Survey Report and Corrective Action Plan Submittal Form, ICP-12-5-i7-f3 Sample Tutorial

In an effort to provide ongoing clarification and promote transparency of the Corrective Action Plan (CAP) expectations, DNV GL Healthcare is providing instructions for accredited or certified organizations in making their submissions. This guide clarifies the elements required in the submission of a CAP and the example template with tutorial below reflects the required elements for acceptable CAP submission, on the DNV GL Healthcare provided Survey Report and Corrective Action Plan Submittal Form, ICP-12-5-i7-f3.

**Final Survey Report**

- The Team Leader will compile and submit a preliminary survey report to DNV GL, with findings corresponding to those presented to the organization at the closing meeting.

- DNV GL Healthcare USA, Inc. shall provide final written report(s) to the Organization within ten (10) business days of the last day of the survey. Business days exclude US national holidays, DNV GL recognized holidays, and special events during which the accreditation office may be closed, such as surveyor training meetings, the DNV GL Healthcare Symposium, and CMS Accreditation Organization meeting dates.

- The final written report will contain all identified Nonconformities relative to the NIAHO® requirements and/or ISO standards that were identified by the team during the performance of the survey.

**Corrective Action Plan Submission**

- The Organization will submit Corrective Action Plans to address the nonconformities identified within ten (10) calendar days to DNV GL Healthcare USA, Inc. The Organization may at that time, within the same ten (10) calendar days, request clarification or challenge any Nonconformity findings relative to either NIAHO® requirements or ISO standards as part of the Corrective Action Plan submission.

- The final report with your documented Corrective Action Plans should be attached to an email and returned in Word format (not PDF) to DNVClientDropBox@dnvgl.com.

- DNV GL Healthcare USA, Inc. does not accept encrypted/secure emails. All correspondence should be submitted by regular email.

- DNV GL Healthcare USA, Inc. does not review specific policies, procedures or forms as part of a hospital’s Corrective Action Plan. Please note that DNV GL Healthcare USA, Inc. 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.

- DNV GL Healthcare USA, Inc. will acknowledge receipt of the Corrective Action Plan and request any clarifications or additional information requirements, with timelines for re-submission, OR declare acceptance of the submitted Corrective Action Plan. DNV GL Healthcare USA, Inc.’s final approval of Corrective Action Plans for a survey requires complete submission of Corrective Action Plans for all nonconformances identified on the final report.

**Condition Level Findings**

All Condition Level Findings not involving Immediate Jeopardy will require an unannounced follow-up survey within sixty (60) calendar days of the last day of the survey in which the nonconformance was identified.

**Challenge of a Nonconformance Finding on the Final Report**

- If the organization wishes to challenge a specific finding or nonconformance issued on the final report, the request for an additional review shall be submitted in writing. The challenge shall be submitted after receipt of the final report and as part of the corrective action plan (CAP) submission, within the same ten (10) calendar days. The organization shall submit supporting evidence, including the details of the organization’s internal review, to be reviewed as part of the DNV GL CAP review process. In line with the NIAHO® Accreditation Process consistent with the expectations of CMS, all nonconformances identified during the survey will be cited when supporting information is not presented to the surveyor to verify compliance during the on-site survey.

- To protect your organization as the covered entity, and DNV GL 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.
Corrective Plan Implementation and Objective Evidence Submission

- The organization is required to submit corrective action plan(s) for all Category 1 Nonconformities and Category 2 Nonconformities on the final report and is expected to implement corrective action plans within sixty (60) days post survey activity. When this is not feasible DNV GL 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, milestones and justification for the extended implementation plan must be included in the CAP submission.

- For Category 1 Nonconformities, within sixty (60) business days of DNV GL Healthcare USA, Inc. communication to the organization of the final CAP approval, the customer shall submit performance measure(s) data, findings, results of internal reviews (internal audits), or other supporting detail, including timelines to verify implementation of the corrective action measure(s). This due date will be assigned and provide to the Organization once all corrective action plans, and any applicable follow up survey, have been completed.

- For Category 2 Nonconformities, if the corrective action plan(s) requirements are met including submission and approval within the required timelines outlined above, validation of effective implementation of the agreed corrective action plan will take place at the next annual survey.

General Instructions for Objective Evidence Submission

Provide 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). Documentation should also include, as applicable:

1. Policy name and number / version, approval date & approved by
2. Date education completed, % of education completed, plans for staff who did not complete education, including current staff, new hires and plans for ongoing competency
3. Internal Audit (IA): objective evidence should reference the audit schedule including the cycle or time period for which it covers (i.e. 2017, 2017-2018, etc.), audit titles or key processes covered, date(s) audits were conducted, date(s) IA findings were addressed/followed up, CAP validation date, etc.
4. Management Review: meeting dates, summarized information that addresses the inputs and outputs as required

Providing dates, internal file titles and numbers (i.e. policy number, form number, etc.), and titles of those involved in the implementation are key. The objective evidence 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 IA to attest to implementation of the corrective action.

DNV does not review or request the submission of specific policies, procedures 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.

Questions, concerns or additional information or clarification

The client drop box remains the central source for questions related to the Organization’s account including standards interpretation and report submittals and will ensure inquiries are routed appropriately. Direct specific questions to the DNVClientDropBox@dnvgl.com email account.

Clients may also request or download a copy of the DNV GL NIAHO® Accreditation Program Accreditation Process.

Note: The tutorial below is provided for the NIAHO® Accreditation Program but may be followed for submission of corrective plans for Certification programs offered by DNV GL Healthcare, as applicable to the Organization.
Organization:

Survey Date:  
Survey type: 
DNV GL Project #: 

Report Date:

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

CAP received date:

Total Number of Nonconformities:  ____ NC-1 Condition Level  ____ NC-1  ____ NC-2

The Organization must complete the Corrective Action Plan in the section(s) below marked “Organization Response.” DNV GL 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.

The Corrective Action Plan submission must:

- 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 (generally 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.

The Organization is expected to implement corrective action plans within sixty (60) days post survey activity. When this is not feasible DNV GL 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, milestones and justification for the extended implementation plan must be included in the Date of Implementation section(s) below.

NOTE: CMS has specifically determined that all Life Safety Code® (LSC) nonconformance(s) must be corrected within sixty (60) calendar days of the last day of survey in which the finding was identified. All 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) by submitting a waiver request within the Corrective Action Plan submission below.

DNV GL’s collaborative review of a Time-Limited Waiver request is treated as a survey follow-up activity. The review may result in a recommendation to the CMS Regional Office that the waiver be granted or may result in no
recommendation. DNV GL processes Time-Limited Waiver requests for LSC nonconformances on behalf of CMS. However, the CMS Regional Office has exclusive authority to grant Time-Limited Waivers.

Additionally, CMS has specifically determined that all nonconformances related to ligature risks must be corrected within sixty (60) calendar days of the last day of survey in which the finding was identified. The ability of hospitals to achieve compliance related to ligature risks within the expected number of days allotted for the correction may be burdensome based on a number of variables. Therefore, CMS has outlined a Ligature Risk Extension Request (LRER) process for hospitals to request additional time to address ligature risks.

Deemed hospitals must submit the LRER request to the AO as soon as the hospital identifies that more than sixty (60) calendar days are needed for necessary changes. The LRER must include the corrective action plan, mitigation plan that ensures patient safety, and how the evaluation of the effectiveness of the mitigation plan will occur. The LRER must also include a rationale for why it is not reasonable to meet the required compliance timeframe.

Please note, compliance with ligature risks requirements are not eligible for life safety code waivers as they are not life safety code deficiencies.

As a requirement of the NIAHO® Accreditation Program Accreditation Process: “For Category 1 Nonconformities, within sixty (60) [business] days (of notification to the client) of DNV GL Healthcare USA, Inc. acceptance, the customer shall submit performance measure(s) data, findings, results of internal reviews (internal audits), or other supporting detail, including timelines to verify implementation of the corrective action measure(s).” If the hospital audit identifies continued noncompliance (<100%) the hospital should include additional planned actions to address the nonconformance identified during monitoring. This due date will be assigned by DNV GL Healthcare in the section above once a final approved Corrective Action Plan has been received and processed.
### Organization:

<table>
<thead>
<tr>
<th>NC Number</th>
<th>Process or Standard</th>
<th>Nonconformance category</th>
<th>DNV GL requirement(s) and other applicable standard(s)</th>
<th>CMS CoP reference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NC-1 Condition Level</td>
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<td></td>
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<td>NC-1</td>
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<td>NC-2</td>
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#### Requirement (Description):

The requirement was NOT MET as evidenced by the following:

#### ORGANIZATION RESPONSE

The responses below should clearly address all reported elements of the nonconformance and/or all individual Findings identified in the nonconformance, with separation of response for each Finding identified in the subsequent section below.

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 impact on other processes to use in formulating the corrective action(s).

This section should include the identification and understanding as to why the nonconformity was present within the organization. To ensure continual improvement and a sustainable quality management system (QMS) the organization should take time to analyze why the nonconformance(s) occurred. Understanding why the nonconformity was present should assist your organization in the development of an effective Corrective Action Plan and Quality Management System and sustainable compliance.

Example:

**Finding**: Organization not following policy; nonconformances identified
**Cause**: Inadequate education re: changes made to the policy, policy not communicated to all areas via email, revised policy had not been updated on the intranet.

#### 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;

This section should address the actions taken to correct the specific nonconformity identified in the report as well as include the organization’s hospital wide actions and corrective plans when nonconformances have been identified in one area of the hospital (or off-site location), with the potential to have an impact on other areas of the hospital (or off-site location). If the organization has determined that no other areas, off-site location and/or processes have
the potential to be impacted, this should also be stated.

<table>
<thead>
<tr>
<th>Staff Training/Education Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Identify the process or system changes that will be made to ensure that the nonconformity does not recur, including a staff training/education plan.</td>
</tr>
<tr>
<td>✓ Training/education should be addressed for all areas of the hospital (or off-site locations) in which the nonconformity may (re)occur.</td>
</tr>
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</table>

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

This section should include both short term and long-term training and education plans as well as inclusion into new employee orientation, as applicable. While it is understood that revision and implementation may be complex and require additional time until formal training can be conducted, in some instances, more immediate staff communication should be outlined in the CAP submission. This interim communication would bring the practice towards compliance while working towards an extended formal training date for improved compliance with the standard requirements.

Example: staff meetings, email or newsletter communications provided to staff post survey while formal education is being developed and the plan to incorporate the training into new employee orientation and annual training, as applicable.

<table>
<thead>
<tr>
<th>Person and/or Function responsible for implementation of Corrective Action Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This section may include the name(s) and/or the title for the person(s) responsible for implementation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date for implementation of Corrective Action Plan:</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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. * 

<table>
<thead>
<tr>
<th>Date(s) CAP will begin</th>
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<tbody>
<tr>
<td>This section should 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.</td>
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</table>

Example: Leadership met to discuss nonconformance identified MM/DD/YY; Task team established MM/DD/YY

<table>
<thead>
<tr>
<th>Date(s) Projected Completion / Compliance with the Standard Requirements (generally within 60 days of survey end date)*</th>
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<tbody>
<tr>
<td>This section should include the organization’s projected completion dates, to include process changes, education and corrections to the identified nonconformance. With the exception of the Life Safety Code and ligature risks outlined above, these dates should generally be within 60 days of the survey end date, with allowance outside that range when details are presented including interim, short term and long-term compliance plans.</td>
</tr>
</tbody>
</table>

Example: projected completion MM/DD/YY; completed MM/DD/YY; training will be completed by MM/DD/YY

<table>
<thead>
<tr>
<th>Specific Date(s) for completion of actions taken since survey end date</th>
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<tbody>
<tr>
<td>This section should include the date(s) for those actions and corrections the organization has already taken prior to submission.</td>
</tr>
</tbody>
</table>

Example: policy revised MM/DD/YY; staff communication sent/staff meeting MM/DD/YY; Finding #1 corrected MM/DD/YY
### 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.

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

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.

| 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) for 3/6/9/12 months, including planned actions for any continued nonconformance identified during monitoring. |