Survey Report and
Corrective Action Plan Submittal Form

Organization: McCurtain Memorial Hospital - Idabel, OK

DNV Project #: PRJC-582926-2018-AST-USA

Survey Date: May 21 - 22, 2024

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

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

Report Date: June 5, 2024

Corrective Action Plan due date: June 15, 2
A Corrective Action Plan (CAP) must be deli ed to NV Healthcare within ten (10) calendar days from date of receipt of the final report.

CAP received date:

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

Total Number of Nonconformities

NC-1 Condition Level	NC-1	NC-2
0	0	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 a hospital's CAP and DNV does not approve or endorse the use of any specific policy, procedure, or form. The decision to use such documents rests solely with the hospital and specific documentation will be reviewed as part of the next annual survey activity. Do not submit copies of pictures, policies, procedures, sign in sheets, training documents or forms. You may reference revisions to documents by including the Policy name and number / version, approval date & approved by detail.

CoP – Conditions of Participation (NIAHO® Accreditation)

Date for implementation of Corrective Action Plan

The Organization is expected to implement corrective action plans within sixty (60) calendar days post survey activity. When this is not feasible DNV Healthcare will consider and evaluate the circumstances involved and approve a suitable timeframe to enable the customer to implement the corrective action plans.

Specific timelines and milestones, including interim or short term compliance plans, must be included in the *Date(s) of Projected Completion / Compliance with the Standard Requirements* section below for any date outside the 60 calendar days post survey.

Life Safety Code® (LSC) nonconformance

CMS has specifically determined that Life Safety Code® (LSC) nonconformances 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 LSC nonconformances within the required 60 calendar day timeframe, the organization may request a Time-Limited Waiver (TLW) as part of the Corrective Action Plan submission below. A DNV Healthcare representative will follow up with the primary contact.

Requirements for Objective Evidence Submission

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

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

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

Instructions for Objective Evidence Documentation

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

Organization: McCurtain Memorial Hospital – Idabel, OK

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-1	**Patient Rights** Specific Rights		NC-1 Condition Level	**PR.2 (SR.1) / (SR.1a)** *ISO9001:2015:8.2.1*	485.614(a)(1)
			NC-1		
		X	NC-2		

Requirement (Description):

PR.2 SPECIFIC RIGHTS

The CAH shall inform, whenever possible, each patient and/or legal representative of the patient's rights in advance of providing or discontinuing care. The written listing of these rights shall be provided to the patient and /or family and shall include policies and procedures that address the following:

SR.1 Beneficiary Notices:

SR.1a Of non-coverage and right to appeal premature discharge; and,

Interpretive Guidelines:

Hospital Delivery of the IM

Hospitals shall deliver the IM to all beneficiaries eligible for the expedited determination process per §200.2. An IM shall be delivered even if the beneficiary agrees with the discharge.

- *The hospital shall ensure that the beneficiary or representative signs and dates the IM to demonstrate that the beneficiary or representative received the notice and understands its contents. See 200.3.7 'Ensuring Beneficiary Comprehension'.*

- *Use of assistive devices may be used to obtain a signature.*

- *Electronic issuance of the IM is permitted.*

If a hospital elects to issue an IM viewed on an electronic screen before signing, the beneficiary shall be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary shall be given a paper copy of the IM, as specified in 200.3.9, and the required beneficiary specific information shall be inserted, at the time of notice delivery.

200.3.4- Required Delivery Timeframes First IM

Hospitals shall deliver the first copy of the IM at or near admission, but no later than 2 calendar days following the date of the beneficiary's admission to the hospital.

Hospitals may deliver the first copy of the notice if the beneficiary is seen during a preadmission visit, but not more than 7 calendar days in advance of admission.

A hospital shall deliver the IM to all inpatients, including those in the hospital for a short sta

Once the discharge date is planned, a hospital does not need discharge orders in advance of de ering the IM.

Timing of First IM Delivery

- *Pre-Admission – Up to 7 days before admission*
- *At Admission – At admission*
- *After Admission – Up to 2 days following admission*

ISO9001:2015: 8.2.1 Customer communication
Communication with customers shall include:
a) providing information relating to prod s and e ces;

The requirement was NOT MET as evide ced by e follo

During review of medical records, three (3) of thr (3) records reviewed with documentation of the delivery of Important Message from Medicare (IM) beneficia notice to eligible inpatients, had objective evidence of expired notices per CMS. The IM notices in use had a expiration date of 12/31/2022.

A. MR#14 (DMH) - a 5-year-old female p ient with Medicare as the payor was admitted on 9/29/2023 and expired during e a mission The ial IM notice was delivered within 24 hours after her admission; h wever, here no ective evidence the most current version of the notice was provided.

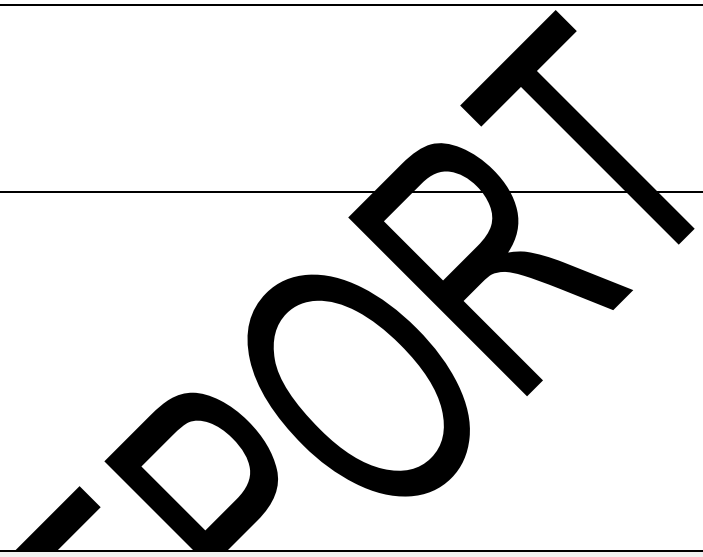
B. MR#15 (DMH) - an 4-year-old female patient with Medicare as the payor was admitted on 2/28/2024 and ransi ned t a bed on 3/3/2024. The initial IM notice was delivered within 24 hours after er ad ssion; however, here was no objective evidence the most current version of the notice was provided

C. MR 16 (DMH) - an 87-year-old female patient with Medicare as the payor was admitted on 12/2023 and transitioned to swing bed on 12/18/2023. An IM notice was delivered/signed on 12 7/2023; however, there was no objective evidence the initial IM notice was delivered within 2 days admission or that the most current version of the notice was provided.

Per the Centers for Medicare and Medicaid Services at https://www.cms.gov/Medicare/Medicare-General-Information/BNI:
The current form CMS 10065-IM has an expiration date of 12/31/2025 (OMB approval 0938-1019).
The current form CMS 10611-MOON has an expiration date of 11/30/2025 (OMB approval 0938-1308).

Surveyor ID # 65107
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: o Finding #1: [insert response] o Finding #2: [insert response] o 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.
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.
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.*
Person and/or Function responsible for implementation of Corrective Action Plan:
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). If a TLW 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.	
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".*	
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.*	

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.*	
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	
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.*	
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.*	

DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID:	
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.*
	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: McCurtain Memorial Hospital - Idabel, OK

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-2	**Physical Environment** Life Safety Management System		NC-1 Condition Level	**PE.2 (SR.1) / (SR.1a) / (SR.9)** *NFPA 14 (2010); 4.7, 4.7.3* *NFPA 72 (2010); 14.4.5* *ISO 9001:2015; 7.1.3*	485.623(c)(1)
			NC-1		
		X	NC-2		

Requirement (Description):

PE.2 LIFE SAFETY MANAGEMENT SYSTEM

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

SR.1a The CAH shall meet the applicable provisions and shall proceed in accordance with the 2012 Life Safety Code (NFPA 101 and Tentative Interim Amendments 12-1, TIA 12- 2, TIA 12- 3, and TIA 12-4). Outpatient surgical departments shall meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served.

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

Finding #1

NFPA 14, Standard for the Installation of Standpipe and Hose Systems, 2010 Edition
4.7 Hose Connections.
4.7.3 *Hose connections shall be equipped with caps to protect the hose threads.*

Finding #2

NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition
14.4.5* Testing Frequency. *Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction.*
Table 14.4.5 *– (6) Battery – Load Voltage Test – Semi-annual*

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 tour, all fire cabinets within the facility did not have capped hose connections, as required by NFPA 14 (2010).

Finding #2
During the physical environment/life safety document review with hospital staff, objective evidence was not presented to validate whether the battery load voltage tests have been completed semi-annually in 2023 for the fire alarm panel and its associated components, as required by NFPA 72 (2010). The only voltage inspection for the fire alarm back up batteries was dated April 2023.

Surveyor ID # 64108, 65107

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.

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.

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.

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

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). If a TLW 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.*	
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".*	
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.*	

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.*	
Frequency of monitoring *Select a defined frequency to monitor effectiveness.* *Example: concurrent, prior to procedure, monthly, quarterly, etc.*	
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.*	
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.*	

DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID:	
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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.*
	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).*
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	Submitted by (Client name and/or title):
	Submission date:

Organization: McCu[illegible]in Me[illegible]or[illegible] Hospital - Idabel, OK

NC Number	Process or Standard	Nonconformance category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC[illegible]3	**Infection Prevention and Control Program** Infection Prevention and Control Program **Physical Environment** Safety Management System		NC-1 Condition Level	**IC.1 (SR.3) / (SR.3h)** **PE.3 (SR.4)** *NFPA 70 (2011);314.28* *NFPA 99 (2012); 5.1.3.5.3* *ISO 9001:2015; 7.1.4*	485.623(a) 485.623(d) 485.623(b)(1)
			NC-1		
		X	NC-2		
Requirement (Description):					

IC.1 INFECTION PREVENTION AND CONTROL PROGRAM

The CAH shall have an 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.3 The CAH's Infection Prevention and Control System shall have documented processes, policies and procedures to define how infections and communicable diseases are prevented, controlled and investigated throughout the CAH including, but not limited to:

SR.3h Maintenance of a sanitary environment for personal, patients, visitors, contracted personnel, volunteers and students;

PE.3 SAFETY MANAGEMENT SYSTEM

SR.4 The CAH shall maintain an environment free of hazards and manages staff activities to reduce the risk of occupational related illnesses or injuries.

Finding #1

NFPA 70, National Electric Code, 2011 Edition

314.28 Pull and Junction Boxes and Conduit Bodies.

3 (C) Covers. *All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110.*

Finding #2

NFPA 99, Health Care Facilities Code, 2012 Edition

5.1.3.5.3 *Support Gases. Central supply systems for support gases shall not be piped to, or used for, any purpose except medical support applications.*

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:

Finding #1

During the Physical Environment/Life Safety tour with hospital staff, the surveyor observed electrical junction boxes without covers in the following locations:

A. Two (2) Junction boxes within the Emergency Department

B. Large open junction box within the Sterile Processing Clean Supply Room

Finding #2

During the clinical tour, it was identified that Room 203 was a patient care double-occupancy room that had been permanently repurposed to a supply room. Currently, the room is used to store supplies including dressings, IV tubing, Foley insertion and other kits, as well as patient hygiene supplies. The room still has active plumbing in two sinks, which are in close enough proximity to the supplies that splashing could occur, should the sinks be used. There is also a restroom (shower and toilet) in the room, which could pose a contamination risk if used. Additionally, the wall gas connections (oxygen, air, and vacuum) were still active.

Surveyor ID # 64108, 65107

ORGANIZATION RESPONSE

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  Example:
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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".*	
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.*	
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DNV HEALTHCARE USE ONLY	
CAP Accepted - DNV technical reviewer ID:	
Clarification requested - DNV technical reviewer ID:	
Clarification request:	
CAP verified effective/closed date:	**DNV surveyor/auditor ID:**
DNV final follow-up:	
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	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: McCurtain Memorial Hospital - Idabel, OK

NC Number	Process or Standard	Nonconformance Category		DNV requirement(s) and other applicable standard(s)	CMS CoP reference
NC-2-4	**Physical Environment** Utility Management System		NC-1 Condition Level	**PE.8 (SR.6) / (SR.8) / (SR.8a)** *NFPA 110 (2010); 7.3, 7.3.1* *NFPA 101 (2012);7.9.3, 7.9.3.1.1, 7.9.3.1.2, 7.9.3.1.3* *ISO 9001:2015;7.1.3*	485.623(b)(1) 485.623(b)(5) 485.625(e)(2)
			NC-1		
		X	NC-2		

Requirement (Description):

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.8 There shall be emergency power and lighting in at least the operating, recovery, intensive care, emergency rooms, and in other areas where invasive procedures are conducted, stairwells, and other areas identified by the CAH (e.g., blood bank refrigerator, etc.). In all other areas not serviced by the emergency supply source, battery lamps and flashlights shall be available.

SR.8a Emergency lighting standards shall comply with Section 7.9 of Life Safety Code, 101- 2012, and applicable references, such as, NFPA-99, 2012: Health Care Facilities Code for emergency lighting and emergency power.

NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition
7.3 Lighting
7.3.1 *The Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access.*

NFPA 101 Life Safety Code, 2012 Edition
7.9.3 Periodic Testing of Emergency Lighting Equipment.
7.9.3.1 *Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3.*
7.9.3.1.1 *Testing of required emergency lighting systems shall be permitted to be conducted as follows:*
(1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between
tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2).
*(2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having*
jurisdiction.
(3) Functional testing shall be conducted annually for a minimum of 1½ hours if the emergency lighting system is battery powered.
(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3).
(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having
jurisdiction.

7.9.3.1.2 *Testing of required emergency lighting systems shall be permitted to be conducted as follows:*
(1) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.
(2) Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.
(3) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator.
(4) A visual inspection shall be performed at intervals not exceeding 30 days.
(5) Functional testing shall be conducted annually for a minimum of 1½ hours.
(6) Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1½-hour test.
(7) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having
jurisdiction.

7.9.3.1.3 *Testing of required emergency lighting systems shall be permitted to be conducted as follows:*

(1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.
(2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.
(3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1½ hours.
(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3).
(5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.

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 document review with hospital staff, no evidence was presented that battery backup egress lights were tested (monthly and annually) within the main electrical room housing the emergency generators electrical transfer switches.

Surveyor ID # 64108

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.

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.

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.*
Person and/or Function responsible for implementation of Corrective Action Plan:
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). If a TLW is being requested, include the details and request below.*

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