



2026 Joint Commission Physical Environment Update

David C Thompson II, MPA, CHFM, CHSP, CHC

Associate Field Director, Life Safety Code Surveyors
Accreditation and Certification Operations
Joint Commission

DISCLAIMER

- This presentation reflects information as of the date it was originally presented and is intended only as a high-level overview for discussion purposes. Joint Commission reserves the right to update, modify, or revise the information as needed.
- The content herein is intended to highlight key topics for informational purposes only. This content does not represent all the supplementary verbal discussion from the original live presentation. Relying only on the written content here may not provide a full account of the complete discussion and range of viewpoints that were shared. No representations or warranties are made concerning the accuracy, completeness, or suitability of the information for a particular purpose. Joint Commission, or other requirements, should not be interpreted or implemented based solely on this presentation.
- This content and intellectual property are copyrighted and intended for the original presentation purposes only. Further use, sharing, reproduction, or distribution is prohibited without express permission from Joint Commission.

Topics/Learning Objectives

LSCS Leadership Updates

Homecare
Hospice

Hospital Offsite Facilities

Accreditation 360

Joint Commission Physical Environment/Life Safety Leaders



Jim Grana, MBA, CHSP, CLSS-HC

Dir, Standard Development
& Interpretation Physical
Environment



Tim Markijohn, MBA\MHA,
CHFM

Life Safety Code Field Director



Dave Thompson, MPA, CHFM,
CHSP, CHC

Life Safety Code, Assoc Field
Director

Open Position

Life Safety Code Field Director

Surveying Outpatient Facilities and Hospice:

The Why

- Providing accredited organizations with a consistent of survey process
- Ensuring the survey process is comparable with CMS State Operations Manual
- All accrediting organizations are expected to follow the guidance outlined in the CMS State Operations Manual

Hospice

- March 2025
- Home Care Program
- Deemed Only
- Different Program, Different CoP's (418.110)
- Inpatient
- Both Hospital Based and/or Free-Standing
- LSCS complement
 - Hospital Based — Built into hospital complement
 - Free-Standing — 1 LSCS day for each inpatient location

Hospice Agenda

Time	Activity
<i>Arrival first day of Inpatient Hospice survey</i>	
8:00 – 8:30 a.m.	Surveyor Arrival and Facility Orientation with Document Review • Visit main fire alarm panel, generator, fire pump, if applicable • Discuss waivers and equivalencies • Review ILSM policy and procedures • Review written fire response plan • Review LS drawings
8:30 – 9:00	
9:00 – 9:15	Opening Conference – Introductions only (approximately 15 minutes)
9:15 – 10:00	Facility Orientation with Document Review, <i>continued</i> • Review other standards required documentation items on the <i>Life Safety and Environment of Care Document List and Review Tool</i>
10:00 – 10:30	
10:30 – 11:00	Life Safety Code® Building Assessment • Building Tour
11:00 – 11:30	
11:30 – 12:00 p.m.	
12:00 – 12:30	Surveyor Lunch
12:30 – 1:00	Life Safety Code® Building Assessment, <i>continued</i> • Building Tour
1:00 – 1:30	
1:30 – 2:00	Emergency Management
2:00 – 2:30	
2:30 – 3:00	Surveyor Report Preparation
3:00 – 3:30	
3:30 – 4:00	Interim Exit Conference
4:00 – 4:30	

Outpatient Facilities

- Separate survey process apart from A360
- Started July 2025
- HAP to start (HAP Psych, CAH in the future)
- Deemed (Not VHA or DHA)
- Staffing complement matches the clinical ambulatory days minus ASC\FSED because those are already included.
- Scoring will be based on occupancy type using the new PE/NPG standards

Outpatient Facilities

- Clinical surveyor assigned to off-site locations identifies locations to be visited and shares plan with LSC surveyor prior to survey.
- LSC surveyor is not required to visit additional locations at same time as clinical surveyor, but needs to prioritize visits to sites:
 - Hospital (2004)
 - ASC (2020)
 - FSED (2020)
 - Outpatient (2025)

Outpatient Facilities

- All moderate or deep sedation and anesthetizing locations
- All Complex out-patient care locations
 - Intensive Chemotherapy
 - Complex Wound Care
 - Advanced Cardiac Rehab
 - Intensive Medication Management
- Sample a mix of large, medium, small clinics
- Application & SOC/BBI Accuracy

Business/Ambulatory Occupancy Building Tour Guidance

Topic	Notes	Ambulatory Scoring Location	Business Scoring Location
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 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
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 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Battery back-up	If battery back-up lights exist, are they functional and being tested on monthly/ annual basis?	PE.04.01.01 EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).	
Corridors			
Corridor widths	Minimum 44 inches wide in Ambulatory, In Business 44” min only if 50+ occupants, 36 inches if fewer than 50 occupants	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Visible exit signs	Look to see there are exit signs that are visible to direct occupants out of the building.	PE.03.01.01 EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	
Junction Boxes			
	Look for any open electrical junction boxes that have the cover removed.	PE.04.01.01 EP 2 The hospital maintains essential equipment in safe operating condition.	
Electrical Outlets			
	GFI if within 6 ft of sinks	PE.04.01.01 EP 2 The hospital maintains essential equipment in safe operating condition.	

Electrical Panel	Locking - If policy requires locking due to public access	PE.04.01.01 EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).
	Accurate panel legends, circuit breakers in panels need to be identified on the panel legend	PE.04.01.01 EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).
Safety Data Sheets (SDS)	Does the organization have an inventory of the chemicals? Do staff have access to SDS for any chemicals used in the environment? If the organization uses electronic SDS, is there a way for employees to access SDS during computer downtime?	PE.02.01.01 EPs 1, 2 EP 1 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. EP 2 For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation.
Security/ Access	Look at how the org controls access to facility. Can the public enter parts of the facility without authorization? Backdoors unsecured etc.?	NPG.11.01.01 EP 1 The hospital controls access to and from areas it identifies as security sensitive.

Fire Extinguishers		
Inspection	Fire extinguishers inspected monthly and maintained annually. This is documented on the tag or electronically.	PE.04.01.01 EP 2 The hospital maintains essential equipment in safe operating condition.
Mounting and Visibility	- Proper mounting height between 4” and 60” off the floor - Extinguishers are conspicuously visible. Need to be able to see them or a sign of where they are.	PE.04.01.01, EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).
MRI	- MRI-safe fire extinguisher	PE.04.01.01, EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).

Biohazardous and Pharmaceutical Waste	-Is biohazard waste stored in proper containers with proper labeling -Are sharps containers locked and not overfilled Is Biohazard and pharm waste stored so public cannot access while awaiting pickup?	PE.02.01.01, EP 4 The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure Note 1: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs). Note 2: Hazardous gases and vapors include but are not limited to ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9). PE.02.01.01, EP 6 The hospital has procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.	Alcohol-based hand rub (ABHR) Dispensers	- Not directly over outlets - Corridor clear width of 44 inches is not compromised by dispenser (Business) -Only allowed in corridors over 6' wide (Ambulatory) - 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 - Storing more than five gallons of fluid on a single story or in a single fire compartment complies with NFPA 30
--	---	---	---	---

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 The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment and prompt correction of hazards found during inspection - Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure	Medical Equipment	-Is the medical equipment in the medical equipment inventory? -Has the org identified the equipment as high risk or non-high risk? -Can the org tell you what type of maintenance they are doing, OEM or AEM -Is the equipment up to date on PM's?	PE.04.01.01, EP 2 The hospital maintains essential equipment in safe operating condition.
			Compounding	See MST template library	
			Cylinder Storage	-Are there cylinders that are not secured? -Are they storing more than 12 E cylinders outside of a secure storage room of non-or limited- combustible construction (do not count cylinder in use)	PE.04.01.01, EP 1 The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6).
Storage Rooms	Existing construction - If greater than 50 ft, they must have a one-hour fire barrier or automatic sprinkler. New construction storage areas – they must either have a one-hour fire barrier, or be sprinkled with a self-closing door and smoke resistive construction Hazardous Area. Hazardous areas include areas for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).	Sprinkler Heads/ System	Clearances, Cubicle Curtain Mesh	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).
				Sprinkler heads are not obstructed (18” rule)	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).
				Sprinkler heads are not damaged/dirty, escutcheon plates installed	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).
			Fire Drills	Documentation of quarterly (Ambulatory) or annual (Business) fire drill	PE.03.01.01, EP 3 The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4).

Outpatient Facilities

- Inspection/Testing/Maintenance (ITM) Document Review
- LSCS Drawings
- Above Ceiling
- SOC\BBI

Accreditation 360: The New Standard

Intent & Purpose Of Updated Manual

- Streamlined approach that more directly identifies the CoPs
- Differentiate what Joint Commission requirements rise above the regulatory requirements
- Overall EP reduction
 - 46% of EPs were eliminated for critical access hospitals
 - 48% of EPs were eliminated for hospitals
- Manuals will display regulation number in new section below each EP text that is associated with a CoP

Manual Redesign

Accreditation Participation Requirements (APR)

Emergency Management (EM)

Human Resources (HR)

Infection Prevention and Control (IC)

Information Management (IM)

Leadership (LD)

Medication Management (MM)

Medical Staff (MS)

National Performance Goals (NPG)

Nursing (NR)

Provision of Care, Treatment, and Services (PC)

Physical Environment (PE)

Performance Improvement (PI)

Record of Care, Treatment, and Services (RC)

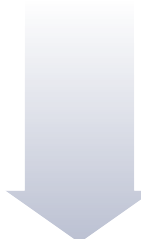
Rights and Responsibilities of the Individual (RI)

Transplant Safety (TS)

Moving from Complexity to Clarity



Historical....



Present....

CFR Number §482.24(c)(2)	Medicare Requirements	Joint Commission Equivalent Number	Joint Commission Standards and Elements of Performance
§482.24(c)(2)	TAG: A-0454 (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	PC.02.01.03	The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
		EP 1	For hospitals that use Joint Commission accreditation for deemed status purposes: Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a physician or other licensed practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations. Note 1: Outpatient services may be ordered by a physician or other licensed practitioner not appointed to the medical staff as long as the practitioner meets the following: - Responsible for the care of the patient - Licensed to practice in the state where the practitioner provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements - Acting within the practitioner's scope of practice under state law - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the physician or other licensed practitioner responsible for the patient's care, or by a qualified dietician or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.
		RC.01.01.01	The hospital maintains complete and accurate medical records for each individual patient.
		EP 7	All entries in the medical record are dated.
		EP 13	For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.
		RC.01.02.01	Entries in the medical record are authenticated.
		EP 2	The hospital defines the types of entries in the medical record made by licensed practitioners that require countersigning, in accordance with law and regulation.
		EP 3	The author of each medical record entry is identified in the medical record.
		EP 4	Entries in the medical record are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author. Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key. Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or hospital policy. For electronic records, electronic signatures will be date-stamped. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering physician or other licensed practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy, law and regulation, and medical staff bylaws, rules, and regulations, is authorized to write orders.
		EP 5	The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.
		RC.02.03.07	Qualified staff receive and record verbal orders.
		EP 3	Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.
		EP 4	Verbal orders are authenticated within the time frame specified by law and regulation.
		EP 6	For hospitals that use Joint Commission accreditation for deemed status purposes: Documentation of verbal orders includes the time the verbal order was received.

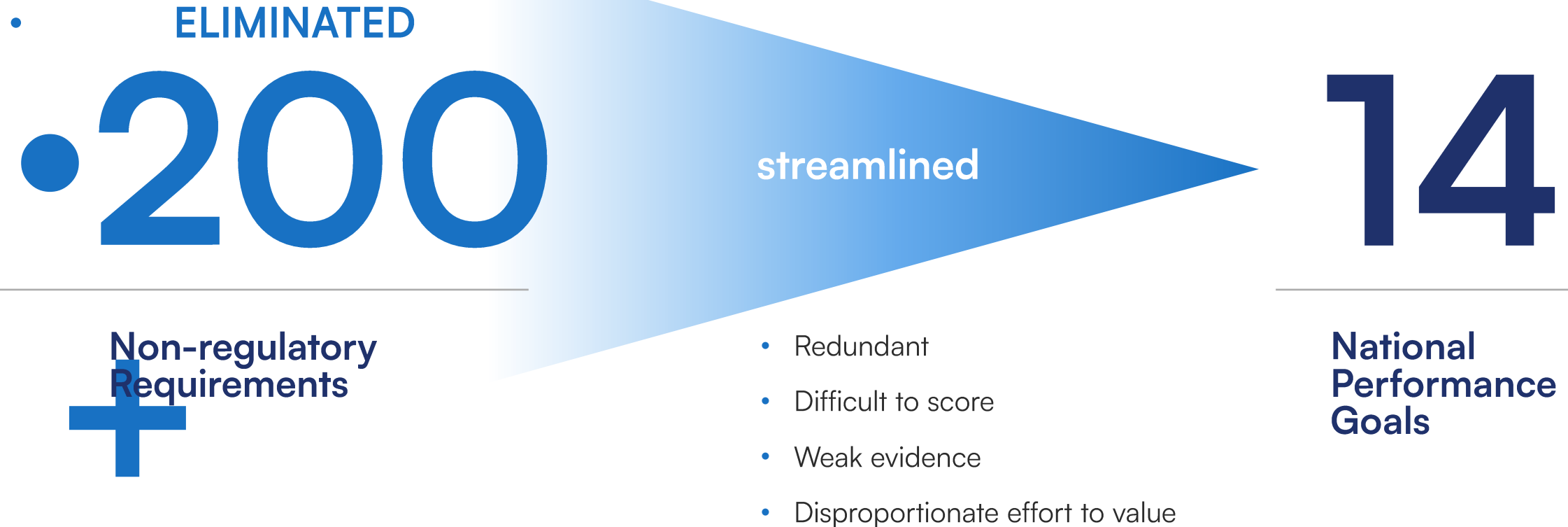
Medicare Hospital Requirements to 2024 Joint Commission Hospital Standards & EPs
Page 159 of 400
Report Generated by DSSM
November 16, 2023
© 2024 The Joint Commission

§482.24(c)(2)	TAG: A-0454 (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	RC.11.02.01	Entries in the medical record are authenticated.
		EP 1	All orders, including verbal orders, are dated, timed, and authenticated by the ordering physician or other licensed practitioner who is responsible for the patient's care and who is authorized to write orders, in accordance with hospital policy, law and regulation, and medical staff bylaws, rules, and regulations.

Medicare Hospital Requirements to 2025 Joint Commission Hospital Standards & EPs
Page 110 of 245
Report Generated by DSSM
April 25, 2024
© 2025 The Joint Commission

Burden Reduction Initiative for Hospitals

Scrutinized our quality & safety requirements that go beyond the CMS Conditions of Participation (CoPs)



National Performance Goal Topics

1. Right Patient, Right Care

- Critical results
- Two patient identifiers
- Flow of patients through the hospital
- Handoff communication
- Clinical alarm safety
- Recognizing and responding to changes in pt condition
- Preprocedural verification

2. Emergency Management

3. Pain Management

- Safe opioid prescribing

4. Excellent Health Outcomes for All (EHO4All)

5. Culture of Safety

- Conflict of interest & ethics
- Designing work processes that focus on safety/quality
- Workplace Violence Prevention

6. Infection Prevention & Control

- Identifying risks based on geographic location, community, and population served
- High consequence infectious diseases or special pathogens
- Hand hygiene

National Performance Goal Topics, cont.

7. Patient Rights

- Effective communication
- Right to give/withhold informed consent
- Identification of possible victims of abuse, neglect, and exploitation
- Treatment in dignified, respectful manner

8. Suicide Risk Reduction (based on CoPs)

9. Safe Transplant Practices

- Bidirectional tracing of tissue

10. Waived Testing (point of care)

- Following manufacturers' IFUs
- Evaluating staff competency

11. Workplace and Patient Safety

- Managing security risks
- Fall risk reduction

12. Staffing

- Competency & training
- Evaluating staffing when undesirable patterns or trends are identified

National Performance Goal Topics, cont.

13. Imaging Safety

- Staff qualifications
- Policies and procedures based on safe imaging practices
- Managing imaging safety risks
- Monitors quality related to imaging safety (dosing)

14. Medication Management

- Override review
- Labeling in procedures
- Anticoagulation safety
- Medication reconciliation
- Antibiotic stewardship



Survey Process Guide

Survey Process Guide (SPG) — Overview

- Replaces Survey Activity Guide (SAG)
- Better reflects State Operations Manual (SOM) related to survey process for the CoPs
- Same version shared between surveyors and accredited organizations
- SPG updated 01/01/2026



Hospital Accreditation

Survey Process Guide

Survey Process Guide (SPG) — Overview

- Organized into sections based on the CMS CoP structure
- Contains separate section for evaluating NPG Chapter
- Includes updated Compliance Evaluation Tools



Hospital Accreditation

Survey Process Guide

Survey Process Remains the Same

Surveyors will continue to conduct the following activities:

- Document Review
- Life Safety Code Building Assessment



Hospital Accreditation

Survey Process Guide

Survey Process Guidance - Modules

Hospital Physical Environment Evaluation Module (482.41)		
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.	§482.41 Condition of Participation: Physical Environment The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.	Observation: □ Verify that all locations of the hospital, including all campuses, satellites, provider-based activities, and inpatient and outpatient locations meet this CoP.

New Standard/EP

CoP

Survey Process Guidance
(Interview, Document Review, Observation)

Survey Process Guidance - Modules

Hospital Radiologic Services Evaluation Module (482.26)

PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following:	§482.26(b) Standard: Safety for Patients and Personnel The radiologic services, particularly ionizing radiology procedures, must be free from hazards for patients and personnel.	Interview ☐ Radiologic services staff to determine: ☐ Familiarity with policies and procedures related to safety in general and to specific clinical protocols. ☐ Training at appropriate intervals to on
--	---	--

Hospital Nuclear Medicine Services Evaluation Module (482.53)

LD.13.03.01, EP 9: For hospitals that use the Joint Commission for deemed status purposes: If the hospital provides nuclear medicine services, and nuclear medicine staff perform laboratory tests, the services meet the applicable requirements for laboratory services specified in 42 CFR 482.27.	§482.53(b) Standard: Delivery of Service Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.	Interview ☐ Ask the hospital to demonstrate how it limits access to radioactive materials at all times. ☐ Determine if staff use their dosimeters according to manufacturer's instructions, particularly in the appropriate placement of the dosimeter on the body, as indicated on the dosimeter.
---	---	--

☐☐☐☐☐

Compliance Evaluation Tools

- Compliance Evaluation Tools:
 - CMS K-Tag tools for ambulatory and health care occupancies
 - Kitchen Tracer Survey Tool
 - Fire Drill Matrix
 - Document List and Review Tool

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-tag Safety Code and NFPA 99 Health Care Facilities Code requirements that are evaluated for compliance to determine if hospitals meet Conditions of Participation. Hospitals and critical access hospitals and surveyors must refer to the tool for the content of Code elements that appear in individual elements of performance under the new, streamlined Joint Commission Physical Environment (PE) standard.

The tool will assist both organizations and surveyors in identifying the hospital and critical access hospital Conditions of Participation requirements that relate to the hospital's physical environment. The tool will also assist in identifying the hospital's current physical environment requirements and Joint Commission accreditation requirements.

K-tag	Code
SECTION 1 – GENERAL INFORMATION	
K100	General Information Any L... not a... inform... shoul...

Revised - Effective: 4/20/2024

The following pages present documentation required by the Hospital Accreditation program Physical Environment (PE) standards. Turn in all of these documents soon after arrival for the on-site survey. Surveyors may request other documents, as needed, throughout the survey. Elements of performance that do not require documentation but appear as reminders to both organizations and surveyors of these elements are indicated by a dashed line.

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)		
					Current and accurate drawings w/ fire safety features & related square footage		

Survey Process Guide (SPG) PE Examples

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					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					
EP 2					Duct, heat, smoke detectors, and manual fire alarm boxes NFPA 72-2010: Table 14.4.5; 17.14	Annually				
EP 2					Notification devices (audible & visual), and door-releasing devices NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Emergency services notification transmission equipment NFPA 72-2010: Table 14.4.5	Annually				
EP 2					Electric motor-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Monthly				
					Diesel-engine-driven fire pumps tested under no-flow conditions NFPA 25-2011: 8.3.1; 8.3.2	Weekly				

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	TJC 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 <i>Repair, Renovation, Modification, or Reconstruction</i> 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 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	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 Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2.	

Chapter Updates — Physical Environment (PE)

Concepts in the PE Chapter

**Safe, Adequate
Environment**
PE.01.01.01

**Hazardous
Materials &
Waste**
PE.02.01.01

**Comply with
Life Safety Code**
PE.03.01.01

**Interim Life
Safety Measures**
PE.03.02.01

**Building Safety
& Facility
Management**
PE.04.01.01

Utility Systems
PE.04.01.03

**Water
Management**
PE.04.01.05

Imaging Safety
PE.05.01.01

Numbering and Location Changes

Current Standard Numbering
EC.01.01.01
EC.02.01.01
EC.02.01.03
EC.02.02.01
EC.02.03.01
EC.02.03.03
EC.02.03.05
EC.02.04.01
EC.02.04.03
EC.02.05.01
EC.02.05.02

Current Standard Numbering
EC.02.05.03
EC.02.05.05
EC.02.05.07
EC.02.05.09
EC.02.06.01
EC.02.06.05
EC.03.01.01
EC.04.01.01
EC.04.01.03
EC.04.01.05



Future Standard Numbering
PE.01.01.01
PE.02.01.01
PE.04.01.01
PE.04.01.03
PE.04.01.05
PE.05.01.01

Future Standard Numbering
NPG.02.04.01
NPG.11.01.01
NPG.11.03.01
NPG.13.03.01

Numbering and Location Changes

Current Standard Numbering	Current Standard Numbering
LS.01.01.01	LS.03.01.30
LS.01.02.01	LS.03.01.34
LS.02.01.10	LS.03.01.35
LS.02.01.20	LS.03.01.40
LS.02.01.30	LS.03.01.50
LS.02.01.34	LS.03.01.70
LS.02.01.35	LS.05.01.10
LS.02.01.40	LS.05.01.20
LS.02.01.50	LS.05.01.30
LS.02.01.70	LS.05.01.34
LS.03.01.10	LS.05.01.35
LS.03.01.20	



Future Standard Numbering
PE.03.01.01
PE.03.02.01
PE.04.01.01

PE Concepts in the NPG Chapter

**Workplace
Violence Worksite
Analysis**
NPG.02.04.01

Security Risks
NPG.11.01.01

Utility Systems
NPG.11.03.01

Imaging Safety
NPG.13.03.01

Surveyor Impact

- Reduced number of EPs to choose from, improving consistency and ease of scoring
- Easier selection of CoP due to direct connections of CoP language with EPs
- Potential improvement of CMS validation survey results

Top Physical Environment Opportunities

Interior Spaces Safe-Suitable (EC.02.06.01 EP 1)
Utility Systm Control Labels (EC.02.05.01 EP 9)
Clean Envmt-No Odors (EC.02.06.01 EP 20)
Non-High Risk Utility Sys Test (EC.02.05.05 EP 6)
NFPA Auto Extinguishment (LS.02.01.35 EP 14)
Furnish-Equip Safe-Maintained (EC.02.06.01 EP 26)
Haz Chemical Handling-Storage (EC.02.02.01 EP 5)
Dedicated Sprinkler Piping (LS.02.01.35 EP 4)
Fire Barrier Penetration Seal (LS.02.01.10 EP 14)
Non-Crit Pressure Relationship (EC.02.05.01 EP 16)
Fire Rated Door Requirements (LS.02.01.10 EP 11)
Sprinkler Maintenance (LS.02.01.35 EP 5)
Ceiling Membrane Integrity (LS.02.01.34 EP 9)
Critical/Non-Critical Pressure Relationship (EC.02.05.01 EP 15/16)
Cylinder Handling Policy (EC.02.05.09 EP 12)

EC.02.06.01 EP 1

Interior Spaces Safe-Suitable

- **Ceiling and Wall Damage:** Numerous observations report issues such as stained or damaged ceiling tiles, peeling paint, holes in walls, and exposed drywall. These conditions are noted in a variety of locations including patient rooms, operating rooms, storage areas, and public corridors, often raising concerns about infection control and cleanability.
- **Emergency Pull Cord Accessibility:** Multiple entries highlight problems with emergency pull cords in patient restrooms and other areas. Issues include cords being tied up, wrapped around grab bars, or positioned too high above the floor, making them inaccessible to patients who may need assistance from the floor.
- **Unsecured Sharps and Equipment:** Several observations detail unsecured carts or cabinets containing needles, sharps, or other medical supplies left accessible in public or patient areas. This presents safety risks for unauthorized access by patients or visitors.

EC.02.06.01 EP 1 — PE.01.01.01 EP 1

Interior Spaces Safe-Suitable

- Ceiling and Wall Damage:
- Emergency Pull Cord Accessibility
- Unsecured Sharps and Equipment:

Hospital Physical Environment Evaluation Module (482.41)

Note: [K-tag/CoP/EP review tool](#) is required to evaluate compliance with the Life Safety Code.

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients. Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria.	§482.41 Condition of Participation: Physical Environment The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.	Observation: ☐ Verify that all locations of the hospital, including all campuses, satellites, provider-based activities, and inpatient and outpatient locations meet this CoP.

EC.02.05.01 EP 9

Utility System Control Labels

- **Spare/Energized Breakers Labeled Incorrectly:** Numerous observations report circuit breakers labeled as "spare" but found in the "ON" position. This issue is noted across various locations, including operating rooms, kitchens, and electrical closets, and is consistently verified by facility managers or directors.
- **Missing or Inaccurate Panel Schedules/Labels:** Many entries highlight electrical panels with missing, incomplete, or inaccurate labeling and legends. This includes panels without any schedule, schedules listing incorrect or outdated information, or breakers in use without identification of what they serve.
- **Unlabeled Utility Shutoff Valves:** Several observations point out that natural gas, oxygen, or other utility shutoff valves are not labeled or lack signage, making emergency shutdowns difficult. This theme is seen in kitchens, boiler plants, and bulk utility areas, and is often confirmed by facility leadership.

EC.02.05.01 EP 9 — PE.04.01.01 EP 1

Utility System Control Labels

- Spare/Energized Breakers Labeled Incorrectly:
- Missing or Inaccurate Panel Schedules/Labels:
- Unlabeled Utility Shutoff Valves:

PE.04.01.01, EP 1: The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.	§482.41(c) Standard: Building Safety Except as otherwise provided in this section, the hospital must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the hospital, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely <u>affect</u> the health and safety of patients.	Document Review: ☐ Review plans, policies and procedures, and documentation to determine compliance with Health Care Facilities Code requirements. Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Health Care Facilities Code.
---	--	---

EC.02.06.01 EP 20

Clean Environment – Cleanliness, No Odors or unsanitary conditions

- **Dust and Debris Accumulation:** Numerous observations highlight the presence of dust and debris on various surfaces, including medical equipment (e.g., infant warmers, refrigerators, monitors), vents, ceiling tiles, and storage units. This issue is noted across multiple departments such as pharmacy, emergency, ICU, and kitchen areas.
- **Soiling and Residue on Equipment and Surfaces:** Many entries report soiled or sticky residues on equipment like trauma scissors, IV poles, patient tables, and adhesive residue on medical devices. These findings often include confirmation by department leadership and immediate cleaning actions in some cases.
- **Infection Control and Sanitation Concerns:** Several observations point to infection control risks, such as growth substances near drains, dirty utility rooms, unsanitary kitchen areas, and improper cleaning practices (e.g., infrequent changing of protective coverings). These concerns are frequently validated by facility managers or clinical leadership.

EC.02.06.01 EP 20 – PE.01.01.01 EP 3

Clean Environment - Cleanliness, No Odors or unsanitary conditions

- **Dust and Debris Accumulation:**
- **Soiling and Residue on Equipment and Surfaces:**
- **Infection Control and Sanitation Concerns:**

PE.01.01.01, EP 2: The hospital has adequate space and facilities for the services provided, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served.
Note: The extent and complexity of facilities is determined by the services offered.

PE.01.01.01, EP 3: The hospital's premises are clean and orderly.
Note: Clean and orderly means an uncluttered physical environment where patients and staff can function. This includes but is not limited to storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat.

Interior locations

Document Review:

- ☐ Review the hospital's routine and preventive maintenance schedules to determine that ongoing maintenance inspections are performed and that necessary repairs are completed.
- ☐ Review a copy of the most recent environmental risk assessment to determine if the hospital has identified any accessibility, age-related, security, suicide and/or weather-related risks or concerns. If environmental safety concerns have been identified in this assessment, what plans have been implemented by the hospital to ensure patient/staff safety?

Communication with Team

- ☐ Refer any potential power strip use deficiencies to Life Safety Code surveyors.

EC.02.05.05 EP 6

Non-High Risk Utility System Testing

- **Blocked or Obstructed Electrical Panels and Equipment:** Numerous observations report electrical panels, line isolation monitors, and disconnect switches being blocked by carts, equipment, storage materials, or furniture. This includes panels in operating rooms, storage rooms, kitchens, and hallways, often confirmed by facility directors or staff.
- **Open or Uncovered Electrical Junction Boxes:** Many findings highlight open electrical junction boxes, often with exposed wiring, located above ceilings, in mechanical rooms, corridors, and patient care areas. These conditions are frequently verified by facilities or plant operations staff.
- **Unlocked or Accessible Electrical Panels:** Several observations note that electrical panels were found unlocked and accessible to unauthorized individuals or the public, including in common corridors, waiting areas, and near nurse stations. These issues were validated by safety officers, facility managers, or clinical leadership.

EC.02.05.05 EP 6 – PE.04.01.01 EP 2

Non-High Risk Utility System Testing

- Blocked or Obstructed Electrical Panels and Equipment:
- Open or Uncovered Electrical Junction Boxes:
- Unlocked or Accessible Electrical Panels: .

PE.04.01.01, EP 2: The hospital maintains essential equipment in safe operating condition. PE.04.01.01, EP 5: The hospital maintains supplies to ensure an acceptable level of safety and quality. Note: Supplies are stored in a manner to ensure the safety of the stored supplies and to not violate fire codes or otherwise endanger patients. PE.04.01.05, EP 1: The water management program has an individual or a team responsible for the oversight and implementation of the program, including	§482.41(d)(2) - Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.	Interview: Interview personnel in charge of equipment maintenance to determine: ☐ If the hospital has identified equipment that is essential for both regular operations and in an emergency situation. ☐ If the hospital has made adequate provisions to ensure the availability of those and equipment when needed. Interview equipment users on units/departments to determine: ☐ If equipment failures are occurring and causing problems for patient health or safety. Document Review: Review equipment inventory to verify the following:
--	--	--

LS.02.01.35 EP 14

NFPA Auto Extinguishment

- **Obstructed or Blocked Fire Extinguishers and Sprinkler Heads:** Numerous observations report fire extinguishers and sprinkler heads being blocked by various objects such as desks, carts, storage racks, furniture, or equipment. These obstructions were found in diverse locations including medical supply rooms, hallways, kitchens, and mechanical rooms, and were often corrected onsite prior to surveyor departure.
- **Ceiling Membrane Gaps and Unsealed Penetrations:** Many findings highlight gaps, missing tiles, or unsealed penetrations in ceiling membranes, particularly in areas protected only by sprinklers. These gaps, often greater than 1/8 inch, were noted around pipes, conduits, or due to missing tiles, potentially compromising the effectiveness of fire suppression systems.
- **Improper Installation or Maintenance of Fire Suppression Equipment:** Several observations detail issues such as misaligned or improperly oriented sprinkler heads, mixed types of sprinkler heads in the same compartment, and fire suppression nozzles not directed at the intended area. These deficiencies were confirmed by facilities staff and typically addressed during the survey.

LS.02.01.35 EP 14 – PE.03.01.01 EP 3

NFPA Auto Extinguishment

- **Obstructed or Blocked Fire Extinguishers and Sprinkler Heads:**
- **Ceiling Membrane Gaps and Unsealed Penetrations:**
- **Improper Installation or Maintenance of Fire Suppression Equipment:**

PE.04.01.01, EP 1: The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5, and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity;	§482.41(e) through (e)(1)(xi) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federalregulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	PE.04.01.01, EP 5 (482.41(e)(1)(vii) through (e)(1)(xi)) PE.05.01.01, EP 1 (482.41(e)(1)(i) through (e)(1)(vi))
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity. PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Standards for Health Care Facilities Code of the National Fire Protection Association 99, 2012 edition, issued August 11, 2011. (ii) TIA 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, <u>2011</u>. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30,	

EC.02.06.01 EP 26

Furnishings - Equipment are Safe - Maintained

- **Damaged or Degraded Patient Care Equipment and Furniture:** Numerous observations highlight torn upholstery, cracked vinyl, exposed foam, and degraded metal on items such as mattresses, chairs, IV poles, and exam tables. These conditions are frequently cited as infection control concerns and barriers to effective cleaning and disinfection.
- **Environmental and Facility Maintenance Issues:** Recurring issues include excessive ice or moisture buildup in freezers and refrigerators, water leaks, accumulation of dust or debris on vents and equipment, and malfunctioning or uncalibrated devices. These problems are noted in both patient care and support areas, impacting safety and cleanliness.
- **Improper Repairs or Temporary Fixes:** Several observations describe the use of tape, gauze, or makeshift repairs on equipment and furniture, such as taping over torn areas or using non-standard materials to cover damage. These temporary solutions are consistently identified as inadequate for maintaining a safe, clean, and functional environment.

EC.02.06.01 EP 26 – PE.01.01.01 EP 2

Furnishings - Equipment are Safe - Maintained

Damaged or Degraded Patient Care Equipment and Furniture:

Environmental and Facility Maintenance Issues:

Improper Repairs or Temporary Fixes:

PE.01.01.01, EP 1: The hospital's building is constructed, arranged, and maintained to allow safe access and to protect the safety and well-being of patients.	\$482.41(d) Standard: Facilities The hospital must maintain adequate facilities for its services.	Document Review: ☐ Review the facility's water supply and distribution system to ensure that the water quality is
Joint Commission Standards / EPs Note 1: Diagnostic and therapeutic facilities are located in areas appropriate for the services provided. Note 2: When planning for new, altered, or renovated space, the hospital uses state rules and regulations, or the current Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute. If the state rules and regulations or the Guidelines do not address the design needs of the hospital, then it uses other reputable standards and guidelines that provide equivalent design criteria. PE.01.01.01, EP 2: The hospital has adequate space and facilities for the services it provides, including facilities for the diagnosis and treatment of patients and for any special services offered to meet the needs of the community served. Note: The extent and complexity of facilities is determined by the services offered.	Hospital CoP	Hospital Survey Process acceptable for its intended use (drinking water, irrigation water, lab water, etc.). Review the facility water quality monitoring and, as appropriate, treatment system. Observation: ☐ Observe the facility layout and determine if the patient's needs are met. Toilets, sinks, specialized equipment, etc. should be accessible.

EC.02.02.01 EP 5

Hazardous Chemical Handling-Storage

- **Eyewash Station Accessibility and Functionality Issues:** Numerous observations highlight that eyewash stations were either missing, not readily accessible within the required 10 seconds, blocked by equipment, or not functioning properly (e.g., insufficient water pressure, caps not falling off, or improper installation height).
- **Non-compliance with Inspection and Maintenance Protocols:** Many entries report missed or incomplete weekly inspections and maintenance of eyewash stations, including missing documentation, expired spill kits, and lack of adherence to ANSI Z358.1 standards or internal policies requiring regular testing and flushing.
- **Inadequate Hazard Controls and Personal Protective Equipment (PPE):** Several observations note the absence of required PPE (such as eye protection or gloves) when handling hazardous chemicals, improper storage or labeling of chemicals, and lack of risk assessments or mitigation strategies for hazardous material handling and disposal.

EC.02.02.01 EP 5 – PE.02.01.01 EP 4

Hazardous Chemical Handling-Storage

- Eyewash Station Accessibility and Functionality Issues:).
- Non-compliance with Inspection and Maintenance Protocols:
- Inadequate Hazard Controls and Personal Protective Equipment (PPE):

PE.02.01.01, EP 4: The hospital develops and implements policies and procedures to protect patients and staff from exposure to hazardous materials. The policies and procedures address the following: - Minimizing risk when selecting, handling, storing, transporting, using, and disposing of radioactive materials, hazardous chemicals, and hazardous gases and vapors - Disposal of hazardous medications - Minimizing risk when selecting and using hazardous energy sources, including the use of proper shielding - Periodic inspection of radiology equipment			§482.53(b)(2) <u>There</u> is proper storage and disposal of radioactive material. §482.53(b)(3) If laboratory tests are performed in the nuclear medicine service, the 40 42 CFR Ch. IV (10–1–23 Edition) §482.54 service must meet the applicable requirement for laboratory services specified in §482.27.			- If radiopharmaceuticals are prepared in-house, determine that the preparation is performed by, or supervised by, a registered pharmacist or MD/DO. ☐ Ask the supervising pharmacist or MD/DO how technicians who prepare radiopharmaceuticals are supervised. Are supervision policies based on the recommendations of the Society of Nuclear Medicine and Molecular Imaging? If not, what is the basis for the supervision policies? ☐ Ask what policies and procedures the hospital uses to ensure proper preparation. ☐ Ask what guidelines the hospital relies on for radio pharmaceutical preparation. Document Review General ☐ Verify that radioactive materials are prepared, labeled, used, transported, stored, and disposed of in accordance		
Joint Commission Standards / EPs			Hospital CoP			Hospital Survey Process		
and prompt correction of hazards found during inspection						with hospital policies that are based on acceptable standards of practice.		
- Precautions to follow and personally protective equipment to wear in response to hazardous material and waste spills or exposure						☐ Verify that the hospital maintains accurate records of the receipt, distribution, and disposal of radioactive materials, including radiopharmaceuticals.		
Note 1: Hazardous energy is produced by both ionizing equipment (for example,						☐ If radiopharmaceuticals are obtained from an outside source, verify that the receipt and storage are appropriately tracked.		
						☐ Verify that the hospital has policies regarding the		

LS.02.01.35 EP 4

Dedicated Sprinkler Piping

- **Sprinkler piping used to support other items:** The most frequent theme is the observation of various items—such as cables, wires, electrical conduits, ductwork, and insulation—being supported by or resting on dedicated sprinkler piping. This includes instances where items are tied, draped, or wrapped around the sprinkler pipes, often above ceilings in patient rooms, corridors, mechanical rooms, and utility areas.
- **Immediate onsite correction and compliance documentation:** Many observations note that the identified deficiencies were corrected onsite prior to the surveyor's departure. However, it is repeatedly emphasized that the corrective action taken must be included in the organization's Evidence of Standards Compliance submission, indicating a focus on both immediate remediation and formal documentation.

LS.02.01.35 EP 4 – PE.03.01.01 EP 3

Dedicated Sprinkler Piping

- Sprinkler piping used to support other items:
- Immediate onsite correction and compliance documentation:

PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	§482.41(b) (1) Except as otherwise provided in this section—	Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

LS.02.01.10 EP 14

Fire Barrier Penetrations

- **Unsealed or Improperly Sealed Penetrations:** Many observations highlight issues where penetrations—such as pipes, conduits, cable trays, or ducts—pass through fire-rated barriers and are either left unsealed or sealed with non-compliant materials. Examples include open penetrations around electrical conduits, cable trays, and pipes that require additional fire-rated caulk or approved fire stop systems.
- **Use of Non-Compliant Materials:** Several findings specifically note the use of materials that do not meet fire safety standards, such as polyurethane expanding foam or non-fire-rated caulking, to seal penetrations in fire barriers. These materials are explicitly identified as unacceptable for maintaining the integrity of fire-rated assemblies.

LS.02.01.10 EP 14 – PE.03.01.01 EP 3

Fire Barrier Penetrations

- Unsealed or Improperly Sealed Penetrations:
- Use of Non-Compliant Materials:

PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	§482.41(b) (1) Except as otherwise provided in this section—	Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

LS.02.01.10 EP 11

Fire Rated Door Requirements

- **Failure of Fire Doors to Latch or Close Properly:** Many observations report that fire-rated doors did not latch or close as required. Examples include doors in stairwells, corridors, equipment rooms, and hazardous storage areas that failed to latch when tested or were not self-closing due to hardware issues.
- **Improper Door Conditions Affecting Fire Rating:** Several entries highlight physical deficiencies that compromise fire door integrity, such as excessive gaps between doors or between door and frame, unapproved or oversized protective plates, and doors with unsealed holes. These conditions were noted to potentially affect the fire rating and compliance.
- **Doors Propped or Wedged Open:** Multiple observations describe fire doors being intentionally propped or wedged open by equipment or objects, including in medical vacuum pump rooms, sterile storage, and elevator machine rooms. This practice was consistently identified as a safety concern and a violation of fire safety standards

LS.02.01.10 EP 11 – PE.03.01.01 EP 3

Fire Rated Door Requirements

- Failure of Fire Doors to Latch or Close Properly:
- Improper Door Conditions Affecting Fire Rating:
- Doors Propped or Wedged Open:

PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	§482.41(b) (1) Except as otherwise provided in this section—	Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

LS.02.01.35 EP 5

Sprinkler Maintenance

- **Missing or Improperly Installed Escutcheon Plates:** Numerous observations report sprinkler heads missing escutcheon plates or having plates that are not properly installed, resulting in gaps or exposure. These issues are noted in a variety of locations, including patient rooms, kitchens, corridors, and specialized areas such as the OR, pharmacy, and mechanical rooms.
- **Accumulation of Dust, Dirt, or Debris on Sprinkler Heads:** Many findings highlight sprinkler heads covered with dust, lint, dirt, or debris. This theme is observed in areas such as kitchens, patient rooms, storage rooms, and utility areas, with several reports confirming that such conditions could impede sprinkler functionality.
- **Corrosion, Paint, or Ice on Sprinkler Heads:** Several observations mention sprinkler heads affected by corrosion, paint, or ice accumulation. These issues are found in locations like laundry rooms, kitchens, and walk-in freezers, and are often confirmed by facilities or engineering staff as not meeting NFPA standards.

LS.02.01.35 EP 5 – PE.03.01.01 EP 3

Sprinkler Maintenance

- Missing or Improperly Installed Escutcheon Plates:
- Accumulation of Dust, Dirt, or Debris on Sprinkler Heads:
- Corrosion, Paint, or Ice on Sprinkler Heads:

PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	§482.41(b) (1) Except as otherwise provided in this section—	Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

LS.02.01.34 EP 9

Ceiling Membrane Integrity

- **Ceiling membrane penetrations and gaps:** Many observations report unsealed penetrations, gaps greater than 1/8 inch, or missing ceiling tiles in various rooms such as equipment rooms, IT closets, and laboratories. These deficiencies are frequently noted around conduits, pipes, or sprinkler escutcheons, and are consistently cited as compromising the integrity of the fire and smoke barrier.
- **Impact on fire suppression and smoke detection:** A recurring theme is the risk that these ceiling deficiencies pose to the timely activation of smoke detectors and fire suppression systems. Observations often specify that such gaps or penetrations could delay or prevent proper smoke detection, potentially compromising safety in areas protected by both sprinklers and smoke detectors.
- **Immediate corrective actions and compliance requirements:** Most findings indicate that the deficiencies were corrected onsite prior to the surveyor's departure. However, organizations are repeatedly reminded that corrective actions must be documented and included in their Evidence of Standards Compliance submissions, emphasizing the importance of ongoing compliance and documentation.

LS.02.01.34 EP 9 – PE.03.01.01 EP 3

Ceiling Membrane Integrity

- Ceiling membrane penetrations and gaps:
- Impact on fire suppression and smoke detection:
- Immediate corrective actions and compliance requirements:

PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	§482.41(b) (1) Except as otherwise provided in this section—	Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

EC.02.05.01 EP 15

Critical Ventilation Pressure Relationship

- **Improper Pressure Relationships in Critical Areas:** Numerous observations highlight that operating rooms, sterile storage, and clean utility areas frequently had negative or neutral pressure relative to adjacent corridors or sterile cores, when positive pressure is required. This was confirmed by facilities or plant operations staff in multiple instances.
- **Temperature and Humidity Non-Compliance:** Many entries document temperatures in operating rooms falling below required standards (often below 68°F), and humidity levels either exceeding or dropping below policy thresholds (e.g., below 30% or above 60%), with a lack of corrective actions or case-based justifications. These issues were often confirmed during document reviews or by facility leadership.
- **Lack of Documentation and Corrective Action:** Several observations note missing documentation for required annual air exchange testing, temperature/humidity monitoring, or corrective actions when environmental parameters were out of range. In some cases, policies were not followed or forms were outdated, and leadership confirmed the absence of required records or mitigation steps.

EC.02.05.01 EP 15 – PE.04.01.01 EP 3

Critical Ventilation Pressure Relationship

- Improper Pressure Relationships in Critical Areas:
- Temperature and Humidity Non-Compliance:
- Lack of Documentation and Corrective Action:

PE.03.01.01, EP 3: The hospital meets the applicable provisions of the Life Safety Code (NFPA 101-2012 and Tentative Interim	§482.41(b) (1) Except as otherwise provided in this section—	Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Life Safety Code.
Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
Amendments [TIA] 12-1, 12-2, 12-3, and 12-4). Note 1: Outpatient surgical departments meet the provisions applicable to ambulatory health care occupancies, regardless of the number of patients served. Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare & Medicaid Services (CMS) finds that a fire and safety code imposed by state law adequately protects patients in hospitals. Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: In consideration of a recommendation by the state survey agency or accrediting organization or at the discretion of the Secretary for the US Department of Health & Human Services, CMS may waive, for periods deemed appropriate, specific provisions of the Life	(i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.	

EC.02.05.01 EP 16 – PE.04.01.01 EP 3

Non-Critical Ventilation Pressure Relationship

PE.04.01.01, EP 3: The hospital has proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.	§482.41(d)(4) - There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas.	Observation: ☐ Verify that food and medication preparation areas are well lit ☐ Verify the hospital <u>is in compliance with ventilation requirements</u> ☐ Verify that food products are stored under appropriate conditions based on nationally accepted sources ☐ Verify pharmaceuticals are stored in accordance with manufacturer’s recommendations Document Review: ☐ Review monitoring records for temperature to make certain that appropriate levels are maintained
--	---	---

EC.02.05.09 EP 12

Cylinder Handling Policy

- **Unsecured or Improperly Secured Gas Cylinders:** Numerous observations report gas cylinders (oxygen, nitrogen, carbon dioxide, helium, etc.) found unsecured, freestanding, or not properly chained in various hospital locations such as storage rooms, patient care areas, kitchens, and loading docks. This includes instances where chains or securing devices were present but not used correctly or were too loose to prevent cylinders from falling.
- **Improper Labeling and Segregation of Cylinders:** Several observations highlight deficiencies in labeling and segregating full, partial, and empty cylinders. Examples include cylinders stored in racks labeled incorrectly, comingling of full and empty cylinders, and missing signage or unclear definitions of what constitutes a full or empty tank. These issues were noted in both policy documents and physical storage areas.
- **Non-Compliance with Storage Environment Requirements:** Some observations point to environmental non-compliance, such as cylinders stored outdoors without protection from weather or ground contact, and cylinders placed directly on floors or shelves without mats or grates to prevent rusting. These findings also include policy gaps regarding environmental protection and adherence to NFPA 99-2012 standards.

EC.02.05.09 EP 12 – PE.04.01.01 EP 1

Cylinder Handling Policy

- **Unsecured or Improperly Secured Gas Cylinders:**
- **Improper Labeling and Segregation of Cylinders:**
- **Non-Compliance with Storage Environment Requirements:**

PE.04.01.01, EP 1: The hospital meets the applicable provisions and proceeds in accordance with the Health Care Facilities Code (NFPA 99-2012 and Tentative Interim Amendments [TIA] 12-2, 12-3, 12-4, 12-5 and 12-6). Note 1: Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: If application of the Health Care Facilities Code would result in unreasonable hardship for the hospital, the Centers for Medicare & Medicaid Services may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. Note 3: All inspecting activities are documented with the name of the activity; date of the activity; inventory of devices, equipment, or other items; required frequency; name and contact information of person who performed the activity; NFPA standard(s) referenced for the activity; and results of the activity.	§482.41(c) Standard: Building Safety Except as otherwise provided in this section, the hospital must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospital. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the hospital, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely <u>affect</u> the health and safety of patients.	Document Review: ☐ Review plans, policies and procedures, and documentation to determine compliance with Health Care Facilities Code requirements. Observation: ☐ Use the K-tag/CoP/EP Review tool to evaluate compliance with the Health Care Facilities Code.
---	--	---

Top 10 Medical Equipment Non-Compliances Scored in 2025 with the 2026 Standard Conversion

Number 10: EC.02.04.03 EP 18 Diagnostic Image Quality

A360: NPG.13.03.01

- **Missing or Incomplete Quality Control (QC) Documentation**

Numerous observations report missing documentation for required daily or weekly QC checks on CT and MRI machines. Examples include missing daily CT scanner readiness documentation, unperformed or undocumented QC logs on specified dates, and lack of notations explaining missed checks.

- **Non-Adherence to Hospital or Regulatory QC Policies**

Several entries highlight failure to comply with organizational or manufacturer guidelines for equipment quality assurance. This includes inconsistencies with policies dictating daily or weekly equipment checks and unaddressed quality failures despite explicit procedural requirements.

- **Identification of Equipment Failures Without Corrective Action**

Observations indicate that when checks were performed, repeated failures (such as identified noise or performance issues on CT scans) were not always followed by corrective measures or reported to relevant experts for further investigation.

Number 9: EC.02.04.01 EP 4 Equipment Maintenance/Testing Schedule

A360: PE.04.01.01 EP 1

- **Medical Equipment Inventory and Documentation Gaps:** Multiple entries note that various medical devices, including beds, lifts, scales, and critical care equipment, were either missing from the hospital's official inventory or lacked documentation to prove periodic maintenance, inspection, or testing had been performed.
- **Preventive Maintenance and Inspection Compliance Issues:** Observations frequently highlight failures in achieving the required 100% completion rate for preventive maintenance (PM) activities. Causes cited include staff shortages, process changes, omission of maintenance for new equipment, and the closure of PM work orders without actual completion.
- **Non-Adherence to Manufacturer and Policy Requirements:** Several instances were noted where hospital procedures did not align with manufacturer's instructions or organizational policy for equipment maintenance. These include missed or improperly performed checks (such as AED, phototherapy lights, and dialysis machines), inadequate maintenance schedules, and lack of documented processes for defining PM activities and frequencies

Number 8: EC.02.04.01 EP 10 Quality Control CT-PET-MRI-NM

A360: Deleted

- **Missing or Incomplete Daily/Weekly QC Documentation on Imaging Equipment**

A consistent theme across observations is that **required daily or weekly quality control (QC) checks for CT, MRI, and nuclear medicine equipment are often missing or incompletely documented**. Examples include missing documentation for multiple days or weeks, such as “multiple days in 2022, 2023 and 2024”, “17 days missing QC measurements” for two CT scanners, and failures to log daily checks for one or more days each month.

- **Non-Compliance with Manufacturer, Hospital Policy, or Accreditation Requirements**

Many entries highlight that the lack of QC documentation is “not in accordance” with manufacturer instructions, hospital policy, or accreditation guidelines (e.g., ARC accreditation for MRI). Phrases like “**not in accordance with the MIFU,**” “**contrary to the manufacturer's instructions,**” and “**not in accordance with the guidelines of ARC accreditation**” frequently appear, emphasizing compliance gaps.

Number 7: EC.02.04.03 EP 1 Medical Equipment Initial Tests

A360: PE.04.01.01 EP 2

- **Lack of Evidence of Safety/Functional Checks Before Use**

Multiple observations indicate that medical equipment—such as RO machines, hemodialysis machines, weight scales, EC devices, and more—lacked documentation or clear evidence of safety, operational, and functional checks before initial use or service, contrary to organizational policies.

- **Missing or Outdated Maintenance/Inspection Stickers**

Many reports point to the absence of current bio-medical inspection or preventative maintenance stickers on patient care equipment (e.g., exercise tables, centrifuges, pacemaker programmers, ECG machines), reflecting either missing or outdated maintenance documentation.

- **Failure to Adhere to Cleaning, Inventory, or Special Equipment Procedures**

Some observations highlight failures such as not adhering to cleaning procedures (e.g., monthly cleaning logs not completed), equipment not included on hospital's written inventory, or improper handling of patient-owned or special equipment (e.g., CPAP devices, biofeedback machines, incubators) without required safety evaluations.

Number 6: EC.02.04.01 EP 2 Inventory Medical Equipment Risk

A360: PE.04.01.01 EP 2

- **Medical Equipment Missing from Inventory:** Numerous observations note that medical devices such as incubators, sphygmomanometers, scales, dialysis machines, and specialized equipment (e.g., pacemaker integrator, ophthalmoscope, exam table, blood pressure devices) were in use but not included in the hospital's medical equipment inventory.
- **Lack of Initial Inspection or Risk Assessment:** Several entries mention that equipment in use was not initially inspected or had no evidence of preventive maintenance or safety evaluation prior to use, in some cases contrary to hospital policy requirements.
- **Insufficient or Incomplete Written Inventories:** Multiple observations highlight deficiencies such as lack of a comprehensive or current written inventory, inventories not including certain risk categories, or an absence of risk assessments for equipment.

Number 5: EC.02.04.03 EP 4 Sterilizer Test

A360: PE.04.01.01 EP 2

- **Failure to perform and/or document required maintenance and testing:** Multiple observations identify that preventative maintenance, cleaning, or qualification testing of sterilizers was either missed, not documented, or not performed as per manufacturers' instructions for use (MIFU). This includes missed filter replacements, lack of maintenance logs, and incomplete records for periodic cleaning or leak testing.
- **Non-adherence to manufacturer or regulatory guidelines:** Observations frequently note that organizations were not following MIFU or industry standards (such as AAMI) regarding maintenance schedules, cleaning protocols, and testing requirements (e.g., leak tests and biologic testing not performed at specified intervals).
- **Equipment performance or condition issues impacting compliance:** Some observations highlight physical deficiencies or malfunctions, such as sterilizers with overdue preventive maintenance, equipment out of service due to obsolescence or lack of parts, or damage (e.g., water softener failure with associated building damage, peeling paint in disinfecting basins).

Number 4: EC.02.04.03 EP 2 High-Risk Equipment Maintenance

A360: PE.04.01.01 EP 2

Failure to Perform or Document Scheduled Preventive Maintenance (PM)

- Numerous observations note **expired PM stickers**, equipment overdue for service, or absence of required documentation.
- Several high-risk/life support devices were found with **missing or late PMs**, some not inspected or maintained due to being “unable to locate,” vendor contract issues, or being removed from inventory without follow-up.
- Completion rates for high-risk equipment PM are often **below 100%** as required.

Non-Adherence to Manufacturer’s Instructions for Use (MIFU) and Hospital Policy

- Repeatedly cited is **inconsistent or missing routine maintenance/cleaning** such as not changing filters, not calibrating equipment on schedule, or skipping functional tests (examples include endoscope washers, oxygen delivery equipment, dental water lines).
- **Deviation from required frequencies** (weekly, monthly, quarterly, annual) for both cleaning, disinfection, testing.

Gaps in Routine Equipment Checks, Readiness, and Safe Operating Condition

- Regular **daily/weekly checks of crash carts, code carts, and emergency equipment** are frequently missed or insufficiently documented.
- Equipment identified as broken, unlabeled, untested, or co-mingled with functional units, as well as logs indicating no corrective actions when out-of-range parameters are detected (e.g., temperature logs, battery status checks, missing filter changes).

Number 2: EC.02.04.03 EP 3 Low-Risk Equipment Maintenance

A360: PE.04.01.01 EP 2

Preventive Maintenance (PM) Not Performed or Overdue

- Numerous observations document medical equipment not receiving preventive maintenance as required by manufacturer instructions or organizational policy, with overdue PMs on refrigerators, thermometers, beds, glucometers, infusion pumps, scales, and major devices like blanket warmers, anesthesia machines, and physiotherapy equipment.

Failure to Follow Manufacturer's Instructions for Use (MIFU) and Internal Policy

- Staff and departments repeatedly fail to follow MIFU or internal policies regarding cleaning, calibrating, maintaining, and operating equipment, covering items such as hydrocollators, thermometers, blanket warmers, glucometers, water lines, and sterilizing devices.
- Cleaning and maintenance were performed less frequently than required (e.g., monthly instead of every two weeks).

Inadequate Documentation and Monitoring

- Observations repeatedly note missing or incomplete documentation, including maintenance logs, temperature logs, cleaning records, calibration certificates, and equipment inventories.
- Essential monitoring steps such as daily or weekly checks, recording corrective actions for out-of-range values, and verification of maintenance tasks are often absent.

Number 3: EC.02.05.01 EP 24 Extension Cord Use

A360: PE.04.01.01 EP 1

Use of Extension Cords or Power Strips as Permanent Wiring:

- A significant number of observations document extension cords, relocatable power taps (RPTs), and power strips being used as substitutes for fixed building wiring. Common locations include various clinical and support areas, with frequent mention of devices being continuously powered using these temporary methods.

Daisy Chaining and Unsafe Arrangements:

- Many observations highlight the practice of daisy chaining, where multiple extension cords and/or power strips are connected in series. This occurred in areas such as IT rooms, labs, and nurse stations, increasing fire risk and noncompliance with facility policies.

Use of Extension Cords/Power Strips for High-power Appliances:

- There are numerous instances where high-power appliances (microwaves, refrigerators, coffee makers) are plugged into extension cords or power strips instead of directly into wall outlets, often in break rooms, kitchens, and staff areas. This is both a common violation and a specific risk area.

Number 1 EC.02.05.01 EP 23 Power Strips Pt Care Areas

A360: PE.04.01.01 EP 1

Improper Use and Installation of Power Strips/RPTs

- There are repeated observations of relocatable power taps (RPTs) and power strips being **used as extension cords or not permanently mounted to equipment assemblies as required**. Examples include RPTs found on the floor, not permanently affixed, mounted to IV poles without equipment, or used to supply power to devices not part of the intended assembly (e.g., operating tables, bear huggers, DVT pumps).

Lack of Compliance with Certification and Maintenance Requirements

- Many cases note **power strips not meeting UL 1363A or UL 60601-1 listing requirements** for patient care environments. Observations also frequently mention the **absence of verification for electrical and mechanical integrity, missing PM stickers, or lack of documentation that ongoing testing and limits monitoring (ampacity) are performed**.

Daisy Chaining and Overloading of Power Strips

- Surveys document **daisy chaining of RPTs together** and scenarios where **multiple devices are plugged in, sometimes exceeding the rated ampacity**, or where no process is in place to control or document load compliance. This includes power strips plugged into power strips, or used to power refrigerators, appliances, or large numbers of devices from a single outlet.

Discontinued EC and LS Requirements

Discontinued Requirements

- EC.01.01.01 EP 1
 - Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results.
- EC.01.01.01 EP 3
 - The hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems
- EC.01.01.01 EP 4
 - The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities
- EC.01.01.01 EP 5
 - The hospital has a written plan for managing the following: The security of everyone who enters the hospital's facilities
- EC.01.01.01 EP 6
 - The hospital has a written plan for managing the following: Hazardous materials and waste

Discontinued Requirements

- EC.01.01.01 EP 7
 - The hospital has a written plan for managing the following: Fire safety
- EC.01.01.01 EP 8
 - The hospital has a written plan for managing the following: Medical equipment
- EC.01.01.01 EP 9
 - The hospital has a written plan for managing the following: Utility systems
- EC.02.01.01 EP 7
 - The hospital identifies individuals entering its facilities
- EC.01.01.01 EP 11
 - The hospital responds to product notices and recalls
- EC.02.01.03 EP 6
 - The hospital takes action to maintain compliance with its smoking policy

Discontinued Requirements

- EC.02.03.03. EP 3
 - When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions.
- EC.02.03.03. EP 5
 - The hospital critiques fire drills to evaluate fire safety equipment, fire safety building
- EC.02.04.01 EP 10
 - The hospital identifies quality control and maintenance activities to maintain the quality of CT, PET, MRI, and NM
- EC.02.04.03 EP 18
 - The hospital maintains the quality of the CT, PET, MRI, and NM images produced
- EC.02.05.01 EP 12
 - The hospital's procedures address performing emergency clinical interventions during utility disruptions
- EC.02.06.01 EP 11
 - Lighting is suitable for care, treatment, and services
- EC.02.06.05 EP 4
 - For CT, PET, NM; prior to installation of new equipment, a physicist conducts a structural shielding design assessment

Discontinued Requirements

- EC.02.06.05 EP 6
 - For CT, PET, or NM services; after installation a physicist conducts a radiation protection survey to verify adequacy of shielding
- EC.03.01.01 EP 2
 - Staff can describe or demonstrate actions to take in the event of an environment of care incident
- EC.04.01.01 EP 3
 - Based on its process(es), the hospital reports and investigates the following: Injuries to patients/others in the hospital's facilities
- EC.04.01.01 EP 4
 - Based on its process(es), the hospital reports and investigates the following: occupational illnesses and staff injuries
- EC.04.01.01 EP 5
 - Based on its process(es), the hospital reports and investigates the following: damage to its property or property of others

Discontinued Requirements

- EC.04.01.01 EP 6
 - Based on its process(es), the hospital reports: Safety/security incidents involving staff or patients related to workplace violence
- EC.04.01.01 EP 8
 - Based on its process(es), the hospital reports and investigates the following: hazardous materials and waste spills/exposures
- EC.04.01.01 EP 9
 - Based on its process(es), the hospital reports and investigates the following: Fire/safety management problems, deficiencies/failures
- EC.04.01.01 EP 10
 - Based on its process(es), the hospital reports and investigates the following: medical and laboratory equipment management problems/failures/errors
- EC.04.01.01 EP 11
 - Based on its process(es), the hospital reports & investigates the following: Utility system management problems/failures/errors

Discontinued Requirements

- **EC.04.01.01 EP 15**
 - Every 12 months, the hospital evaluates each environment of care (EOC) management plans, including goals, objectives, scope, and performance
- **EC.04.01.03 EP 2**
 - The hospital uses the results of data analysis to identify opportunities to resolve environmental safety issues
- **EC.04.01.05 EP 1**
 - The hospital takes action on the identified opportunities to resolve environmental safety issues
- **LS.01.01.01 EP 1**
 - The hospital assigns an individual(s) to assess compliance with Life Safety Code when addressing survey-related deficiencies
- **LS.01.01.01 EP 2**
 - In time frames defined by the hospital, the hospital performs a building assessment for compliance with Life Safety chapter
- **LS.01.01.01 EP 4**
 - When the hospital plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the hospital meets the 60-day time frame

Resources

Survey Process Guide

<https://www.jointcommission.org/en-us/standards/prepublication-standards/critical-access-hospital-and-hospital-requirements-streamlined-to-reduce-burden>

- One Stop Source for new A360
- Survey Tools, checklists, tracers



Hospital Accreditation

Survey Process Guide



Questions?