.01, EP 9; RC.12.01.01, EP 1; RI.11.01.01, EP 1, EP 2, EP 3, EP 4, EP 5, EP 6; RI.11.02.01, EP 1; RI.12.01.01, EP 1, EP 5, EP 7, EP 8, EP 9; RI.12.02.01, EP 1; RI.12.02.03, EP 1, EP 2, EP 3, EP 4, EP 5, EP 6; RI.14.01.01, EP 2
Comprehensive care	MS.16.01.01, EP 13; MS.16.01.03, EP 5; PC.12.03.03, EP 1, EP 2, EP 3; PC.12.03.05, EP 1, EP 2, EP 4, EP 6, EP 10;
Coordinated care	MS.16.01.01, EP 3; NPG.12.04.01, EP 3; PC.11.03.01, EP 4; PC.12.03.03, EP 4, EP 5; PC.12.03.05, EP 3, EP 5, EP 8; PC.14.01.01, EP 3, EP 4, EP 6, EP 7; PC.14.02.03, EP 1; RC.11.01.01, EP 2, EP 4; RC.12.01.01, EP 2
Superb access to care	PC.12.03.01, EP 1, EP 2, EP 3
Systems-based approach to quality and safety	LD.11.01.01, EP 11; LD.12.01.01, EP 2, EP 4; MM.14.01.01, EP 4; MS.16.01.01, EP 1; MS.16.03.01, EP 5; NPG.02.03.01, EP 1, EP 2, EP 3, EP 4, EP 5, EP 6, EP 8, EP 10; NPG.13.04.01, EP 1; PC.11.03.01, EP 5; PI.12.01.01, EP 4, EP 5; PI.13.01.01, EP 1; PI.14.01.01, EP 1, EP 2; RC.11.01.01, EP 4

Please refer to the Joint Commission E-dition®, under JC Manual Documents for additional information regarding the *Primary Care Medical Home Certification Option*.