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CHARTIS

Behind Joint Commission's Accreditation 360

September/October 2025

The webinar will start at the top of the hour.

2

MONTHLY INSIGHTS

Webinar schedule & topics

LIVE WEBINAR START TIMES

10AM Pacific, 1PM Eastern

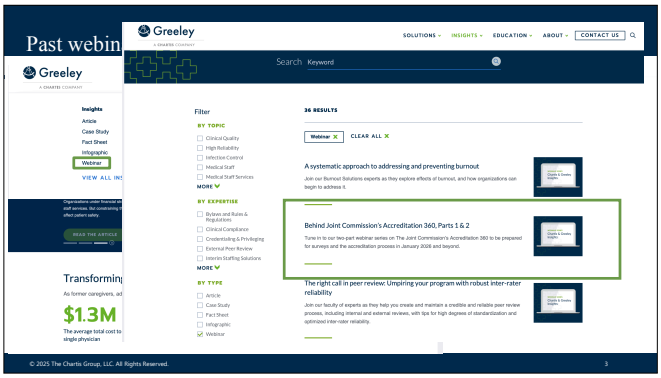
SEPTEMBER 25 and OCTOBER 1

Behind Joint Commission's Accreditation 360, Parts 1 and 2

OCTOBER 16

A systematic approach to addressing and preventing burnout

3



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Navigating the Zoom interface

Handouts:

Check the chat function for copies of the slides for note taking and any other handouts.

Questions and comments:

Please participate in the discussion by asking question through the Q&A function during the webinar.

There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.

Any questions not answered during the webinar will be addressed in a follow-up email or posting.

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Healthcare challenges are not siloed. *Neither are we.*

Chartis has **six lines of business** that together craft **singular solutions**.

- 1000+ Professionals
- Mission: to materially improve healthcare
- Ranked Best Overall Management Consulting Firm by KLAS
- Charis acquires Greeley in 2019, became Chartis Clinical Quality Solutions in 2022
- Greeley brand brought back in 2024 to cover Medical Staff Services Related Offerings and now part of Clinical Transformation

6

High Reliability Care

UNPARALLELED BREADTH AND DEPTH

Our clients are all striving toward the same goal of providing safe, high-quality care—something that's becoming even more important with the many distractions and disruptions in healthcare today. We help clients achieve their organizational reliability, quality, and safety goals, leading to results in areas that matter most—improved care outcomes, staff engagement, operational stability, and total cost of care, enhanced

High Reliability Organization (HRO)

- High reliability organizational design and infrastructure
- Quality, Value, and Performance Improvement
- Quality ratings and rankings optimization
- Patient safety / harm reduction / safety and reliability culture
- Adverse event response and remediation / RCA
- High fidelity measurement / Clinical Documentation Integrity (CDI)
- Care facilitation

Clinical Compliance, Regulatory, and Physical Environment Solutions

- Adverse event response
- Adverse action regulatory response and remediation
- Accrediting body readiness assessment
- Regulatory readiness rehearsal / mock surveys
- Life safety and environment of care assessment
- Policy simplification
- Infection prevention program

Bylaws, Rules and Regulations, and Peer Review

- Bylaws and rules and regulations assessment and redesign
- Peer review assessment and redesign
- Medical staff / medical director structure and governance
- Credentialing, OPPE

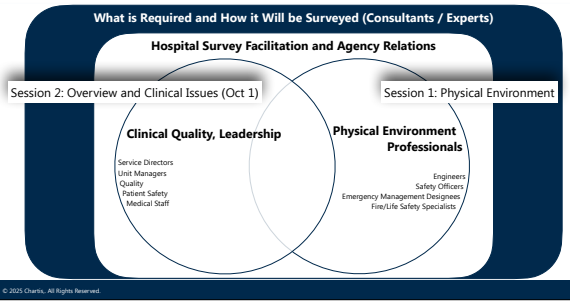
External Peer Review

- Physician/advanced practice professional external peer review
- Focused Professional Practice Evaluation (FPPE)
- Ongoing case review in support of OPPE/FPPE
- Medical necessity reviews
- Patient safety/carequality case reviews

MEMBERSHIP AND PROFESSIONAL EDUCATION SERVICES

Intended Audience

7



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Materials you will need

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- **From The Joint Commission's website**
  - Pre-publication Standards effective January
  - Survey Process Guide
  - Crosswalk CMS to TJC standards 2026
  - Disposition of Changes for the Hospital Proc
- **Downloads** to this presentation
  - Chartis
    - Fact Sheet: Accreditation 360
    - Frequency of CMS Life Safety Code deficiencies for the last 10 years
  - Federal Register June 23, 2025: CMS Approv TJC's Deeming Authority
  - CMS State Operations Manual

TJC Accreditation 360

What providers need to know

Six notable changes

1. **Survey expansion to outpatient spaces:** Life Safety Code (LSC) compliance evaluation now applies to hospitals' outpatient/ambulatory programs. Any outpatient sites that are listed on the hospital's accreditation application and have services billed to the hospital's Centers for Medicare & Medicaid Services Certification Number (CCN) are subject to have an LSC surveyor in addition to a clinical surveyor from The Joint Commission (TJC). As a result, the number of surveyor days for both clinical and LSC surveyors to be on site could significantly increase.
2. **Survey eligibility:** The survey will not start until the surveyors determine that the hospital is eligible. TJC has a list of documents hospitals need to present for review within the first 15 minutes of the surveyors arriving on site. If a hospital does not immediately provide all of these elements, the surveyors could stop activity and leave the grounds. Review the details of these documents in the Survey Process Guide.
3. **Survey Process Guide:** The original Survey Activity Guide consisted of one document for accredited organizations and a separate document for the surveyors. To better align with Centers for Medicare & Medicaid Services (CMS) requirements of hospitals, the new Survey Process Guide is now a single document so both hospitals and surveyors are working off the same information. This provides greater transparency about the activities TJC will cover when reviewing the hospital.
4. **Revised accreditation manual:** TJC removed more than 700 standards. However, they were mostly relocated to the remining standards. The Environment of Care and Life Safety chapters have been combined into a single Physical Environment chapter. National Patient Safety Goals have been revised into National Performance Goals, with 14 requirements. The Waive Testing chapter was removed, with all of these requirements shifted into the National Performance Goals chapter.
5. **Continuous engagement model:** There are now two options for engagement. One is a series of virtual consultations, and the other is a midcycle on-site assessment. In the previous model, this was known as the "periodic performance review" or "intracycle monitoring process." These touch points can be used to discuss challenges your organization is facing or to get a baseline assessment of your continuous

Today's *discussion*

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Understanding the contours of the Joint Commission "Accreditation" initiative, where to find the requirements, and what you really need to know.

> "Not just the 'what'
> Also the 'so what?'

Steve Chinn, DPM
Partner
schinn@chartis.com

Bud Pate
Consultant
bpate@chartis.com

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Today's *agenda*

Overview: Fewer EP's, Same Requirements, More Confusion

- Why change?
- Outline of change
- Impact

Risk Points

Questions

Questions should be posted in the webinar interface throughout the presentation.
We will respond to any unanswered questions in writing following the webinar.

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POLLING QUESTION:

What is your Accreditation status?

We are currently accredited by **The Joint Commission**	We are currently accredited by **Det Norske Veritas and Zgermanishcher Lloyd (DNV GL)**	We are currently accredited by **The Center for Improvement in Healthcare Quality (CIHQ)**
We are currently accredited by **Accreditation Commission for Health Care (ACHC, formerly HFAP, formerly AOA)**	**We are certified by CMS but not accredited by one of the 4 organizations with deeming authority**	**I'm not sure**

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POLLING QUESTION:

What is the likely impact of the Joint Commission's Accreditation 360 initiative on your organization?

We are **MORE LIKELY** to choose the Joint Commission as our accreditor as a result of the Accreditation 360 initiative	We are **LESS LIKELY** to choose the Joint Commission as our accreditor as a result of the Accreditation 360 initiative
Accreditation 360 has had **NO IMPACT** on our decision to be accredited by the Joint Commission	We are **UNSURE** of the impact of Accreditation 360

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Background: The Joint Commission through the years

Deeming Authority and the Accreditation 360 initiative

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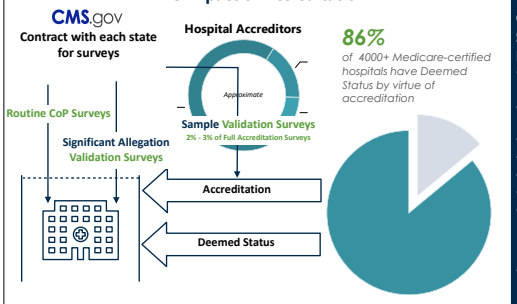
The Impact of Accreditation



86%

of 4000+ Medicare-certified hospitals have Deemed Status by virtue of accreditation

Other Provider/ Suppliers Types Eligible for "Deemed Status"

- Ambulatory Surgical Centers
- Critical Access Hospitals
- ESRD Suppliers
- Home Health Agencies
- Hospices
- Outpatient Physical Therapy and Speech-Language Pathology Services
- Rural Health Clinics

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The Joint Commission's Deeming Authority

1965
Social Security Act amended to create Medicare and MedicAid

- JCAH (now TJC) and AOA (Now ACHC) were granted deeming authority
- HCFA (now CMS) had no authority to grant or terminate the deeming authority of accrediting organizations

2010
Social Security Act amended

- TJC's and AOA's (then HFAP) automatic deeming authorities were terminated.
- CMS was given the duty to grant deeming authority in 2 to 6 year increments based on the Accrediting Organization's performance.
- DNV and CIHQ ultimately received deeming authority
- TJC was given short-duration deeming authority (typically 2 years) based on CMS's concerns over
  - The difference between TJC's standards and the Medicare Conditions of Participation
  - Discrepancies between validation survey findings and TJC survey results
  - Differences in the survey process (e.g., Life Safety Code survey processes)

JUNE 23, 2025

JUNE 23, 2025

Federal Register TJC awarded 5-year deeming authority

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Changes that prompted the approval

- Better alignment between TJC standards and the CMS Conditions of Participation
- Proving additional Life Safety Code guidance and training to surveyors
- Changes to the survey process
  - Complete inspection of all smoke and fire barriers and dampers in penetrating ducts per Appendix I in the State Operations Manual
  - Better review of application to ensure all listed sites fall under the hospitals CMS Certification Number (CCN)
  - Trained and qualified LSC surveyors to review all locations falling under the scope of the survey (can be clinical surveyors who are also qualified as LSC surveyors)
  - Hospital outpatient surgery departments must be reviewed for compliance as an Ambulatory Healthcare Occupancy
- Better scoring of governing body violations (by virtue of other findings)


DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–3468–FN]

Medicare and Medicaid Programs; Application From The Joint Commission for Continued CMS Approval of its Hospital Accreditation Program

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS

Handout

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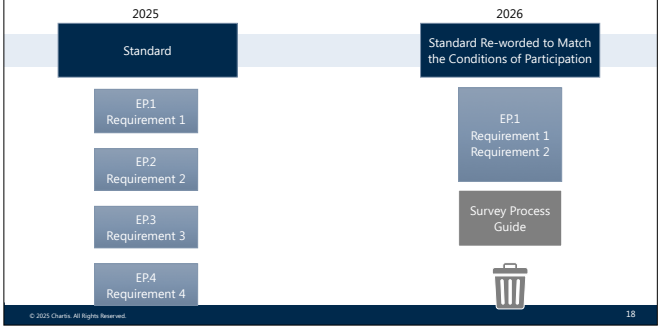
Hunting for the requirements

18

Net Effect: Same Requirements, New Location



National Performance Goals

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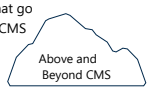
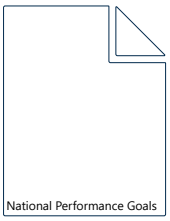
- National Patient Safety Goals

- TJC requirements that go above and beyond CMS requirements





Chapters

20

2025

- Accreditation Participation Requirements (APR)
- Environment of Care (EC)
- Emergency Management (EM)
- Human Resources (HR)
- Infection Prevention and Control (IC)
- Information Management (IM)
- Leadership (LD)
- Life Safety (LS)
- Medication Management (MM)
- Medical Staff (MS)
- National Patient Safety Goals (NPSG)
- Nursing (NR)
- Provision of Care, Treatment and Services (PC)
- Performance Improvement (PI)
- Record of Care, Treatment and Services (RC)
- Rights and Responsibilities of the Individual (RI)
- Transplant Safety (TS)
- Universal Protocol (UP)
- Waived Testing (WT)

2026

- Accreditation Participation Requirements (APR)
- Emergency Management (EM)
- Human Resources (HR)
- Infection Prevention and Control (IC)
- Information Management (IM)
- Leadership (LD)
- Medication Management (MM)
- Medical Staff (MS)
- National Performance Goals (NPG)
- Nursing (NR)
- Physical Environment (PE)
- Provision of Care, Treatment and Services (PC)
- Performance Improvement (PI)
- Record of Care, Treatment and Services (RC)
- Rights and Responsibilities of the Individual (RI)
- Transplant Safety (TS)

National Performance Goals

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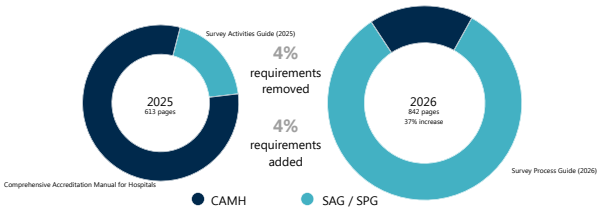
- **Patient ID (NPG.01.01 …)**
- **Critical Results (NPG.01.02 …)**
- **Handoff Communication (NPG.01.04 …)**
- **Clinical Alarms (NPG.01.05.01)**
- **Healthcare Equity (NGP.04.01.01)**
- **Solutions Labeling (NPG.14.03.01 EP 03)**
- **Hand Hygiene (NPG.05.03 …)**
- **Suicide Prevention (NPG.08.01.01)**
- **Universal Protocol (NPG.01.06)**
- Patient Flow (NPG.01.03 …)
- Rescue/Resuscitation (NPG.01.05.02/03/04/05)
- Mission, Vision Goals (NPG.02.01.01)
- Ethics (NPG.02.02.01)Patient Safety (NPG.02.03.01)Workplace Violence (NPG.02.04.01)
- Emergency Management (NPG.03)
- Pain (NPG.06 …)
- Communication (NPG.07.01.01)
- Consent (NPG.07.02.01)
- Abuse, Neglect, Exploitation (NPG.07.03.01)
- Respect for Culture/Religion (NPG.07.04.01)
- Tissue Management (NPG.09)
- Waived Testing (NPG.10 …)
- Security (NPG.11.01.01)
- Falls (NPG.11.02.01)
- Utility Systems (NGP.11.03.01)
- Misc Staffing (NPG.12/01.01)
  - Staff Mix
  - Medical Record
  - Dietetic Service
  - Pharmacy
  - Infection Preventionist
  - Surgical Service
- Nurse Staffing (NPG.12.02.01)
- Psychiatric Hospital Staffing (NPG.12.03.01)
- Scope of Practice (NPG.12.04.01)
- Competence (NPG.12.05.01)
- Evaluation of Staffing (NPG.12.06.01)
- Imaging (NPG.13 …)
- Pharmaceutical Services (NPG.14 …)

Were the standards really reduced?

22



*number of pages

What is the Survey Process Guide?

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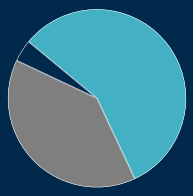

1. Hospital Accreditation Survey Activities and Documents List (21 Pages)
2. CMS Conditions of Participation Evaluation Modules (398 Pages)
3. Compliance Evaluation Tools (204 Pages) *(Caution … some expectations in the evaluation tools are mentioned nowhere else in the ACC 360 materials)*

Hospital Accreditation Survey Process

Survey Process Guide - Part 1

24

Confirmation of eligibility for survey

Intent?

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Before proceeding with the survey, the surveyor(s) must see.

- **Clear**
  - Average daily census
  - Scope of services included under the hospital provider number (CCN)
  - Hospital license
  - Evidence that the organization maintains clinical records on all patients
  - Medical staff bylaws
  - Utilization review plan
  - Discharge planning process
- **Not so Clear**
  - Evidence that the hospital meets the statutory definition of a hospital
  - An overall "plan" and budget in effect
    - operational budget
    - 3-year capital budget
    - Budget = Plan
- Evidence of a requirement that every patient is under the care of a physician (census with attending physician or psychologist).
- Evidence of the provision of 24-hour nursing services rendered or supervised by a RN and has an LPN or RN on duty at all times. (Nurse staffing schedule)
- Notifying the public it serves about how to contact organization management or The Joint Commission to report concerns about patient safety and quality of care (web page, admission packet)

***Items in green are our suggestions, not TJC language.**

Tips for other documents

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Other documents surveyors will need … **selected** tips … OUR recommendations

- List of contracted services
  - Services necessary to operate the hospital (including all services under the hospital's CCN
  - Contracts for directors (e.g., medical directors, managers of contracted services)
  - Onsite laboratory services … not reference labs
  - NOT
    - Purchase agreements for equipment and supplies (unless the purchase includes necessary services, such as routine maintenance)
- Organization Chart
  - To unit level
- Floor plan
  - Suggest high-level, schematic
  - Label units and type of care
  - Not to be confused with Life Safety Code drawings
    - Required for Health Care and Ambulatory Health Care LSC occupancies
    - Recommended for Business Occupancies used for patient care

Scope of Survey

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Locations … Also see State Operations Manual, Appendix A, Task 3

- **Scope of Clinical Reviews**
  - All hospital departments including all types of inpatient units that provide patient care services at the main site and other hospital locations.
  - 100% of all moderate or deep sedation and anesthetizing locations
  - All locations where complex outpatient care
  - Select a sample of each type of other services provided at additional outpatient locations.
  - Sample a mix of large, medium, and small volume clinics
  - Sample both onsite and offsite clinics.
  - All outpatient behavioral health services
  - Main pharmacy
    - Satellite compounding pharmacies
- **Life Safety Code survey**
  - All services selected by the clinical surveyor
  - All inpatient
  - Surgical locations
  - Emergency departments
  - Fire/smoke barriers for all Health Care and Ambulatory Health Care occupancies
- **Patient records (survey process guide)**
  - Open records preferred
  - At lease one patient per unit
  - 10% of average daily census or 30 records, whichever is more
    - If ADC is less than 30, sample may be as low as 20 patients
  - At least one patient from each type of nursing unit (med/surg, labor and delivery)
  - Ambulatory care

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CMS Conditions of Participation Evaluation Modules

Survey Process Guide - Part 2

29

Survey Procedures … our analysis

- Specified in the CMS CoP Modules
- Survey actives are not necessarily limited to the traditional system tracers
- There are more survey activities than than the time allotted

- Materials reviewed in addition to patient records
  - Environment of Care Documents
  - Personnel files
  - Occupational Health Records
  - Credentials files
  - Maintenance records
  - Staffing documents
  - Policies and procedures
  - Contracts

30

Excerpt: Appendix A

A-0702
(Rev.)

Condition!! Standard

§482.41(a)(1) Element

§482.41(a)(1) - There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available. Regulation

Interpretive Guidelines §482.41(a)(1)

NOT Included in TJC SPG

The hospital must comply with the applicable provisions of the 2012 edition of the National Fire Protection Amendments (NFPA) LSC and mandatory references, such as, Health Care Facilities Code and National Electric Code, which contain requirements for emergency lighting and emergency power. In locations not required to have emergency power and lighting by the LSC or its applicable references, battery lamps and flashlights must be readily available.

Survey Procedures §482.41(a)(1)

Included in TJC SPG

LSC surveyors will assess the NFPA requirements for emergency power and lighting. However, health and safety surveyors should also assess whether emergency power and lighting are observed in operating, recovery, intensive care, emergency rooms, and stairwells.

COMPARING DOCUMENTS

CMS Appendix A: Practitioner Assessment for Violent Restraint

31

Regulation

A-0179
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

[the patient must be seen face-to-face within 1 hour after the initiation of the intervention –]

§482.13(e)(12)(ii)To evaluate –

(A) The patient's immediate situation;
(B) The patient's reaction to the intervention;
(C) The patient's medical and behavioral condition; and
(D) The need to continue or terminate the restraint or seclusion.

Interpretive Guidelines

Interpretive Guidelines §482.13(e)(12)(ii)

The 1-hour face-to-face evaluation includes both a physi
the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition would include a complete review

of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior.

Training for an RN or PA to conduct the 1-hour face-to-face evaluation would include all of the training requirements at §482.13(f) as well as content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition (documented training in conducting physical and behavioral assessment); and the need to continue or terminate the restraint or seclusion.

Survey Procedures

Survey Procedures §482.13(e)(12)(ii):

- Was the 1-hour face-to-face evaluation conducted by a practitioner authorized by hospital policy in accordance with State law to conduct this evaluation?
- If the 1-hour face-to-face evaluations are conducted by RNs who are not advanced practice nurses (APN), verify that those RNs have documented training that demonstrates they are qualified to conduct a physical and behavioral assessment of the patient that addresses: the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion.
- Does documentation of the 1-hour face-to-face evaluation in the patient's medical record include all the listed elements of this requirement?
- Did the evaluation indicate whether changes in the patient's care were required, and, if so, were the changes made?
- Is practice consistent with hospital policy and State law?

Comparing Documents: TJC Survey Process Guide: Practitioner Assessment for Violent Restraint

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Regulation

PC.13.02.11, EP 2: The in-person evaluation is conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. The evaluation includes the following:
- An evaluation of the patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavioral condition
- The need to continue or terminate the restraint or seclusion

§482.13(e)(12)(ii)(A) (B) (C) (D)
When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—
(ii) To evaluate—

(A) The patient's immediate situation;

(B) The patient's reaction

Guidelines Missing

Interpretive Guidelines §482.13(e)(12)(ii)

The 1-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition would include a complete review

of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior.

Training for an RN or PA to conduct the 1-hour face-to-face evaluation would include all of the training requirements at §482.13(f) as well as content to evaluate the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition (documented training in conducting physical and behavioral assessment); and the need to continue or terminate the restraint or seclusion.

Survey Process

Document Review
Patient Health Record
- Review a sample of health records for patients for whom restraint or seclusion was used. Confirm that the 1-hour face-to-face evaluation was conducted by a practitioner authorized by hospital policy in accordance with state law to conduct this evaluation.
  - If the 1-hour face-to-face evaluations were conducted by RNs who are not advanced practice nurses (APNs), verify that those RNs have documented training that demonstrates they are qualified to conduct a physical and behavioral assessment of the patient that addresses the following:
    1. Patient's immediate situation
    2. Patient's reaction to the intervention
    3. Patient's medical and behavioral condition
    4. Need to continue or terminate the restraint or seclusion

hat documentation of the 1-hour face-to-face ion in the patient's medical record includes listed elements of this requirement. ine whether the evaluation indicated that s in the patient's care were required and, if changes were made.

n

Confirm that actual practice is consistent with the hospital's policy on restraint and seclusion and state law.

Comparing Documents: TJC Survey Process Guide vs CMS SOM: Outpatient Occupancies

33

Interpretive Guidelines §482.41(b)(1)–(3)

Medicare-participating hospitals must comply with the *2012 edition of the LSC and Tentative Interim Amendments 12-1 through 12-4* for all patient care locations, *including* locations such as emergency departments, outpatient care locations, etc.

Outpatient surgical departments of a hospital that meet the LSC definition of an Ambulatory Health Care Occupancy (AHCO) must meet the AHCO chapters requirements, regardless of the number of patients served. The LSC would permit a reduction in the level of fire protection to that of a Business Occupancy at facilities providing services simultaneously to less than four patients who are incapable of self-preservation. However, considering the complexity and elevated risk associated with surgical procedures performed in hospitals outpatient surgical departments and because such departments are comparable to ASCs (see 42 CFR 416.44), CMS requires that the minimum level of fire protection afforded by the AHCO requirements be maintained, regardless of the number of patients being served by the department.

Corridor doors and doors to rooms containing flammable or combustible materials provided with hardware that has a latch to keep the door in a closed position. Rolle which will release by pushing on the door, are prohibited on such doors.

As part of its survey Plan of Correction, a hospital may request a waiver of specific provisions that would result in unreasonable hardship on the hospital and would not adversely affect the health and safety of patients. The State survey agency (SAs) or CMS approved

May 2025 Changes
Transmitted in September 2025

Comparing Documents: TJC Survey Process Guide vs CMS SOM: Alcohol-Based Hand Rubs

34

PE.03.01.01, EP 7: When the hospital installs alcohol-based hand rub dispensers, it installs the dispensers in a manner that protects against inappropriate access.

Interpretive Guidelines, 482.41(b)(7):

Alcohol-based hand rub (ABHR) dispensers are a common infection control method. Healthcare-acquired infections are of increasing concern, and many such infections are transmitted because health care workers do not wash their hands or do so improperly or inadequately. An important aspect of getting health care workers to use ABHR dispensers is their accessibility. The American Hospital Association commissioned a study to determine the safest method to place ABHR dispensers in corridors. As a result of this study, the *LSC was amended to permit their use under certain conditions in patient care rooms and egress corridors.*

In addition, CMS requires that ABHR dispensers be installed in a manner that protects against inappropriate access by persons who may not comprehend the associated risks of misusing ABHR solutions, which are both toxic and flammable (e.g., children, individuals with intellectual disabilities, psychiatric patients, etc.). In order to avoid dangerous situations, a facility must take appropriate precautions to secure ABHR dispensers from inappropriate access. This means facilities could choose not to install ABHR dispensers in locations where vulnerable populations exist, or a facility may choose to install ABHR dispensers only in areas that can be easily and frequently monitored, such as in view of a nurse's station or areas that are continuously monitored with a security camera, or not install them at all in other areas. It is up to the hospital to decide how best to secure ABHR dispensers against inappropriate access.

Regular maintenance *of ABHR dispensers* is seen as a crucial step in making sure that dispensers *do not leak contents, which would allow inappropriate access*. Hospitals are expected to maintain ABHR dispensers in accordance with manufacturers' guidelines. If the manufacturer does not have specific maintenance requirements, the facility is expected to develop its own policies and procedures *to maintain all ABHR dispensers*.

are installed in
Code requirements
ool) and maintained in
rer recommendations
procedures.

35

Compliance Evaluation Tools

Survey Process Guide - Part 3

Requirements Only Found in Evaluation Tools

36

One example out of many

Kitchen Tracer Survey Guide from Survey Process Guide (Pages 541 to 547)

Cutting boards/prep surfaces: are they cleaned and sanitized properly to avoid contamination? E.g., one for meat, one for veggies & sanitized between uses
~~(CAH 485.640(a)(3))~~
(HAP 482.42(a)(3))
~~(CAH 485.640(a)(3))~~
Does the staff use clean utensils with bulk foods/ice?
(HAP NPG.12.01.01, EP 8; 482.28(a)(1)(ii))
(CAH NPG.11.04.01 EP 1)

???

Hospital implements IP program.

The regulation requires that the IP program include surveillance.

CMS Interpretive Guidelines from September 2025 discuss the scope of the surveillance program, but nothing specific to the kitchen or food handling.

Compliance Evaluation Tools

204 Pages

Not all elements of the survey covered

May or may not be used in the actual survey

- Medical Records per CoPs (No TJC Reference)
- Ambulatory Health Care Occupancy by K-Tag with references to TJC standards
- Physical Environment Documents by TJC standard (No CoP reference)
- Health Care Occupancies by K-Tag with references to TJC standard
- Kitchen Review Tool by Subject with both CMS and TJC references
- Infection Prevention Tools by Subject with TJC standards (No CoP reference) … overlap with other tools (e.g. Kitchen)
- Imaging Document Review Guide with TJC standards (No CoP reference)
- QAPI Tool with by subject with CMS and TJC references
- Performance Improvement Project Tool with TJC references (No CoP references)
- Emergency Management Documents with CMS and TJC references
- Workplace Violence Tool with TJC references (No CoP references)
- Healthcare Equity Evaluation Tool TJC references (No CoP references)
- Antibiotic Stewardship Evaluation Tool TJC references (No CoP references)
- National Performance Goals Tool TJC references (No CoP references) … many subject areas repeat in this tool (Emergency Management)
- Primary Care Home

Many subjects within survey scope are not covered in "Compliance Evaluation Tools."

37

In *Plain Language*, please!

- Same requirements, different survey process
- Requirements more difficult to find: look in TJC Standards, CMS requirements, Evaluation Tools, etc.
  - ↗ Reliance on the State Operations Manual (CMS) (**Know your CMS Appendices**!)
- More survey time
- More citations for the Governing Body Condition of Participation

Joint Commission surveys will look more and more like Routine State Agency surveys.

- ? Restraint
- ? Grievance
- ? Contract

? Will there be a better definition of a "Condition-Level Finding" vs. a "Standard-Level Finding?"

? Will Joint Commission complaint surveys become more like State Agency complaint investigations?

38

CMS Complaint Triage Criteria (State Agency Rules)

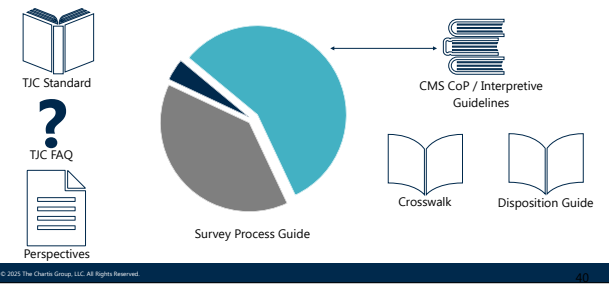
Unannounced. No prior contact with the provider.

Complaint Triage Level	Criteria	Onsite Investigation by Accreditors
IJ	**An ongoing likelihood of serious injury, harm, impairment or death of a patient or resident**	**Within 2 business days of receipt**
Non-IJ High	**EMTALA or condition-level finding likely**	**Within 45 calendar days of prioritization**
Non-IJ Moderate	**Standard-level finding likely with limited patient impact**	**Investigated during next on-site survey (complaint, special cause, or full)**
Non-IJ Low	**Standard-level finding likely with only discomfort**	**Track and trend?** **Next survey?** *Inconsistent Communication from CMS*

39

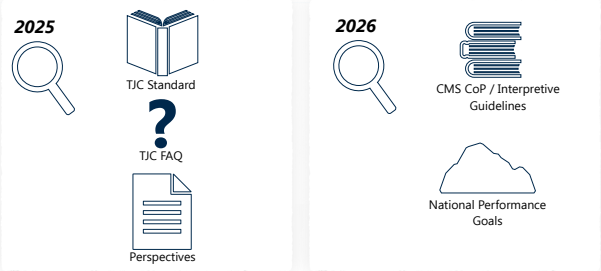
Lots of places to look … where to start?

40



Where we look first for the core requirement

41



Appendix A: Conditions of Participation for Hospitals

42

Includes Interpretive Guidelines and Survey Process

- §482.11 Compliance with Federal, State and Local Laws
- §482.12 Governing Body
  - Contracting
- §482.13 Patient's Rights
  - Care in a Safe Environment
  - Restraint
  - Grievances
- §482.21 Quality Assessment and Performance Improvement Program
- §482.22 Medical staff
- §482.23 Nursing Services
  - Care Plan
  - RN Supervision
- §482.24 Medical Record Services
- §482.25 Pharmaceutical Services
- §482.26 Radiologic Services
- §482.27 Laboratory Services
- §482.28 Food and Dietetic Services
- §482.30 Utilization Review
- §482.41 Physical Environment
- §482.42 Infection Prevention and Control and Antibiotic Stewardship Programs
- §482.43 Discharge Planning
- §482.45 Organ, Tissue and Eye Procurement
- §482.51 Surgical Services
- §482.52 Anesthesia Services
- §482.53 Nuclear Medicine Services
- §482.54 Outpatient Services
- §482.55 Emergency Services
- §482.56 Rehabilitation Services
- §482.57 Respiratory Services
- §482.60 Special provisions applying to psychiatric hospitals
  - §482.61 Special medical record requirements for psychiatric hospitals
  - §482.62 Special staff requirements for psychiatric hospitals

Risk points

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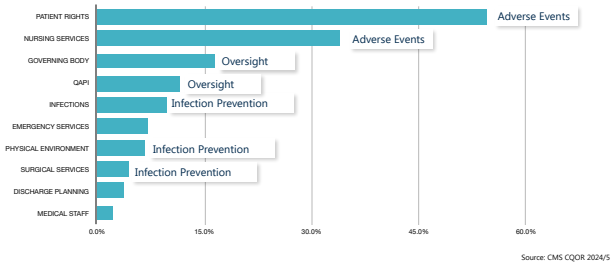
Frequency of Condition-Level Findings for CMS Hospital Surveys (excluding EMTALA)



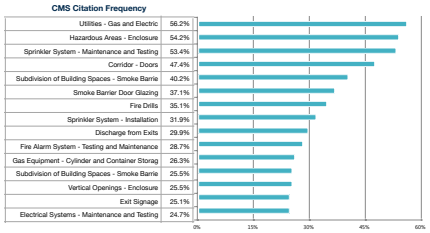
Source: CMS CQOR 2024/5

44

44

Frequency of LSC Findings by State Survey Agencies

2015 TO 2025



See Handout for Complete Listing

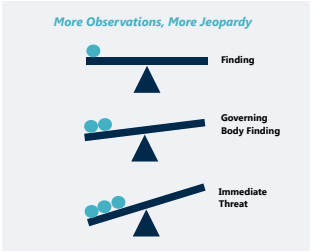
45

45

It could happen to you…

46

- High Profile academic medical center with world-wide reputation
- Known issue
  - Old kitchen
  - Significant sanitation challenges
  - Was not escalated
- Add on observations
  - Furniture
  - Flaws in Environment
- Immediate Threat to Health and Safety
  - Preliminary Denial of Accreditation
  - Next triennial survey move to 18 months (vs 36 months)



Closing the loop

47

Focus, follow-up, and escalate

Connecting the Physical Environment with Leadership

48

- Inform and Educate Leadership:
  - EoC has received 50%+ of survey findings in recent past
  - It's probably going to be a lot worse:
    - More Survey Time
    - More Survey Locations
    - Same Issues … more observations … more likelihood of governance citations.
- Escalate unresolved issues beyond the EOC and Infection Prevention committees
- Focus
  - Rounding … avoid death by a thousand cuts
    - Submit work orders directly
    - Connect with leadership (e.g., COO on rounds)
    - Educate the folks at the point of care/service
    - Don't play "gotcha!"
  - Analyze vulnerabilities for oversight bodies … not just what, but also why and how they can be resolved
    - Infection Prevention
    - Environment of Care
    - QAPI
    - Board

Effective Oversight for ALL Issues / Vulnerabilities

49

- Don't try to boil the ocean … focus, simplify
- Low tolerance for continued poor performance
  - Either fix it or, if it's not truly important, STOP measuring it
- Efficient oversight meeting
  - Action-oriented agenda
  - Executive suite
  - Clear recommendations presented
  - Action taken for EACH agenda item.
- Leaders and Board involvement and buy in
  - Avoid Myth
  - Analyze before presenting the issue
  - Don't give undue emphasis to trial issues
  - Present RELIABLE data
  - Don't fool yourself by setting unrealistic expectations
  - Answer the question: Stay Course or Change Course?
- Effective Oversight DEPENDS on
  - Effective communication within and between silos
  - Effective monitoring: adverse events AND metrics
  - Effective process. Implementation

Ambulatory Health Care Occupancies vs. Business Occupancies

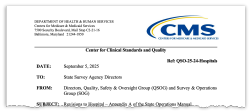
50

Be prepared

Ambulatory healthcare vs. business occupancies

51

- Most ambulatory care provided by a hospital may be conducted in Business Occupancies.
- However *(QSO-25-24-Hospitals: A-0710 (§482.41(b))*:
  - … "the [Life Safety Code] would permit a reduction in the level of fire protection to that of a Business Occupancy at facilities providing services simultaneously to less than four patient who are incapable of self-preservation" …
  - … "Outpatient surgical departments of a hospital … must meet … [Ambulatory Health Care Occupancy] requirements, regardless of the number of patients served."



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C1-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-25-24-Hospitals

DATE: September 5, 2025

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Revisions to Hospital – Appendix A of the State Operations Manual

See Handouts

Differences between Ambulatory Health Care Occupancies and Business Occupancies

52

**See ASHE analysis in Handouts*

- Very similar to Health Care Occupancies (for inpatients)
- 1-hour separation from Business Occupancies
- With some exceptions
  - Sprinklered
  - Emergency lighting
  - Emergency power (in some circumstances)
  - Fire alarm
  - Smoke compartments
  - Tenant separations
  - Fire drills
  - Etc.

- For this reason we strongly recommend preparing LSC drawings for Business Occupancies where ambulatory healthcare is given under the hospital's CCN.
- Ask
  - Is general anesthesia administered?
  - Are 4 or more patients incapable of self preparation given care simultaneously. (Trigger = moderate sedation or above)

Summary … see LSC and ASHE for a more in-depth description

Bottom Line

53

- Expect longer surveys with more findings
- Physical Environment will continue to draw the lion's share of findings
- Escalate and resolve significant PE vulnerabilities to the governing body
- Be proactive … test for Ambulatory Health Care occupancies
- Stay flexible … things will clarify (i.e., change)

POLLING QUESTION:

What is the likely impact of the Joint Commission's Accreditation 360 initiative on your organization?

54

We are **MORE LIKELY** to choose the Joint Commission as our accreditor as a result of the Accreditation 360 initiative

We are **LESS LIKELY** to choose the Joint Commission as our accreditor as a result of the Accreditation 360 initiative

Accreditation 360 has had **NO IMPACT** on our decision to be accredited by the Joint Commission

We are **UNSURE** of the impact of Accreditation 360

55

Questions/concerns?

Are we *better off*, *worse off*, or *the same*?

56

Thank *you*

Stay Tuned!

Bulletins as the situation evolves

CHARTIS