Survey Report and
Corrective Action Plan Submittal Form

Organization: Jasper Memorial Hospital – Monticello, GA

DNV Project #: PRJN-541875

Survey Date: July 2 – 3, 2024

	NIAHO® Survey type
	Initial (855)
	Initial
X	Annual
	Reaccreditation
X	Critical Access Hospital (CAH)
	Psychiatric Hospital
	Non-deemed
	Complaint for Cause
	Remote Survey Activity
	Other

	ISO 9001:2015 Survey type
	Stage 1
	Stage 2 (certification)
	Periodic
	Recertification
	Compliance
	Other

Report Date: July 17, 2024

Corrective Action Plan due date: July 27, 2024
A Corrective Action Plan (CAP) must be delivered to DNV Healthcare within ten (10) calendar days from date of receipt of the final report.

CAP received date: July 26, 2024

CAP Report approval date: August 9, 2024
This date is used to calculate the Objective Evidence due date, as applicable.

Objective Evidence for NC-1 non-conformance category finding(s) due: November 6, 2024 (within 60 **business** days from date the client is notified via email of approval by DNV HC)

Total Number of Nonconformities:

NC-1 Condition Level	NC-1	NC-2
0	2	2

The Organization must complete the Corrective Action Plan in the section(s) below marked "Organization Response" for all nonconformances identified, including the NC-1 Condition Level, NC-1 and NC-2 nonconformance category. DNV Healthcare surveyors will follow up on all corrective action plans during the next survey or as required if prior to next survey.

Use the "*Organization Response*" section to document your Corrective Action Plans.

Click here to download Corrective Action Plan submission instructions and Sample Tutorial

The Corrective Action Plan submission must include the following or clarifications may be requested:

- Identify the cause that led to the nonconformity;
- Identify the actions taken to correct the nonconformity in the affected areas and/or processes;
- Identify other areas and/or processes (if applicable) that have the potential to be affected by the same nonconformity;
- Identify the process or system changes that will be made to ensure that the nonconformity does not recur including a staff training plan, as applicable;
- Identify the timeframe for the implementation of the corrective action measure(s) including dates the CAP will begin, projected completion dates (within 60 days of the survey end date) and specific dates of completion for corrections that have already been implemented before the CAP is submitted.
- Identify the name of the person/function responsible for implementing the corrective action measure(s) and,
- Identify the performance measure(s) and/or other supporting evidence that will be monitored to ensure the effectiveness of the corrective action(s) taken.

Organizational Impact of Nonconformity: Where the survey team identifies nonconformances in one area of the organization that have the potential to impact other areas of the organization, the expectation is that the CAP shall include organization wide corrective actions, including off-site locations.

Submission Details:

- This form must remain in its original format, including font, color and style.
- All fields are required to be completed.
- Address all reported elements of the nonconformance and/or all individual Findings identified in the nonconformance.
    - Finding #1: [insert response]
    - Finding #2: [insert response]
    - Finding #3: [insert response]

- **The documented Corrective Action Plans must be included on this report, attached to an email and returned in Word format (not PDF) to HealthcareReports@dnv.com**

- DNV Healthcare does not review specific pictures, policies, procedures, sign in sheets, training documents or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure, or form. The decision to use such documents rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Do not submit copies of pictures, policies, procedures, sign in sheets, training documents or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

CoP – Conditions of Participation (NIAHO® Accreditation)

Date for implementation of Corrective Action Plan

The Organization is expected to implement corrective action plans within sixty (60) calendar days post survey activity. When this is not feasible DNV Healthcare will consider and evaluate the circumstances involved and approve a suitable timeframe to enable the customer to implement the corrective action plans. Specific timelines and milestones, including interim or short-term compliance plans, must be included in the *Date(s) of Projected Completion / Compliance with the Standard Requirements* section below for any date outside the 60 calendar days post survey.

Life Safety Code® (LSC) and Health Care Facilities Code® (HCFC) Non-conformance

CMS has determined that all Life Safety Code® (LSC) and Health Care Facilities Code® (HCFC) non-conformances must be corrected within sixty (60) calendar days of the last day of survey in which the finding was identified. Corrective Action Plans addressing cited NFPA Code deficiencies shall be fully completed within 60 calendar days from the last day of the survey. If the organization concludes that it cannot correct specific non-conformances within the required 60-calendar-day timeframe, the organization may request a Temporary (Time-Limited) Waiver. If the organization concludes that it cannot correct specific non-conformances without incurring unreasonable hardship, the organization may request a Continuing Waiver as part of the survey Corrective Action Plan. A Continuing Waiver may be granted when an organization provides sufficient evidence that a noncompliance cannot be corrected without unreasonable hardship on the facility and there is no adverse effect on patient health or safety. DNV's collaborative review of a LSC or HCFC waiver request is treated as a survey follow-up activity. The review may result in a recommendation to the CMS Location that the waiver be granted or may result in no recommendation. DNV processes waiver requests for non-conformances on behalf of CMS, however the CMS Location has exclusive authority to grant waivers. A DNV Healthcare representative will follow up with the primary organization contact.

Requirements for Objective Evidence Submission

As a requirement of the NIAHO® Accreditation Program Accreditation Process objective evidence is required "for Category 1 Nonconformities, within sixty (60) business days of DNV Healthcare USA, Inc. communication to the organization of the acceptance, the customer shall submit performance measure(s) data, findings, results of internal reviews (internal audits), or other supporting documentation, including timelines to verify implementation of the corrective action measure(s)." If the hospital audit identifies continued noncompliance (<100%), the hospital should include ongoing actions to address the continued nonconformance(s) identified.

The due date will be assigned by DNV Healthcare once a final approved Corrective Action Plan has been received and processed, and after any follow up survey activity, as applicable. The objective evidence must be documented on this form and will not be accepted as separate attachments outside of the final version of this report.

Objective evidence is required for all NC-1 level nonconformances including any NC-1 Condition Level nonconformances; submissions are not required for NC-2 level nonconformances. Due date will be listed on Page 1 at the time the Corrective Action Plan report, in its entirety, is approved.

Instructions for Objective Evidence Documentation

OBJECTIVE EVIDENCE SUBMISSION
General instructions: **The objective evidence summary must be included on this report and will not be accepted if the documentation is submitted on separate attachments. Documentation of objective evidence on this report will ensure a final controlled version of the organization's survey activity, including the objective evidence submission. Return this document as a word version attachment via email to HealthcareReports@dnv.com**. Provide a summary of performance measure(s) data, findings, results of internal reviews (internal audits), or other supporting documentation, including timelines to verify implementation of the corrective action measure(s). The objective evidence summary submitted should allow for an auditor to trace the corrective action with enough specificity at the next onsite survey activity and provide performance measure(s) data, findings, and results of audits to attest to implementation of the corrective action. Documentation should include, as applicable, a summary of: - The most recent monitoring results to validate the effectiveness of the actions taken and sustained compliance. - Update on the implementation status of the above listed Organization Corrective Plan and additional implementation plans if compliance is not yet achieved. - Providing dates, internal file titles and numbers (i.e. policy number, form number, etc.), and titles of those involved in the implementation are key. - Date(s) education completed, % of education completed, plans for staff who did not complete education, including current staff, new hires and plans for ongoing competency **DNV Healthcare does not review specific pictures, policies, procedures, sign in sheets, training documents or forms as part of a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure, or form. The decision to use such document(s) rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Do not submit copies of pictures, policies, procedures, sign in sheets, training documents or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.** **DNV Healthcare accesses, uses, and retains the minimal amount of protected health information necessary to fulfill our accreditation responsibilities. To protect your organization as the covered entity, and DNV as a business associate, from unnecessary risk of a breach or disclosure, we do not accept copies of medical records or screen shots outside of the on-site survey process as evidence of compliance. This includes any document containing medical record numbers and all other patient identifiers.**

Organization: Jasper Memorial Hospital – Monticello, GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-1	**Physical Environment** Life Safety Management System		NC-1 Condition Level	**PE.2 (SR.1) / (SR.1a) / (SR.9)** *NFPA 54 (2012); 9.6.1.1, 9.6.1.2 NFPA 96 (2011); 12.1.2.3.1 NFPA 418, (2011); 3.3.5*, 9.2, 9.3,*	485.623(c)(1) 485.623(c)(1)(i)
		X	NC-1		
			NC-2		

Requirement (Description):

PE.2 LIFE SAFETY MANAGEMENT SYSTEM

SR.1 Except as otherwise provided in NIAHO® Accreditation Requirements:

SR.1a The CAH shall meet the applicable provisions and shall proceed in accordance with the 2012 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 shall meet the provisions applicable to Health Care Occupancies, regardless of the number of patients served.

SR.9 The CAH shall require that Life Safety systems (e.g., fire suppression, notification, and detection equipment) shall be tested, inspected, and maintained (including portable systems) in accordance with applicable requirements.

Finding #1

NFPA 54, National Fuel Gas Code, 2012 Edition

9.6.1.1 Commercial Cooking Appliances.

Commercial cooking appliances that are moved for cleaning and sanitation purposes shall be connected in accordance with the connector manufacturer's installation instructions using a listed appliance connector complying with ANSI Z21.69/CSA 6.16, Connectors for Movable Gas Appliances. The commercial cooking appliance connector installation shall be configured in accordance with the manufacturer's installation instructions.

9.6.1.2 Restraint.

Movement of appliances with casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's installation instructions.

NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition

12.1.2.3.1 *An approved method shall be provided that will ensure that the appliance is returned to an approved design location.*

Finding #2

NFPA 418, Standard for Heliports, 2011 Edition

3.3.5* Heliport.

An identifiable area located on land, on water, or on a structure that also includes any existing buildings or facilities thereon, used or intended to be used for landing and takeoff of helicopters.

***9.2 Minimum Requirement**. At least one portable fire extinguisher as specified in Table 9.2 shall be provided for each takeoff and landing area, parking area, and fuel storage area.*

Table 9.2 Minimum Ratings of Portable Fire Extinguishers for Heliport Categories

Heliport Category	Helicopter Overall Length*	Minimum Rating
H-1	Less than 50 ft (15.2 m)	4-A:80-B
H-2	50 ft (15.2 m) up to but not including 80 ft (24.4 m)	10-A:120-B
H-3	80 ft (24.4 m) up to but not including 120 ft (36.6 m)	30-A:240-B

*Helicopter length, including the tail boom and the rotors.

***9.3** Extinguishers Subject to Damage, Theft, or Tampering. Where the portable extinguisher cannot be maintained and safeguarded against damage, theft, or tampering, the portable fire extinguisher shall be omitted with the approval of the AHJ.*

The requirement was NOT MET as evidenced by the following:

Finding #1

During the physical environment/life safety tour with hospital staff of the kitchen area the surveyor noted commercial cooking appliances that are moved for cleaning and sanitation purposes in which movement of those appliances are not limited as required by NFPA 54 and 96.

Finding #2

During the physical environment/life safety tour of the facility with hospital staff, the surveyor observed the hospital heliport had no fire extinguisher located at the heliport. The heliport is located across the street from the hospital several hundred feet away with the nearest fire extinguisher being inside of the hospital. There was no portable fire extinguisher provided for each takeoff and landing area, parking area, and fuel storage area as required by NFPA 418.

Surveyor ID # 275902

ORGANIZATION RESPONSE

- All fields are required and must be completed.
- All reported elements of the nonconformance and/or all individual Findings identified must be addressed.
  Example:
  - Finding #1: [insert response]
  - Finding #2: [insert response]
  - Finding #3: [insert response]

Cause that led to the nonconformity:

✓ Provide an in-depth understanding as to why the nonconformity was present and its impact on other processes in formulating the corrective action(s). This section should not be a restatement of the nonconformance identified above.

- Finding #1: Flex hose was not tethered.
- Finding #2: There was no policy on helicopter safety and no instructions to staff to take a fire extinguisher to the helipad when a helicopter was inbound.

Organization Corrective Action Plan (CAP):

✓ Identify the actions taken to correct the nonconformity in the affected areas and/or processes;

✓ Identify other areas, off-site location(s) and/or processes (if applicable) that have the potential to be affected by the same nonconformity.

✓ Include dates and actions taken since survey end date.

- Finding #1: On 7/23/2024, two metal braces were ordered to be added to the gas line. On 7/25/2024, a steel cable restraining device was ordered to affix between the metal braces on each end of the gas line to prevent it from being pulled out further than allowed. Caster safety set positioning devices were also ordered for the casters to lock them in position and prevent pulling or pushing further than allowed.
- Finding #2: 7/18/2024: A policy has been developed for helicopter safety. This policy includes instructions for staff to take a fire extinguisher to the helipad area when a helicopter is inbound. The policy states that the fire extinguisher will be placed onto a bracket at the power pole when the lights are turned on. 7/23/2024: The mounting bracket was installed onto the power pole.

Staff Training/Education Plan:

✓ Identify the process or system changes that will be made to ensure that the nonconformity does not recur, including a staff training/education plan.

✓ Training/education should be addressed for all areas of the organization (or off-site locations) in which the nonconformity may (re)occur.

✓ Include dates and actions taken since survey end date.

Note: It is expected that identified process or system changes and applicable training plans are considered for the orientation of staff and will take place prior to the individual functioning independently in their job.

- Finding #1: All plant engineering staff will be educated on ensuring the gas line is properly tethered with life safety rounds monthly.
- Finding #2: All ED staff will be educated on taking the fire extinguisher to the helipad when a helicopter is inbound, securing the extinguisher to the power pole, and returning the extinguisher to the building once the helicopter has departed.

Person and/or Function responsible for implementation of Corrective Action Plan:

- Finding #1: Ricky Haizlip, Plant Engineering
- Finding #2: Ricky Haizlip, Plant Engineering; Crystal Gresham, Emergency Department Nurse Manager

Date for implementation of Corrective Action Plan:

✓ Identify the timeframe for the implementation of the corrective action measure(s) for compliance with the standard requirements including 1) dates the CAP will begin, 2) projected completion dates 3) specific dates of completion for actions that have already been implemented before submission.

**Note: All Corrective Action Plans addressing cited NFPA Code deficiencies shall be fully completed within 60 calendar days from the last day of the survey or the organization may request a Time-Limited Waiver (TLW) or Continuing Waiver (CW). If a TLW or CW is being requested, include the details and request below.*

Date(s) CAP will begin. *Include the date(s) the organization began discussion and plans for action, typically within days of the survey end date or receipt of the report.*	• Finding #1: 7/23/2024 • Finding #2: 7/23/2024
Date(s) and actions taken since survey end date, prior to CAP submission. *If these dates <u>and</u> actions are included in the sections above, reply with "see above".*	• Finding #1: See Above • Finding #2: See Above
Date(s) of Projected Completion / Compliance with the Standard Requirements *These dates should be within 60 calendar days of survey end date** *For submission dates outside the 60 days, the response must detail interim actions taken, including staff communication, within the 60 days post survey.*	• Finding #1: 8/9/2024 • Finding #2: 7/23/2024

Organization method for follow-up:

✓ Address how the quality management system shall ensure that corrective actions taken by the organization are implemented, measured and monitored. Specify 1) the method for monitoring or follow-up, 2) frequency of monitoring, 3) measures of effectiveness, 4) evidence of sustained compliance.

It is expected that this will be provided to the Quality oversight group in whole or in summary.

Full compliance with the NIAHO® standards and Conditions of Participation is the expectation of our accreditation program and CMS. Rather than place a threshold for achieving partial compliance (i.e. <100%), the corrective action plan should be measured for effectiveness to continually improve. While this may not reach 100% compliance, over time efforts will be made to work toward this goal and then reevaluate the processes or other methods in place as needed to sustain improvements made.

For submissions <100% the organization attests that efforts will be made to work toward this goal of 100% while evaluating the processes or other methods in place as needed to sustain improvements made.

Method for monitoring or follow-up *Select a method for monitoring effectiveness.* *Example: Chart review, internal audits, etc.*	• Finding #1: Monthly Life Safety Rounds • Finding #2: Concurrent direct observation or audit of camera footage for each helicopter landing.
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	• Finding #1: Monthly. Reported in EOC and QAPI monthly. • Finding #2: After each helicopter landing. Reported in EOC and QAPI monthly.
Measures of effectiveness *Select a measure/metric that measures effectiveness.* *Example: Chart review demonstrating 100% of charts reviewed were compliant or no findings of nonconformance during audit.*	• Finding #1: During Life Safety monthly rounds, the gas line will be observed and will be properly tethered 100% of the time. • Finding #2: No non-conformance will be observed during each helicopter landing.
Evidence of sustained compliance *Select a measure/metric that verifies sustained compliance.* *Example: 100% compliance/conformity, including planned actions for any continued nonconformance identified during monitoring.*	• Finding #1: 100% compliance each month. At any time the tethering is found to not be in place, plant engineering will immediately replace or repair tethering. • Finding #2: 100% compliance with each landing. If any landings are observed to not have a fire extinguisher on hand, the staff will be re-educated, and a root cause analysis will be performed to identify other ways of ensuring that the fire extinguisher is available.

DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID: 39475	
Clarification requested - DNV technical reviewer ID:	
Clarification request:	
CAP verified effective/closed date:	**DNV surveyor/auditor ID:**
DNV final follow-up:	

OBJECTIVE EVIDENCE RESPONSE

Objective evidence of sustained compliance is required for all NC-1 level nonconformance; submissions are not required for NC-2 level nonconformance.

Due date will be listed on Page 1 at the time the Corrective Action Plan report, in its entirety, is approved.

If a NC-1 Condition Level is identified, the Objective Evidence due date will be assigned after the onsite follow up survey activity and paperwork are complete.

	No objective evidence required. • *Compliance will be reviewed at the next annual survey activity.*

X	**Objective Evidence required**. • *Compliance will be reviewed at the next annual survey activity and Objective Evidence is required.* • *See instructions above for submission details.* • *The summary must be included in the section below and will not be accepted as separate attachment(s).*
	Document summary here. *Finding #1: Life Safety rounds monitored monthly and reported in both Environment of Care and Quality Assurance Performance Improvement Committees. 100% compliance with gas lines being tethered.* *Finding #2: Security video reviewed for each helicopter landing and the fire extinguisher has been transported to the designated area at the helipad 100% of the time prior to the helicopter landing and remained in place until after takeoff. Compliance reported Environment of Care and Quality Assurance Performance Improvement Committees.*
	Submitted by (Client name and/or title): Robin Carey, Chief Compliance Officer
	Submission date: 11/6/2024

Organization: Jasper Memorial Hospital – Monticello, GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC-1-2	**Physical Environment** Utility Management System		NC-1 Condition Level	**PE.8 (SR.2) / (SR.3) / (SR.6) / (SR.10)** *NFPA 110-2010; 8.2, 8.2.1, 8.2.4, 8.2.4.1 NFPA 70 (2011); 314.28, 408.4*	485.625(b)(1)(ii) 485.623(b)(1) 485.625(e)(2)
		X	NC-1		
			NC-2		

Requirement (Description):

PE.8 UTILITY MANAGEMENT SYSTEM

SR.2 The Utility Management System shall provide a process in place to evaluate critical operating components, to include, but not limited to, cybersecurity issues.

SR.3 The Utility Management System shall develop maintenance, testing, and inspection processes for critical utilities.

SR.6 The Utility Management System shall provide for reliable emergency power sources with appropriate maintenance as required. The CAH shall implement emergency power system inspection and testing requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.

SR.10 All relevant utility systems shall be maintained inspected, and, tested.

Finding #1

NFPA® 110, Standard for Emergency and Standby Power Systems, 2010 Edition
8.2* Manuals, Special Tools, and Spare Parts.
8.2.4 *Replacement for parts identified by experience as high mortality items shall be maintained in a secure location(s) on the premises.*
8.2.4.1 *Consideration shall be given to stocking spare parts as recommended by the manufacturer.*

Finding #2

NFPA 70, National Electrical Code, 2011 Edition
408.4 Field Identification Required.
(A) Circuit Directory or Circuit Identification. *Every circuit and circuit modification shall be legibly identified as to its clear, evident, and specific purpose or use. The identification shall include sufficient detail to allow each circuit to be distinguished from all others. Spare positions that contain unused overcurrent devices or switches shall be described accordingly. The identification shall be included in a circuit directory that is located on the face or inside of the panel door in the case of a panelboard, and located at each switch or circuit breaker in a switchboard. No circuit shall be described in a manner that depends on transient conditions of occupancy.*

The requirement was NOT MET as evidenced by the following:

Finding #1
During the physical environment/life safety tour with hospital staff the surveyor noted the hospital does not maintain a set of high mortality spare parts in a secure location as required by NFPA 110 (2010).

Finding #2
During the physical environment/life safety tour, the surveyor observed circuit directories that were not legibly identified as to its clear, evident, and specific purpose or use in the following electrical panels:

A. Mechanical Room - Panel EP-1
B. Mechanical Room – Panel EP-2
C. Mechanical Room – Unmarked Panel

Surveyor ID # 275902

ORGANIZATION RESPONSE

- All fields are required and must be completed.
- All reported elements of the nonconformance and/or all individual Findings identified must be addressed.
  Example:
  - Finding #1: [insert response]
  - Finding #2: [insert response]
  - Finding #3: [insert response]

Cause that led to the nonconformity:

✓ Provide an in-depth understanding as to why the nonconformity was present and its impact on other processes in formulating the corrective action(s). This section should not be a restatement of the nonconformance identified above.

- Finding #1: No spare parts have been kept on site as all repairs are done by generator maintenance company.
- Finding #2: Unused breakers were not labeled as not in use.

Organization Corrective Action Plan (CAP):

✓ Identify the actions taken to correct the nonconformity in the affected areas and/or processes;
✓ Identify other areas, off-site location(s) and/or processes (if applicable) that have the potential to be affected by the same nonconformity.
✓ Include dates and actions taken since survey end date.

- Finding #1: 7/19/2024: Called Yancey Bros. (generator maintenance contractor) to inquire about what repairs can be made on-site in an emergency situation. 7/24/2024: The contractor stated there is a kit we can purchase to have on hand and will email more information. 7/25/2024: Received parts list from the contractor and is putting a quote together for the purchase of the kit. The kit contains 1-2 gallons of oil, 1-2 gallons of coolant, a spare oil filter, a spare air filter, a spare belt, and a spare radiator cap.
- Finding #2: 7/22/2024: Each breaker was labeled with the location it controls or that it is not in use.

Staff Training/Education Plan:

- ✓ Identify the process or system changes that will be made to ensure that the nonconformity does not recur, including a staff training/education plan.
- ✓ Training/education should be addressed for all areas of the organization (or off-site locations) in which the nonconformity may (re)occur.
- ✓ Include dates and actions taken since survey end date.

Note: It is expected that identified process or system changes and applicable training plans are considered for the orientation of staff and will take place prior to the individual functioning independently in their job.

- Finding #1: All plant engineering staff will be educated on the repairs that can be made on-site and instructed on how to make the repairs.
- Finding #2: All plant engineering staff will be educated on the importance of labeling each breaker, whether it is in use or not.

Person and/or Function responsible for implementation of Corrective Action Plan:

- Finding #1: Ricky Haizlip, Plant Engineering
- Finding #2: Ricky Haizlip, Plant Engineering

Date for implementation of Corrective Action Plan:

- ✓ Identify the timeframe for the implementation of the corrective action measure(s) for compliance with the standard requirements including 1) dates the CAP will begin, 2) projected completion dates 3) specific dates of completion for actions that have already been implemented before submission.

**Note: All Corrective Action Plans addressing cited NFPA Code deficiencies shall be fully completed within 60 calendar days from the last day of the survey or the organization may request a Time-Limited Waiver (TLW) or Continuing Waiver (CW). If a TLW or CW is being requested, include the details and request below.*

Date(s) CAP will begin. *Include the date(s) the organization began discussion and plans for action, typically within days of the survey end date or receipt of the report.*	• Finding #1: 7/19/2024 • Finding #2: 7/22/2024
Date(s) and actions taken since survey end date, prior to CAP submission. *If these dates <u>and</u> actions are included in the sections above, reply with "see above".*	• Finding #1: See above • Finding #2: See above
Date(s) of Projected Completion / Compliance with the Standard Requirements *These dates should be within 60 calendar days of survey end date** *For submission dates outside the 60 days, the response must detail interim actions taken, including staff communication, within the 60 days post survey.*	• Finding #1: 8/2/2024 • Finding #2: 7/22/2024

Organization method for follow-up: ✓ Address how the quality management system shall ensure that corrective actions taken by the organization are implemented, measured and monitored. Specify 1) the method for monitoring or follow-up, 2) frequency of monitoring, 3) measures of effectiveness, 4) evidence of sustained compliance. *It is expected that this will be provided to the Quality oversight group in whole or in summary.* *Full compliance with the NIAHO® standards and Conditions of Participation is the expectation of our accreditation program and CMS. Rather than place a threshold for achieving partial compliance (i.e. <100%), the corrective action plan should be measured for effectiveness to continually improve. While this may not reach 100% compliance, over time efforts will be made to work toward this goal and then reevaluate the processes or other methods in place as needed to sustain improvements made.* ***For submissions <100% the organization attests that efforts will be made to work toward this goal of 100% while evaluating the processes or other methods in place as needed to sustain improvements made.***	
Method for monitoring or follow-up *Select a method for monitoring effectiveness.* *Example: Chart review, internal audits, etc.*	• Finding #1: Plant engineering will report to EOC committee what spare parts are on hand and if they have been used. • Finding #2: Plan engineering will report to EOC committee that labeling of electrical panels remains in place and if there are any changes made to the labeling
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	• Finding #1: Monthly • Finding #2: Monthly
Measures of effectiveness *Select a measure/metric that measures effectiveness.* *Example: Chart review demonstrating 100% of charts reviewed were compliant or no findings of nonconformance during audit.*	• Finding #1: Direct observation • Finding #2: Direct observation
Evidence of sustained compliance *Select a measure/metric that verifies sustained compliance.* *Example: 100% compliance/conformity, including planned actions for any continued nonconformance identified during monitoring.*	• Finding #1: 100% compliance. At any time any spare parts are used, plant engineering will immediately replace the used parts. • Finding #2: 100% compliance. At any time the routing of a breaker changes or a spare breaker is put into use, plant engineering will immediately update the panel labeling.

DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID: 39475	
Clarification requested - DNV technical reviewer ID:	
Clarification request:	
CAP verified effective/closed date:	**DNV surveyor/auditor ID:**
DNV final follow-up:	

OBJECTIVE EVIDENCE RESPONSE

Objective evidence of sustained compliance is required for all NC-1 level nonconformance; submissions are not required for NC-2 level nonconformance.

Due date will be listed on Page 1 at the time the Corrective Action Plan report, in its entirety, is approved.

If a NC-1 Condition Level is identified, the Objective Evidence due date will be assigned after the onsite follow up survey activity and paperwork are complete.

	No objective evidence required. • *Compliance will be reviewed at the next annual survey activity.*
X	**Objective Evidence required**. • *Compliance will be reviewed at the next annual survey activity and Objective Evidence is required.* • *See instructions above for submission details.* • *The summary must be included in the section below and will not be accepted as separate attachment(s).*
	Document summary here. *Finding #1: An onsite repair kit has been purchased from Yancey and is maintained in the Plant Engineering Office. The kit contains Air Cleaner filter, belt, oil, coolant, and oil filter. Presence of kit reported monthly at EOC and QAPI Committee meetings.* *Finding #2: Panel labeling has been added to monthly life safety monitors. Life Safety rounds are monitored monthly and reported in both EOC and QAPI Committees. 100% compliance noted.*
	Submitted by (Client name and/or title): Robin Carey, Chief Compliance Officer
	Submission date: 11/6/2024

Organization: Jasper Memorial Hospital – Monticello, GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-2	**Medication Management** Medication Orders		NC-1 Condition Level	**MM.4(SR.1) / (SR.3)**	
			NC-1		
		X	NC-2		

Requirement (Description):

MM.4 MEDICATION ORDERS

All medication orders shall:

SR.1 Include the name of the drug, the dosage and frequency of administration and the route of administration.

SR.3 A licensed pharmacist shall review all medication orders prior to administration of the first dose to a patient, except in emergency situations.

Interpretive Guidelines:

Elements to be included in any medication order (including all written, and verbal/telephone orders):

- *Specific instructions for use including which medication to administer or offer first when more than one medication is ordered for the same indication when applicable, and,*

The requirement was NOT MET as evidenced by the following:

Finding #1

The following nonconformities were identified in two (2) of four (4) medical records related to medication orders:

A. MR#2 (JLG) – An 89-year-old was admitted on 6/18/24 for fall and UTI. The patient had the following orders:
   - Tylenol 325mg, 2 tabs Q6h prn for pain 1-4
   - Tramadol 50mg Q12h prn for pain 4-6

   There was no objective evidence that the above medication orders included specific instructions for use.

B. MR#3 (JLG) – A 71-year-old was admitted on 7/1/24 for hypoglycemia and cellulitis. The patient had the following orders:
   - Norco 5/325mg BID prn for pain 7-10
   - Morphine sulfate 2mg IVP BID prn for pain 7-10

   There was no objective evidence that the above medication orders included specific instructions for use.

Finding #2

The following nonconformity was identified in one (1) of three (3) medical records related to pharmacy review:

A. MR#6 – An 82-year-old was admitted on 3/8/24 for intractable pain. The patient had the following medications ordered:

Order entry date/time	Medication Order	Order start time	First dose given	Reviewed by PharmD
3/8/24 at 1819	Amlodipine 10mg daily, routine	3/9/24 at 0900	3/9/24 at 0809	3/11/24 at 0814
3/8/24 at 1819	Bisoprolol 5mg daily, routine	3/9/24 at 0900	3/9/24 at 0809	3/11/24 at 0814
3/8/24 at 1819	Gabapentin 400mg daily, routine	3/9/24 at 0900	3/9/24 at 0809	3/11/24 at 0814
3/8/24 at 1857	Docusate 100mg BID, routine	3/8/24 at 2100	3/8/24 at 2115	3/11/24 at 0814

There was no objective evidence that the above non-emergent medications were reviewed by a licensed pharmacist prior to administration of the first dose.

Surveyor ID # 282923

ORGANIZATION RESPONSE

- All fields are required and must be completed.
- All reported elements of the nonconformance and/or all individual Findings identified must be addressed.

  Example:
  - Finding #1: [insert response]
  - Finding #2: [insert response]
  - Finding #3: [insert response]

Cause that led to the nonconformity:

✓ Provide an in-depth understanding as to why the nonconformity was present and its impact on other processes in formulating the corrective action(s). This section should not be a restatement of the nonconformance identified above.

- Finding #1: New provider ordered overlapping pain scale with medication orders.
- Finding #2: The patient was admitted on a weekend, and the pharmacy was on-call. The nursing staff gave non-emergent home meds before the pharmacy review without notifying the pharmacy that the patient had been admitted.

Organization Corrective Action Plan (CAP):

- ✓ Identify the actions taken to correct the nonconformity in the affected areas and/or processes;
- ✓ Identify other areas, off-site location(s) and/or processes (if applicable) that have the potential to be affected by the same nonconformity.
- ✓ Include dates and actions taken since survey end date.

- Finding #1: 7/3/2024: ADON reviewed Pain Assessment, Reassessment, and Management policy with new provider and reeducated nursing staff on the need to clarify overlapping or ambiguous PRN pain medication orders. A quick reference guide was developed and provided to both providers and nursing staff. ADON will continue to review all pain medication orders.
- Finding #2: 7/18/2024: Nursing staff was instructed to notify the on-call pharmacist at the time of admission for all patients admitted after pharmacy hours.

Staff Training/Education Plan:

- ✓ Identify the process or system changes that will be made to ensure that the nonconformity does not recur, including a staff training/education plan.
- ✓ Training/education should be addressed for all areas of the organization (or off-site locations) in which the nonconformity may (re)occur.
- ✓ Include dates and actions taken since survey end date.

Note: It is expected that identified process or system changes and applicable training plans are considered for the orientation of staff and will take place prior to the individual functioning independently in their job.

- Finding #1: All nursing staff and providers have been re-educated on the need for a pain scale on each PRN medication order. The staff has been instructed not to administer a PRN medication without a pain scale and to call for clarification. This education will be included in the annual medication administration competencies and in new employee orientation.
- Finding #2: All nursing staff have been instructed to notify the pharmacist on call of every admission so that non-emergent meds are reviewed before administration. This education will be included in the annual medication administration competencies and in new employee orientation.

Person and/or Function responsible for implementation of Corrective Action Plan:

- Finding #1: Samantha Mashburn, RN, ADON
- Finding #2: Jane Conyers, PharmD, Samantha Mashburn, RN, DON

Date for implementation of Corrective Action Plan:

- ✓ Identify the timeframe for the implementation of the corrective action measure(s) for compliance with the standard requirements including 1) dates the CAP will begin, 2) projected completion dates 3) specific dates of completion for actions that have already been implemented before submission.

**Note: All Corrective Action Plans addressing cited NFPA Code deficiencies shall be fully completed within 60 calendar days from the last day of the survey or the organization may request a Time-Limited Waiver (TLW) or Continuing Waiver (CW). If a TLW or CW is being requested, include the details and request below.*

Date(s) CAP will begin. *Include the date(s) the organization began discussion and plans for action, typically within days of the survey end date or receipt of the report.*	• Finding #1: 7/3/2024 • Finding #2: 7/18/2024
Date(s) and actions taken since survey end date, prior to CAP submission. *If these dates <u>and</u> actions are included in the sections above, reply with "see above".*	• Finding #1: See above • Finding #2: See above
Date(s) of Projected Completion / Compliance with the Standard Requirements *These dates should be within 60 calendar days of survey end date** *For submission dates outside the 60 days, the response must detail interim actions taken, including staff communication, within the 60 days post survey.*	• Finding #1: 7/3/2024 • Finding #2: 7/18/2024
Organization method for follow-up: ✓ Address how the quality management system shall ensure that corrective actions taken by the organization are implemented, measured and monitored. Specify 1) the method for monitoring or follow-up, 2) frequency of monitoring, 3) measures of effectiveness, 4) evidence of sustained compliance. *It is expected that this will be provided to the Quality oversight group in whole or in summary.* *Full compliance with the NIAHO® standards and Conditions of Participation is the expectation of our accreditation program and CMS. Rather than place a threshold for achieving partial compliance (i.e. <100%), the corrective action plan should be measured for effectiveness to continually improve. While this may not reach 100% compliance, over time efforts will be made to work toward this goal and then reevaluate the processes or other methods in place as needed to sustain improvements made.* ***For submissions <100% the organization attests that efforts will be made to work toward this goal of 100% while evaluating the processes or other methods in place as needed to sustain improvements made.***	
Method for monitoring or follow-up *Select a method for monitoring effectiveness.* *Example: Chart review, internal audits, etc.*	• Finding #1: Chart reviews • Finding #2: Chart reviews
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	• Finding #1: Concurrent with the placement of the pain medication or retroactive as soon as possible after the placement of the order. • Finding #2: Concurrent with each admission.

Measures of effectiveness *Select a measure/metric that measures effectiveness.* *Example: Chart review demonstrating 100% of charts reviewed were compliant or no findings of nonconformance during audit.*	• Finding #1: 100% of PRN pain medication orders will include a clear pain scale with no overlapping orders. • Finding #2: 100% of admissions will comply with pharmacy review of medications prior to administration.
Evidence of sustained compliance *Select a measure/metric that verifies sustained compliance.* *Example: 100% compliance/conformity, including planned actions for any continued nonconformance identified during monitoring.*	• Finding #1: 100% of PRN pain medication orders will include a clear pain scale with no overlapping orders and reported monthly at QAPI • Finding #2: 100% of admissions will be compliant with pharmacy review and reported monthly at QAPI.

DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID: 38486	
Clarification requested - DNV technical reviewer ID:	
Clarification request:	
CAP verified effective/closed date:	**DNV surveyor/auditor ID:**
DNV final follow-up:	

OBJECTIVE EVIDENCE RESPONSE

Objective evidence of sustained compliance is required for all NC-1 level nonconformance; submissions are not required for NC-2 level nonconformance.

Due date will be listed on Page 1 at the time the Corrective Action Plan report, in its entirety, is approved.

If a NC-1 Condition Level is identified, the Objective Evidence due date will be assigned after the onsite follow up survey activity and paperwork are complete.

X	**No objective evidence required.** • *Compliance will be reviewed at the next annual survey activity.*
	Objective Evidence required. • *Compliance will be reviewed at the next annual survey activity and Objective Evidence is required.* • *See instructions above for submission details.* • *The summary must be included in the section below and will not be accepted as separate attachment(s).*
	Document summary here.
	Submitted by (Client name and/or title):
	Submission date:

Organization: Jasper Memorial Hospital – Monticello, GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-2	**Physical Environment** Hazardous Material Management System		NC-1 Condition Level	**PE.5 (SR.5)**	485.623(a)
			NC-1		
		X	NC-2		

Requirement (Description):

PE.5 HAZARDOUS MATERIAL MANAGEMENT

SR.5 All compressed gas cylinders in service and in storage shall be individually secured and located to prevent abnormal mechanical shock or other damage to the cylinder valve or safety device.

The requirement was NOT MET as evidenced by the following:

During the Physical Environment/Life Safety tour of the facilities with hospital staff, the surveyor observed eleven (11) E cylinders in the main medical gas storage area not individually secured and located to prevent abnormal mechanical shock or other damage to the cylinder valve or safety device.

Surveyor ID # 275902

ORGANIZATION RESPONSE

- All fields are required and must be completed.
- All reported elements of the nonconformance and/or all individual Findings identified must be addressed.
  Example:
  - Finding #1: [insert response]
  - Finding #2: [insert response]
  - Finding #3: [insert response]

Cause that led to the nonconformity:

✓ Provide an in-depth understanding as to why the nonconformity was present and its impact on other processes in formulating the corrective action(s). This section should not be a restatement of the nonconformance identified above.

PAR level for e-cylinders recently increased because of increased usage; however usage went down and PAR level was not decreased. When delivery was made, there wasn't enough space in the storage rack and the driver left the extra tanks sitting between the two racks. Plant engineering did not check the area after delivery was made.

Organization Corrective Action Plan (CAP):

- ✓ Identify the actions taken to correct the nonconformity in the affected areas and/or processes;
- ✓ Identify other areas, off-site location(s) and/or processes (if applicable) that have the potential to be affected by the same nonconformity.
- ✓ Include dates and actions taken since survey end date.

7/8/2024 New storage racks were ordered to accommodate the additional tanks.
7/12/2024 New storage racks were delivered, and all cylinders were placed in the storage racks.
Plant Engineering will inspect the area during delivery to ensure the driver secures all tanks. If Plant Engineering is not available, then Materials Management will accompany the driver.

Staff Training/Education Plan:

- ✓ Identify the process or system changes that will be made to ensure that the nonconformity does not recur, including a staff training/education plan.
- ✓ Training/education should be addressed for all areas of the organization (or off-site locations) in which the nonconformity may (re)occur.
- ✓ Include dates and actions taken since survey end date.

Note: It is expected that identified process or system changes and applicable training plans are considered for the orientation of staff and will take place prior to the individual functioning independently in their job.

7/12/2024: Plant engineering and Materials Management have been educated that someone must accompany the delivery driver to ensure all tanks are individually secured at delivery time.

Person and/or Function responsible for implementation of Corrective Action Plan:

Ricky Haizlip, Plant Engineering

Date for implementation of Corrective Action Plan:

- ✓ Identify the timeframe for the implementation of the corrective action measure(s) for compliance with the standard requirements including 1) dates the CAP will begin, 2) projected completion dates 3) specific dates of completion for actions that have already been implemented before submission.

**Note: All Corrective Action Plans addressing cited NFPA Code deficiencies shall be fully completed within 60 calendar days from the last day of the survey or the organization may request a Time-Limited Waiver (TLW) or Continuing Waiver (CW). If a TLW or CW is being requested, include the details and request below.*

Date(s) CAP will begin. *Include the date(s) the organization began discussion and plans for action, typically within days of the survey end date or receipt of the report.*	7/12/2024
Date(s) and actions taken since survey end date, prior to CAP submission. *If these dates <u>and</u> actions are included in the sections above, reply with "see above".*	See above
Date(s) of Projected Completion / Compliance with the Standard Requirements	7/12/2024

*These dates should be within 60 calendar days of survey end date** *For submission dates outside the 60 days, the response must detail interim actions taken, including staff communication, within the 60 days post survey.*	
Organization method for follow-up: ✓ Address how the quality management system shall ensure that corrective actions taken by the organization are implemented, measured and monitored. Specify 1) the method for monitoring or follow-up, 2) frequency of monitoring, 3) measures of effectiveness, 4) evidence of sustained compliance. *It is expected that this will be provided to the Quality oversight group in whole or in summary.* *Full compliance with the NIAHO® standards and Conditions of Participation is the expectation of our accreditation program and CMS. Rather than place a threshold for achieving partial compliance (i.e. <100%), the corrective action plan should be measured for effectiveness to continually improve. While this may not reach 100% compliance, over time efforts will be made to work toward this goal and then reevaluate the processes or other methods in place as needed to sustain improvements made.* ***For submissions <100% the organization attests that efforts will be made to work toward this goal of 100% while evaluating the processes or other methods in place as needed to sustain improvements made.***	
Method for monitoring or follow-up *Select a method for monitoring effectiveness.* *Example: Chart review, internal audits, etc.*	Inspection of the oxygen storage area will be added to the Life Safety monitoring checklist.
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	Monthly concurrent with oxygen delivery.
Measures of effectiveness *Select a measure/metric that measures effectiveness.* *Example: Chart review demonstrating 100% of charts reviewed were compliant or no findings of nonconformance during audit.*	There will be no findings of non-conformance during monthly inspections.

Evidence of sustained compliance *Select a measure/metric that verifies sustained compliance.* *Example: 100% compliance/conformity, including planned actions for any continued nonconformance identified during monitoring.*	100% conformance with secured oxygen cylinders. Any unsecured cylinders will be secured immediately. Conformance will be reported to QAPI monthly.

DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID: 39475	
Clarification requested - DNV technical reviewer ID:	
Clarification request:	
CAP verified effective/closed date:	**DNV surveyor/auditor ID:**
DNV final follow-up:	

OBJECTIVE EVIDENCE RESPONSE

Objective evidence of sustained compliance is required for all NC-1 level nonconformance; submissions are not required for NC-2 level nonconformance.

Due date will be listed on Page 1 at the time the Corrective Action Plan report, in its entirety, is approved.

If a NC-1 Condition Level is identified, the Objective Evidence due date will be assigned after the onsite follow up survey activity and paperwork are complete.

X	**No objective evidence required.** • *Compliance will be reviewed at the next annual survey activity.*
	Objective Evidence required. • *Compliance will be reviewed at the next annual survey activity and Objective Evidence is required.* • *See instructions above for submission details.* • *The summary must be included in the section below and will not be accepted as separate attachment(s).*
	Document summary here.
	Submitted by (Client name and/or title):
	Submission date: