Survey Report and
Corrective Action Plan Submittal Form

Organization: Jasper Memorial Hospital – Monticello, GA

DNV Project #: PRJN-541875

Survey Date: July 22-23, 2025

	NIAHO® Survey type
	Hospital
X	Critical Access Hospital (CAH)
	Psychiatric Hospital
	Ambulatory Surgical Center (ASC)
	Initial (855)
	Initial
X	Annual
	Reaccreditation
	Complaint for Cause
	Non-deemed
	Other

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

Report Date: August 4, 2025

Corrective Action Plan due date: August 14, 2025
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: August 13, 2025

CAP Report approval date: August 18, 2025
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 13, 2025 (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	**3**	**4**

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 an organization'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 organization 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
CfC – Conditions for Coverage

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 organization audit identifies continued noncompliance (<100%), the organization 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 an organization'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 organization 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 Conditions reference
NC-1-1	**Quality Management System** ISO 9001 Quality Management System Corrective Action **Medication Management** Medication Orders		NC-1 Condition Level	**QM.2 (SR.3) / (SR.3d)** **QM.5 (SR.1)** **MM.4 (SR.3)** *ISO 9001:2015; 8.5.1* *ISO 9001:2015; 10.2* *ISO 9001:2015; 10.2.1* *ISO 9001:2015; 10.2.2*	
		X	NC-1		
			NC-2		

Requirement (Description):

QM.2 ISO 9001 QUALITY MANAGEMENT SYSTEM

SR.3 The CAH will initiate and continue implementation toward conformance with the ISO 9001 methodology as stated in QM.1 (SR.1). At a minimum, the CAH shall be able to demonstrate at the time of their stage one survey (third visit) evidence of active implementation of the following:

SR.3d Nonconformity and Corrective Action: when nonconformity occurs, the CAH will have a mechanism in place to document and monitor actions taken to address improvement and changes, where appropriate.

QM.5 CORRECTIVE ACTION

SR.1 Variations, deficiencies or non-conformities identified by the CAH as well as findings or recommendations of the QIO shall be addressed. Appropriate corrective or preventive action will be determined, applied, and documented. Documentation of activities may take the form of a Failure Mode and Effects Analysis, Root Cause Analysis, Performance Reports, Non-Conformity Report, specific Performance Improvement Project analysis, etc

MM.4 MEDICATION ORDERS

All medication orders shall:

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

ISO 9001:2015; 8.5.1 Control of production and service provision

The organization shall implement production and service provision under controlled conditions. Controlled conditions shall include, as applicable:

a) the availability of documented information that defines:
1) the characteristics of the products to be produced, the services to be provided, or the activities to be performed;
2) the results to be achieved;
b) the availability and use of suitable monitoring and measuring resources;
c) the implementation of monitoring and measurement activities at appropriate stages to verify that criteria for control of processes or outputs, and acceptance criteria for products and services, have been met;
d) the use of suitable infrastructure and environment for the operation of processes;
e) the appointment of competent persons, including any required qualification;
f) the validation, and periodic revalidation, of the ability to achieve planned results of the processes for production and service provision, where the resulting output cannot be verified by subsequent monitoring or measurement;
g) the implementation of actions to prevent human error;
h) the implementation of release, delivery and post-delivery activities

ISO 9001:2015; 10.2 Nonconformity and corrective action

ISO 9001:2015; 10.2.1 *When a nonconformity occurs, including any arising from complaints, the organization shall:*
a) react to the nonconformity and, as applicable:
1) take action to control and correct it;
2) deal with the consequences;
b) evaluate the need for action to eliminate the cause(s) of the nonconformity, in order that it does not recur or occur elsewhere, by:
1) reviewing and analysing the nonconformity;
2) determining the causes of the nonconformity;
3) determining if similar nonconformities exist, or could potentially occur;
c) implement any action needed;
d) review the effectiveness of any corrective action taken;
e) update risks and opportunities determined during planning, if necessary;
f) make changes to the quality management system, if necessary. Corrective actions shall be appropriate to the effects of the nonconformities encountered.

ISO 9001:2015; 10.2.2 *The organization shall retain documented information as evidence of: a) the nature of the nonconformities and*

The requirement was NOT MET as evidenced by the following:

Please note this finding remains open from the previous survey and has been elevated to a NC-1.

During review of patient records, evidence could not be identified in five (5) of eight (8) records that pharmacy had reviewed medication orders prior to the first administration as follows:

A. MR#1 (MN) (Closed) – A 88-year-old patient was admitted on 4/21/2025 at 1943 with cellulitis of the right upper and lower extremities with altered mental status. Albuterol was ordered three times per day (routine) on 4/21/2025 at 2143 and the first dose of the medication was administered on 4/21/2025 at 2210. Evidence could not be identified in the medical record that this was an emergency medication order. The medication was not reviewed by pharmacy until the next day at 0755.

B. MR#2 (MN) (Closed) – A 80-year-old patient was admitted on 4/12/2025 at 2153 with dyspnea and discharged on 4/14/2025 at 1312. Of the following medication orders, neither could be identified as an emergency order. Both medications were identified to have been administered prior to review by pharmacy as follows:

- Colace 100 mg every 24 hours ordered on 4/12 at 2256, and administered on 4/13 at 0014. Pharmacy review conducted later that day at 0843.
- Folic Acid 1 mg daily on 4/12 at 2219, and administered on 4/13 at 0809. Pharmacy review conducted later that day at 0843.

C. MR#4 (MN) (Closed) – A 94-year-old patient was admitted on 4/8/2025 at 1339 after a fall and released back to the nursing home the next day at 1040. Of the following medication orders, neither could be identified as an emergency order. Both medications were identified to have been administered prior to review by pharmacy as follows:

- Sinemet 25/100 mg 1 daily ordered 4/8/2025 at 1604 and administered at 2146. Pharmacy review was conducted on 4/9 at 0751.
- Zosyn 4.5 grams IV every eight hours ordered on 4/8 at 1602 and administered at 2311. Pharmacy review was conducted on 4/9 at 0751.

D. MR#5 (MN) (Closed) – A 81-year-old patient arrived to the emergency department (ED) on 1/20/2025 at 1504, later being admitted. During the patient's ED stay, the following medication orders were written and administered without evidence that the medications were reviewed by pharmacy:

- Eliquis 2.5 mg 1 twice per day ordered at 2149 and administered at 2100
- Atorvastatin 80 mg daily at night ordered at 2149 and administered at 2100
- Bacitracin ointment three drops daily ordered at 2149 and administered at 2100

E. MR#7 (MN) (Closed) – A 56-year-old patient arrived in the ED on 12/15/2024 at 1414 and was subsequently admitted at 1622 with cellulitis. During the patient's ED stay, the following medication orders were written and administered without evidence that the medications were reviewed by pharmacy:

- Tylenol 100 mg ordered at 1425 and administered at 1442
- Morphine 4 mg IV push ordered at 1448 and administered at 1502
- Zosyn 4.5 gm IV every six hours ordered at 1442 and administered at 1503
- Vancomycin 1 gm IV every twelve hours ordered at 1446 and administered at 1612

Surveyor ID # 64050

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.

The nonconformity stemmed from a breakdown in the medication order review process. While policies require pharmacy review prior to administering the first dose, five out of eight patient records lacked evidence of such review. Additionally, nursing staff did not notify pharmacy when a medication order required review. This communication failure and lack of adherence to established procedures contributed to the noncompliance.

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.

- Effective immediately, all medication orders will be reviewed and approved by pharmacy prior to administration, except in emergent situations. Nursing staff will contact the pharmacist on-call to review all new medication orders before administration. Pharmacy will no longer "pre-fill" medication carts for anticipated swing bed admissions. Nursing staff will refrain from entering the pharmacy or obtaining medications from the ED medication room unless the orders have been verified by pharmacy.
- This corrective action applies to all medications that are not ordered in emergent situations within the hospital.
- Dates and Actions Taken Since Survey End Date:
  - 8/4/2025: The "Pharmacy-Medication Verification Report" within Cerner was identified as a tool to track and verify compliance. This report will be generated monthly, and the QAPI committee will review the results.
  - 8/4/2025: Policy RX-6351, "Medication Management and Pharmacy/Medication Orders," was revised to specify that all medications must receive pharmacy verification prior to administration unless ordered STAT or emergently.
  - 8/6/2025: All nursing staff were re-educated on the requirement to notify pharmacy and ensure medication review by a pharmacist before administering any non-emergent medications.

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.

To prevent recurrence of the nonconformity, the following system changes will be implemented:

- Nursing staff will be required to notify pharmacy for medication verification before administering non-emergent medications.
- Pharmacy will ensure all medication orders are reviewed and approved before administration, except in emergent situations.
- The “Pharmacy-Medication Verification Report” will be used monthly to track compliance and ensure the process is being followed across all departments.

Training/Education:

- 8/6/2025: Written education was provided to all nursing staff by Samantha Mashburn, RN, ADON. This was followed by verbal reinforcement of the education. Additionally, pharmacy staff received training on the process of verifying medications before administration.
- Training has been integrated into the orientation process for all new staff to ensure they are knowledgeable about the medication verification procedures prior to functioning independently in their roles.
- If non-conformities persist, further root cause analysis will be conducted, and re-education will be implemented as needed to address any gaps in the process.

Dates and Actions Taken Since Survey End Date:

All actions have been completed as of 8/6/2025, with ongoing monthly monitoring and potential re-education if non-conformities continue.

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

Jane Conyers, PharmD; Samantha Mashburn, ADON

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.*	Leadership, nursing, and pharmacy met to discuss the nonconformance on 7/23/2025, team established on 7/29/2025.
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	Project completion: 9/1/2025; Policy revision completed 8/4/2025; QMS monitoring began 8/4/2025; Training began 8/6/2025 and will be completed by 9/1/2025.

*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.*	Chart Reviews, Discern Analytic Reporting from EHR.
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	Monitoring will be done daily with monthly reporting to QAPI committee.
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.*	Chart review will demonstrate 100% compliance of medication verification by 9/1/2025 and will continue to document 100% compliance going forward.
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.*	Medications will be verified by the pharmacy prior to administration 100% of the time, as demonstrated with monthly chart reviews reported to QAPI and monitored by the QMS. Any non-conformity will have re-education and a root cause analysis if any trends in non-compliance are noted.

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.

	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. 100% of medications that are not ordered stat or once have been reviewed by pharmacy prior to administration. Results reported in QAPI meeting monthly.
	Submitted by (Client name and/or title): Robin Carey, CCO
	Submission date: 11/10/2025

Organization: Jasper Memorial Hospital – Monticello, GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS Conditions reference
NC-1-2	**Infection Prevention and Control** Infection Prevention and Control Program **Physical Environment** Facility		NC-1 Condition Level	**IC.1 (SR.2) / (SR.2c)** **PE.1(SR.1) / (SR.1b)** *ISO 9001:2015; 7.1.4*	485.623(b)(4)
		X	NC-1		
			NC-2		

Requirement (Description):

IC.1 INFECTION PREVENTION AND CONTROL PROGRAM

The CAH shall have an active, facility-wide Infection Prevention and Control Program (IPCP) in place, incorporating the requirements and/or recommendations of the CDC, CMS, OSHA and related professional organizations (e.g., APIC). This program, inclusive of documented policies, procedures, and processes, ensures the safety of patients, healthcare workers, volunteers, contract workers and visitors.

SR.2 The CAH shall demonstrate that:

SR.2c The IPCP includes surveillance, prevention, and control of HAIs, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, addresses any infection control issues identified by public health authorities; and,

PE.1 FACILITY

The CAH shall be constructed, arranged, and maintained to ensure patient safety, and to provide areas for diagnosis and treatment and for special organization services appropriate to the needs of the community.

SR.1 The condition of the physical plant and the overall CAH environment shall be developed and maintained through housekeeping and preventive maintenance programs in such a manner that the safety and well-being of patients, visitors, and staff are assured.

SR.1b The premises are clean and orderly where patients and staff can function safely.

ISO 9001:2015; 7.1.4 Environment for the operation of processes

The organization shall determine, provide and maintain the environment necessary for the operation of its processes and to achieve conformity of products and services. NOTE A suitable environment can be a combination of human and physical factors, such as:

a) social (e.g. non-discriminatory, calm, non-confrontational);
b) psychological (e.g. stress-reducing, burnout prevention, emotionally protective);
c) physical (e.g. temperature, heat, humidity, light, airflow, hygiene, noise). These factors can differ

substantially depending on the products and services provided.

The requirement was NOT MET as evidenced by the following:

Reference: Jasper Health Services, Environmental Services, Cleaning and Disinfecting Environmental Surfaces, Rev. 9/2024, *"Clean surfaces (i.e., floors, tabletops) at a minimum of daily. Some areas may need to be cleaned more frequently if surfaces are visibly soiled…Wet-dust horizontal surfaces regularly."*

According to hospital leadership, environmental services is responsible for cleaning the hospital, and every area of the hospital is to be cleaned every day. The following areas were identified to be unsanitary, and were reported to have been cleaned either the previous day, or the day of survey:

A. Inpatient Area (Central Supply) – Areas under and behind shelving were observed to have dust, dirt, and debris. Darkened adhesive residue was observed on shelving in addition to heavy build-up on the bottom of the shelving around the casters. Dust and debris was observed in supply bins.
(Medication Room) – Floor was observed soiled with dried liquid and dirt, concentrated around the periphery.
B. Emergency Department – (Nurses station) floor was visibly soiled with dirt, dust, and debris, concentrated around the periphery and under the nurses station. Baseboards were observed to have dried liquid splash.
(Exam rooms) Dust accumulation was observed on most horizontal surfaces.
C. Radiology – Floors soiled with dried liquid and dirt, concentrated around the periphery.
D. Rehab – Floors were observed soiled with dirt, concentrated around the periphery. Exercise equipment was observed heavily soiled with dirt and debris.
E. EVS cart in use in hallway was observed laden with dust, dirt, and dried liquid.

Surveyor ID # 64050

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.

The nonconformity stemmed from inadequate oversight, inconsistent cleaning practices, and insufficient accountability within the Environmental Services (EVS) department. Despite existing cleaning protocols, the lack of effective quality control, such as audits and supervisory checks, allowed cleanliness standards to slip. Additionally, staff training gaps on cleaning peripheral areas, behind equipment, and cart hygiene, along with staffing shortages and competing demands, contributed to decreased attention to detail. This lapse could have impacted patient safety, infection control, and overall hygiene.

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.

As of 8/11/2025, Central Supply, Medication Room, Emergency Department, Radiology, and Rehab are undergoing thorough cleaning, including floors, baseboards, shelving, exercise equipment, and EVS carts. Focus was given to areas behind/under shelving, adhesive residue removal, dried splashes, and perimeter cleaning. EVS leadership conducted inspections and documented findings. Damaged EVS carts were flagged for replacement.

7/25/2025: A full EVS department re-education began taking place, covering cleaning policy expectations, documentation practices, and high-touch/perimeter areas. All staff will be educated by 9/1/2025

8/8/2025: EVS checklists were updated to include cleaning under and behind shelving, with added tasks for peripheral and horizontal surfaces.

8/11/2025: Monthly random inspections now include Central Supply and Medication Room.

8/11/2025: Unannounced supervisory checks for the Emergency Department were scheduled twice per month, and the Radiology cleaning log was revised to include perimeter-specific tasks.

Rehab staff will clean equipment, and weekly/monthly inspections of Rehab will be signed off by both EVS and Rehab Supervisors. A hygiene checklist for EVS carts, requiring daily wipe-downs and weekly supervisor checks, was implemented.

8/11/2025: Daily EVS logs are now reviewed weekly by the EVS Manager.

8/11/2025: QA spot audits have been scheduled in each department on a rotating basis.

8/11/2025: Environmental cleanliness has been added to QMS and will be reported in the monthly QAPI Committee agenda for leadership oversight.

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.

•July 24, 2025 – Immediate departmental huddle was conducted to communicate findings, reinforce policy expectations, and outline upcoming changes.

•July 25, 2025- August 18, 2025 – Mandatory EVS staff re-education session conducted, covering:

- Cleaning frequencies and expectations (including periphery, under shelving, and equipment)
- Proper EVS cart maintenance and hygiene
- Documentation of daily cleaning checklists
- Use of visual inspection and peer check
- Infection control implications of inadequate cleaning.

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

Laura Hudgins, EVS Senior Leader; Lawandra Bennett, EVS, Supervisor, Kelly King, RN, Infection Control Practitioner

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.*	7/23/2025
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 *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.*	Project completion by 9/23/2025; All cleaning will be completed by 9/23/2025; All staff training will be completed by 9/1/2025. Rounding will begin 8/13/2025
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.*	Internal environmental audits using a standardized EVS Audit Tool

Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	Weekly environmental audits for all high-risk clinical areas (ED, Radiology, Rehab, Inpatient Units) Monthly audits across all departments, including support and administrative areas
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.*	95% or greater compliance on cleaning audits for all reviewed areas by 9/23/2025.
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.*	At least 3 consecutive months of ≥95% compliance in routine cleaning audits Any deficiencies identified during audits will trigger: • Immediate re-cleaning • Incident tracking • Retraining of staff
DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID: 39475 ***DNV HC NOTE:*** *Full compliance with the NIAHO standards and Conditions of Participation is the expectation of our accreditation program and CMS. While we understand this may not always be achievable in the short term, it is the expectation that the actions taken will achieve 100% compliance. The progress made toward achieving full compliance will be assessed with your periodic assessment regarding the effectiveness of the actions taken. By setting a goal for example of <100% even in the short term, this could result in an outcome or other undesirable result with a patient or staff if <100% compliance is deemed to be acceptable.* *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.* *Continued noncompliance at the next annual survey may result in an elevated non-conformance category.*	
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. 100% of weekly environmental rounds have been conducted by EVS supervisor and a department head or senior leader. Results of inspections have been reported monthly to QAPI
	Submitted by (Client name and/or title): Robin Carey, CCO
	Submission date: 11/10/2025

Organization: Jasper Memorial Hospital – Monticello GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS Conditions reference
NC-1-3	**Physical Environment** Emergency Management System Utility Management System		NC-1 Condition Level	**PE.6 (SR.5) / (SR.5b) / (SR.7)** **PE.8 (SR.6) / (SR.10)** *NFPA 110* *8.3, 8.3.7.1, 8.4, 8.4.9* *ISO 9001:2015; 7.1.3*	485.625(e) 485.625(e)(2) 485.625(b)(1)(ii)
		X	NC-1		
			NC-2		

Requirement (Description):

PE.6 EMERGENCY MANAGEMENT SYSTEM

SR.5 The CAH shall implement emergency and standby power systems based on the emergency plan set forth in PE.6 (SR.1).

SR.5b The CAH shall implement emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and the Life Safety Code.

SR.7 NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009, is incorporated for reference in this chapter in addition to the references incorporated by reference in PE.1.

PE.8 UTILITY MANAGEMENT SYSTEM

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.

NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition
8.3 Maintenance and Operational Testing.
8.3.7.1 *Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.*

8.4 Operational Inspection and Testing.
8.4.9* *Level 1 EPSS shall be tested at least once within every 36 months.*

***ISO 9001:2015;* 7.1.3 Infrastructure**
The organization shall determine, provide and maintain the infrastructure necessary for the operation of its processes and to achieve conformity of products and services.
NOTE Infrastructure can include:

a) buildings and associated utilities;
b) equipment, including hardware and software;
c) transportation resources;
d) information and communication technology.

The requirement was NOT MET as evidenced by the following:

Finding #1
During the Physical Environment/Life Safety document review session with facilities staff, no objective evidence was presented documenting the monthly generator battery conductance test had been performed as required by NFPA 110.

Finding #2
During the Physical Environment/Life Safety document review session with facilities staff, no objective evidence was presented documenting the 3 year load bank test had been performed on the emergency power generator as required by NFPA 110.

Surveyor ID # 297759

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: The battery conductance test was not performed because Plant Engineering thought that monthly load test was a sufficient way to test the battery.
- Finding #2: A triennial 4-hour load test was not performed due to plant engineering's lack of awareness of the requirement beyond the annual 2-hour load test. The generator was commissioned in November 2021.

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:
  - 7/29/2025: Purchased battery conductance tester.
  - 8/7/2025: Added battery conductance testing to monthly Life Safety Monitors.
  - 8/7/2025: Developed Generator Maintenance Policy per NFPA 110 guidelines.
  - 8/12/2025: Completed Battery Conductance testing successfully.

- 8/14/2025: Submit policy to Environment of Care Committee for approval, followed by JHS Board review.
- Finding #2:
  - 8/6/2025: Created Generator Test Log per NFPA 110 guidelines.
  - 8/7/2025: Developed Generator Maintenance Policy.
  - 8/13/2025: Completed 4-hour load test successfully.

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: Educate plant engineering staff on the new Generator Maintenance Policy, testing procedures, and logging requirements.
- Finding#2: Train plant engineering staff on performing the 4-hour load test and maintaining the Generator Test Log.

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.*	• Finding#1: 7/29/2025 • Finding#2: 8/6/2025
Date(s) and actions taken since survey end date, prior to CAP submission. *If these dates and 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**	• Finding#1: 8/12/2025 • Finding#2: 8/13/2025

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.*	• Finding#1: Internal life safety monitoring • Finding#2: Internal reporting
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	• Finding#1: Monthly • Finding#2: Quarterly
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: Life safety monitoring of generator battery conductance will be 100% each month • Finding#2: The 4-hour load test will be conducted every 3 years and documented on the Generator Test Log; the date of last testing will be reported at least quarterly to the QAPI committee.
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 with generator battery conductance testing monthly for at least 6 consecutive months. • Finding#2: 100% compliance with triennial 4-hour load test every 3 years going forward. Any continued nonconformity: • Finding #1: Re-education of Plant Engineering staff • Finding #2: Re-education of Plant Engineering staff.

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: 100% of monthly battery testing has been conducted on generator batteries and reported to EOC Committee and QAPI committee. Finding #2: A 4-load test was conducted on 8/13/2025. This load test is being monitored as part of the internal QMS and is on the QMS dashboard for triennial testing before 8/13/2028.
	Submitted by (Client name and/or title): Robin Carey, CCO
	Submission date: 11/10/2025

Organization: Jasper Memorial Hospital – Monticello, GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS Conditions reference
NC-2-1	**Quality Management System** Patient Safety System		NC-1 Condition Level	**QM.8 (SR.1) / (SR.2) / (SR.2.b)** *ISO 9001:2015; 9.1* *ISO 9001:2015; 9.1.1*	
			NC-1		
		X	NC-2		

Requirement (Description):

QM.8 PATIENT SAFETY SYSTEM

SR.1 The CAH shall have a means for establishing clear expectations for identifying and detecting the prevalence and severity of incidents that impact or threaten patient safety. This shall include medical errors and adverse patient events.

SR.2 The CAH's patient safety system shall be documented and shall address the following: Detection, reporting, investigation and response to medical errors and adverse patient events;

SR.2b Aggregation, trending and analysis of data;

ISO 9001: 2015; 9.1 Monitoring, measurement, analysis and evaluation

ISO 9001: 2015; 9.1.1 General

The organization shall determine:

a) what needs to be monitored and measured;

b) the methods for monitoring, measurement, analysis and evaluation needed to ensure valid results;

c) when the monitoring and measuring shall be performed;

d) when the results from monitoring and measurement shall be analysed and evaluated.

The organization shall evaluate the performance and the effectiveness of the quality management system

The organization shall retain appropriate documentation as evidence of the results.

The requirement was NOT MET as evidenced by the following:

Reference: *Jasper Health Services Patient Safety Plan, effective and revised 3/2025,* states:
"All JMH departments are responsible for reporting patient safety occurrences to the Chief Compliance Officer, who aggregates the data for monthly review."

During review of the organization's patient safety system, the process for detection, reporting, investigation and response to medical errors and adverse patient events was reviewed. In discuss with the Quality leader, it was identified that each specific error and/or event is investigated and responded to; however, there was no objective evidence that data is collectively being aggregated for trends or analysed. In discussion with the Quality Leader, it was explained that they analyse each individual error and/or event but have not consistently been aggregating, trending and analysing the data.

Surveyor ID # 282939

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.

All key performance indicator data was collected and compiled on a monthly basis. Monthly QAPI committee meetings were conducted with full participation from all members. Issues were reported, discussed, and addressed during these meetings. Root cause analyses and performance improvement projects were initiated in response to identified issues. However, the QMS lacked a structured system for aggregating data and documenting trends.

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.

7/22/23: The Quality Leader initiated the development of a comprehensive QMS dashboard system to display all key performance indicators in a standardized format, enabling monthly analysis and trend identification. The Quality Leader, with input from the QAPI committee and Senior Leadership, will revise the QAPI plan to include the aggregation and trending of patient safety data.

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.*
The Quality Leader will present the QMS dashboard process to the QAPI committee during the regular monthly meeting on 8/13/2025. Additionally, the Quality Leader will conduct individual meetings with QAPI committee members to review the development of key performance indicators (KPIs).
Person and/or Function responsible for implementation of Corrective Action Plan:
Robin Carey, Chief Compliance Officer, Quality Leader
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.*	7/22/2025
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 *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.*	9/23/2025

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.*	Effectiveness will be monitored through the monthly aggregation of all KPI data, which will be presented to the QAPI committee on a monthly basis and to the governing body on a quarterly basis.
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	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.*	100% of key performance indicators related to patient safety, medications, life safety will be aggregated, analyzed, and trending as documented on the QMS comprehensive dashboard by 9/10/25.
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% of all key performance indicators monitored by the QMS will be aggregated, analyzed, and trended monthly. The QMS dashboard will be reported to the governing body quarterly. Any KPIs not initially identified will be added and aggregated as needed.
DNV HEALTHCARE USE ONLY	

CAP Accepted - DNV technical reviewer ID: 38486 ***DNV HC NOTE:*** *The customer is expected to implement corrective action plans within sixty calendar (60) days. The 60th calendar day from the end of the survey is 09/21/2025. It appears that you miscalculated the completion due date and since based on the language in the CAP it appears the corrective actions are underway within the 60 day window therefore the CAP is accepted with the implementation dates provided.*	
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 Conditions reference
NC-2-2	**Medical Staff** Appointment, Reappointment and Clinical Privileging Performance Data		NC-1 Condition Level	**MS.7 (SR.6) / (SR.6b) / (SR.6b(1))** **MS.10 (SR.1) / (SR.1d) / (SR.1d(3)) / SR.1d(6)) / SR.1d(10)) / SR.1d(11)) / SR.1d(12)) / (SR.2)** *ISO 9001:2015; 9.1* *ISO 9001:2015; 9.1.1* *ISO 9001:2015; 9.1.3*	485.512(a)(1)
			NC-1		
		X	NC-2		

Requirement (Description):

MS.7 APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGING

SR.6 The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges (initial, renewal, and revision/amendment).

SR.6b Renewal and revision/amendment:

SR.6b(1) In addition to other privileging criteria established in the medical staff bylaws or policy/procedure/delineation, as part of the process for determining whether existing clinical privileges will be renewed or require modification/amendment, a review of individual performance data (see MS.10) shall be performed and documented in order to identify variation from defined criteria/benchmarks established by the medical staff.

MS.10 PERFORMANCE DATA

Practitioner specific performance data for physicians and other practitioners who have been granted clinical privileges is required to be evaluated, analyzed and appropriate action taken as necessary when variation is present and/or standard of care has not been met as defined by medical staff policy/procedures.

SR.1 Performance data will be collected:

SR.1d In order to monitor the clinical performance of physicians with clinical privileges, the medical staff, the areas required to be measured (as applicable to the practitioner's specialty and privileges granted) shall include:

SR.1d(3) Prescribing of medications: prescribing patterns, trends, errors and appropriateness of prescribing for Drug Use Evaluations;

SR.1d(6) Appropriateness of care for non-invasive procedures/interventions;

SR.1d(10) Specific department indicators that have been defined by the medical staff;

SR.1d(11) Significant deviations from nationally recognized standards of practice and guidelines; and,

SR.1d(12) Any variant that shall be analyzed for statistical significance.

SR.2 Performance data shall include comparative and/or national data when available. In the absence of available comparative and/or national data, the medical staff shall determine the appropriate thresholds which would indicate the need for further analysis.

ISO 9001:2015; 9.1 Monitoring, measurement, analysis and evaluation

ISO 9001:2015; 9.1.1 General

The organization shall determine:

a) what needs to be monitored and measured;

b) the methods for monitoring, measurement, analysis and evaluation needed to ensure valid results;

c) when the monitoring and measuring shall be performed;

d) when the results from monitoring and measurement shall be analysed and evaluated.

The organization shall evaluate the performance and the effectiveness of the quality management system.

The organization shall retain appropriate documented information as evidence of the results.

ISO 9001:2015; 9.1.3 Analysis and evaluation

The organization shall analyse and evaluate appropriate data and information arising from monitoring and measurement.

The results of analysis shall be used to evaluate:

a) conformity of products and services;

b) the degree of customer satisfaction;

c) the performance and effectiveness of the quality management system;

d) if planning has been implemented effectively;

e) the effectiveness of actions taken to address risks and opportunities;

f) the performance of external providers;

g) the need for improvements to the quality management system.

NOTE Methods to analyse data can include statistical techniques.

The requirement was NOT MET as evidenced by the following:

Reference: *Provider Performance Policy; Revised and approved 6/2025; states:*
"Peer review applies to the medical staff of this hospital and others who have delineated clinical privileges."

During the Medical Staff session, four (4) medical staff files who have delineated clinical privileges were reviewed. In review, the following files were reviewed:

Finding #1
During Medical Staff Review, there was no objective evidence presented to demonstrate the organization measured the practitioner's prescribing of medications or appropriateness of care for the following two (2) of four (4) medical staff as required by the *Provider Performance Policy*.

A. MD, Clinic Practitioner – Most recent reappointment: 10/01/2024

B. MD, Emergency Department Medical Director – Most recent reappointment: 02/28/2024

Finding #2
During Medical Staff Review, there was no objective evidence presented to demonstrate the organization conducted Provider Performance peer reviews for the following two (2) of two (2) contracted Allied Health practitioners as required by the *Provider Performance Policy*.

A. PA, ED and Hospitalist – Temporary Privileges granted 03/18/2025, Initial appointment 06/25/2025

B. PA, ED and Hospitalist – Most recent reappointment 06/25/2025

Finding #3
There was no objective evidence that performance data included comparative and/or national data, or thresholds determined by the medical staff to be appropriate indicators of the need for further analysis as required.

Surveyor ID # 282939

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: There was no consistent process for measuring prescribing patterns or appropriateness of care, resulting in a lack of objective evidence for certain practitioners.
- Finding #2: Required peer reviews for contracted Allied Health practitioners were not conducted due to gaps in the peer review process, particularly for temporary and newly appointed practitioners..
- Finding #3: The failure to include comparative or national data in performance evaluations resulted from the lack of external benchmarks and predefined thresholds for analysis.

These gaps in policy implementation and performance monitoring led to noncompliance with established requirements and hindered the effectiveness of the review process.

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: 8/11/2025: Developed Performance Scorecard with Performance Metrics, Focused Professional Practice Evaluation, Credentials Committee Recommendation for Reappointment to evaluate cases, improve consistency in capturing performance data, and attest for reappointments.
- Finding #2: 8/11/2025: Use the Performance Scorecard with Performance Metrics, Focused Professional Practice Evaluation, Credentials Committee Recommendation for Reappointment to evaluate five cases of newly granted privileges within three months.
- Finding #3: 8/11/2025: Collect pertinent data on the provider spreadsheet and the performance scorecard to measure provider performance against peer data.

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.

The Quality Leader will ensure that the updated FPPE and OPPE processes are included in ongoing staff education sessions.
Training on the new FPPE format and the updated quality reporting procedures will be conducted for all relevant staff by 8/30/2025.

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

Robin Carey, Chief Compliance Officer, Quality Leader; Miranda Griggs, Medical Staff Credentialing Coordinator; Dr. Laura Moore, Emergency Department Medical Director

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.*	8/11/2025
Date(s) and actions taken since survey end date, prior to CAP submission. *If these dates and actions are included in the sections above, reply with "see above".*	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.*	9/23/2025
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.*	Internal audit of collected peer review data
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	Quarterly

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.*	Achieve 100% completion of FPPE evaluations within three months of granting privileges, quarterly OPPE reviews for all providers, and accurate reappointment data collection for low-volume providers by 9/23/2025
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.*	Ensure 100% compliance with the FPPE and OPPE processes, including the evaluation and documentation of all newly granted privileges, quarterly reviews, reappointments, and low-volume provider performance data. Any nonconformities will be addressed with re-education.

DNV HEALTHCARE USE ONLY

CAP Accepted - DNV technical reviewer ID: 38486

DNV HC NOTE: *The customer is expected to implement corrective action plans within sixty calendar (60) days. The 60th calendar day from the end of the survey is 09/21/2025. It appears that you miscalculated the completion due date and since based on the language in the CAP it appears the corrective actions are underway within the 60 day window therefore the CAP is accepted with the implementation dates provided.*

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

<table>
<tr><th>NC Number</th><th>Process or Standard</th><th colspan="2">Nonconformance category</th><th>DNV requirement(s) and other applicable standard(s)</th><th>CMS Conditions reference</th></tr>
<tr><td rowspan="3">NC-2-3</td><td rowspan="3">Physical Environment
Life Safety Management System</td><td></td><td>NC-1 Condition Level</td><td rowspan="3">PE.2 (SR.7) / (SR.7b) / (SR.7b(1))
ISO 9001:2015; 7.1.3</td><td rowspan="3">485.623(c)</td></tr>
<tr><td></td><td>NC-1</td></tr>
<tr><td>X</td><td>NC-2</td></tr>
<tr><td colspan="6">Requirement (Description):

PE.2 LIFE SAFETY MANAGEMENT SYSTEM

SR.7 Health care occupancies shall conduct unannounced fire drills, but not less than one (1) drill per shift per calendar quarter that transmits a fire alarm signal (i.e., audible alarm) and simulates an emergency fire condition. When fire drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

SR.7b Fire drills shall be thoroughly documented and evaluate the CAH’s knowledge to the items listed in PE.2 (SR.3).

SR.7b(1) At least annually, the CAH shall evaluate the effectiveness of the fire drills. The report of effectiveness shall be forwarded to QMS oversight.

ISO 9001:2015; 7.1.3 Infrastructure
The organization shall determine, provide and maintain the infrastructure necessary for the operation of its processes and to achieve conformity of products and services.
NOTE Infrastructure can include:
a) buildings and associated utilities;
b) equipment, including hardware and software;
c) transportation resources;
d) information and communication technology.</td></tr>
<tr><td colspan="6">The requirement was NOT MET as evidenced by the following:

During the Physical Environment/Life Safety document review session with facilities staff, no objective evidence was presented documenting the annual fire alarm evaluation had been performed as required by NIAHO PE.2 (SR.7b(1)).</td></tr>
<tr><td colspan="6">Surveyor ID # 297759</td></tr>
</table>

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.

Fire drill evaluations were performed with each fire drill, however, an annual summary of the fire drill performance was not completed by either plant engineering or the Safety officer.

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.

8/5/2025: The Safety Officer and Plant Engineering Director met to review the previous years fire drill evaluations.
8/12/2025: The Safety Officer completed an annual fire drill evaluation for presentation to QAPI committee on 8/13/2025 and the Environment of Care Committee on 8/14/2025.

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.

8/5/2025: The Safety Officer reviewed guidelines for writing an annual fire drill summary.

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

Robin Carey, Safety Officer

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.*	8/5/2025
Date(s) and actions taken since survey end date, prior to CAP submission. *If these dates and actions are included in the sections above, reply with "see above".*	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.*	8/14/2025
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.*	Committee review of annual evaluation report
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	Annual

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.*	An annual fire drill evaluation will be completed by the Safety Officer in conjunction with the Plant Engineering Director and presented to the Environment of Care Committee.
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.*	The 2024 evaluation will be presented to QAPI on 8/13/2025 and EOC 8/14/2025 and will be presented to QAPI and EOC annually beginning in January 2026. This will be recorded in the EOC minutes and maintained in the QMS records.

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:

Organization: Jasper Memorial Hospital – Monticello GA

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS Conditions reference
NC-2-4	**Physical Environment** Safety Management System		NC-1 Condition Level	**PE.3 (SR.2)** *NFPA 70 700.12 ISO 9001:2015; 7.1.3*	485.623(a) 485.623(b)(1)
			NC-1		
		X	NC-2		

Requirement (Description):

PE.3 SAFETY MANAGEMENT SYSTEM

SR.2 The CAH shall require that facilities, supplies, and equipment be maintained and ensure an acceptable level of safety and quality and that the premises are clean and orderly. The extent and complexity of facilities shall be determined by the services offered.

NFPA 70 National Electrical Code, 2011 Edition
III. Sources of Power
700.12 General Requirements*. Current supply shall be such that, in the event of failure of the normal supply to, or within, the building or group of buildings concerned, emergency lighting, emergency power, or both shall be available within the time required for the application but not to exceed 10 seconds. The supply system for emergency purposes, in addition to the normal services to the building and meeting the general requirements of this section, shall be one or more of the types of systems described in 700.12(A) through (E). Unit equipment in accordance with 700.12(F) shall satisfy the applicable requirements of this article. In selecting an emergency source of power, consideration shall be given to the occupancy and the type of service to be rendered, whether of minimum duration, as for evacuation of a theater, or longer duration, as for supplying emergency power and lighting due to an indefinite period of current failure from trouble either inside or outside the building. Equipment shall be designed and located so as to minimize the hazards that might cause complete failure due to flooding, fires, icing, and vandalism. Equipment for sources of power as described in 700.12(A) through (E) where located within assembly occupancies for greater than 1000 persons or in buildings above 23 m (75 ft) in height with any of the following occupancy classes — assembly, educational, residential, detention and correctional, business, and mercantile — shall be installed either in spaces fully protected by approved automatic fire suppression systems (sprinklers, carbon dioxide systems, and so forth) or in spaces with a 1-hour fire rating.*

***ISO 9001:2015;* 7.1.3 Infrastructure**
The organization shall determine, provide and maintain the infrastructure necessary for the operation of its processes and to achieve conformity of products and services.
NOTE Infrastructure can include:
a) buildings and associated utilities;
b) equipment, including hardware and software;
c) transportation resources;
d) information and communication technology.

The requirement was NOT MET as evidenced by the following:

During the Physical Environment/Life Safety building tour with facilities staff, the surveyor observed the emergency power generator, located in an area allowing public access, was unlocked providing access to unauthorized personnel. This condition is not permitted per NFPA 70.

Surveyor ID # 297759

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.

The nonconformity occurred because recent work was completed on the emergency power generator, and the plant engineering staff failed to properly secure the enclosure by locking it afterward. This oversight resulted in unauthorized access to the generator, violating safety and regulatory requirements.

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.

7/29/25: Weekly generator security checks have been incorporated into the Life Safety Monitor procedures. This ensures that the generator enclosure will be properly secured and locked, in compliance with NFPA 70, and prevents unauthorized access.

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.

7/22/2025: All plant engineering staff received mandatory training on the new generator security procedure. Staff were instructed that the generator must be secured and locked at all times, and the importance of this practice was emphasized to ensure compliance with safety standards.

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.*	7/22/2025
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 *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.*	8/14/2025

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	Rounding

Select a method for monitoring effectiveness. *Example: Chart review, internal audits, etc.*	
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	Weekly
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.*	100% of weekly rounds will find the generator to be locked and secure by 8/14/2025
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% of weekly security checks will confirm that the emergency power generator is locked and secure during each round. Any discrepancies will be documented and reported to the Environment of Care Committee and the QMS for further review. Any nonconformance identified will be addressed promptly with re-education.

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: