

PROEDGE FM NEWSLETTER

Volume 1, Issue 3: August 2026

A Message from PROEDGE FM's President

Welcome to the third issue of the PROEDGE FM newsletter. This early fall brings two exciting milestones: the relaunch of our website and a new webinar series featuring Jim Kendig, VP of Compliance Services. Prior to joining PROEDGE FM, Jim served as Field Director for the Life Safety Code Surveyors/Engineers at Joint Commission, where he oversaw half of the surveyors specializing in life safety, physical environment, and emergency management standards. That experience translates directly into the guidance he brings to our clients—guidance that reflects our larger purpose.

This issue focuses on regulatory compliance and survey readiness support for accreditation and regulatory bodies such as the Joint Commission, DNV, ACHC, and CMS. Each article addresses real-world questions and challenges our experienced teams encounter regularly in the field.

Jim Kendig examines why water management remains a critical focus for survey readiness, a topic he'll expand on at the Midwest Healthcare Engineering Conference & Trade Show. We encourage attendees to join his session.

Next, Scott B. Cormier, Vice President of Emergency Preparedness at the Virginia Hospital & Healthcare Association, offers strategies to reduce workplace violence in healthcare, a subject that speaks to the broader safety mandate every facility carries.

Then, Ken McGraw, Senior Consultant, tackles a nuanced question from the field: how to handle Life Safety Code deficiencies identified outside a survey that cannot be corrected within the standard 60-day window. Drawing on more than 37 years of experience and direct clarification from Joint Commission, he lays out the practical options for staying compliant.

Our team looks forward to an opportunity to continue conversations on these and other important topics. Let us know if there is a question or article idea you'd like us to cover in a future issue, and we thank you for your continued readership and interest.

Sincerely,
Karim Bhimani
President
PROEDGE FM

What's New

A Message from PROEDGE FM's President

Water Management

Reducing Workplace Violence

Ask the Expert

LS Work Orders Requiring >60 Days to Address

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Why Water Management Remains a Critical Focus for Survey Readiness

By Jim Kendig

Joint Commission Water Management Requirements | Reminder: (D) indicates documentation is required

Standard update: Water management program requirements moved from EC.02.05.02 to PE.04.01.05. The Elements of Performance have not changed.

Water may seem like one of the most basic utilities in a healthcare facility, but when it is not properly managed, it can become a significant patient safety risk. From Legionella outbreaks to stagnant water in unoccupied patient care areas, healthcare organizations continue to face challenges that can have serious clinical, regulatory, and legal consequences.

Recognizing the importance of effective water management, Joint Commission recently relocated its water management requirements from EC.02.05.02 to PE.04.01.05. While the location of the standard has changed, the expectations themselves remain the same. Hospitals are still required to

maintain a comprehensive water management program designed to identify and control risks associated with Legionella and other waterborne pathogens.

The water management program must be maintained in accordance with applicable law and regulation, and organizations should be prepared to show how the program addresses both the operational and documentation expectations of the standard.

Accountability: The Foundation of the Program

EP 1 | CoPs: 482.41(d)(2); 482.42(a)(3)

At the heart of the program is accountability. The Joint Commission expects organizations to designate an individual or multidisciplinary team responsible for overseeing the development, implementation, management, and ongoing maintenance of the water

management program. This team serves as the foundation for ensuring that water safety practices are consistently applied throughout the organization.

Mapping the Water System and Assessing Risk

EP 2 (D) | CoPs: 482.41(d)(2); 482.42(a)(3)

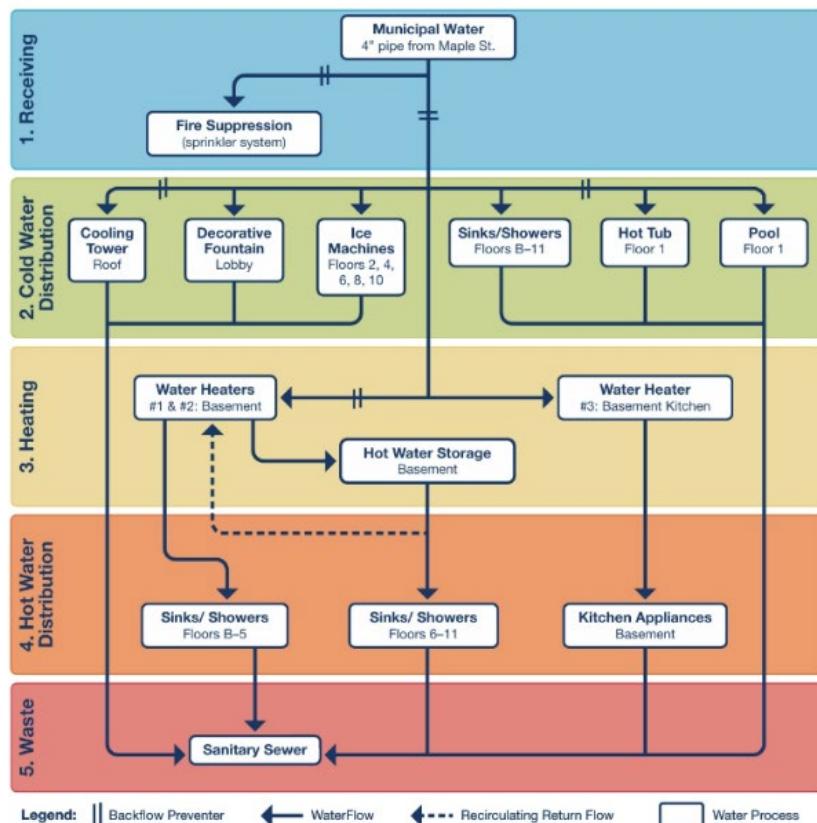
One of the first responsibilities of the water management team is developing a detailed understanding of how water moves through the facility. Hospitals are expected to create a basic diagram that maps all water supply sources, treatment systems, processing steps, control measures, and end-use points such as sinks, showers, water fountains, ice machines, and other water outlets.

The CDC provides an excellent example of a building water system flow diagram:

2 Describe Your Building Water Systems Using a Flow Diagram

EXAMPLE: BUILDING A

In addition to developing a written description of your building water systems, you should develop a process flow diagram. Below is an example of a process flow diagram for Building A. Note that this diagram does not need to be as detailed as your building plans. In fact, it's best if the process flow diagram can be understood easily by all members of your team.



Original graphic from the source article: CDC example of a building water system flow diagram

Once the water system is mapped, organizations must evaluate each stage of the system to identify physical and chemical conditions that could promote the growth of waterborne pathogens. Particular attention should be paid to locations where water may move slowly or become stagnant. The CDC's Water Infection Control Risk Assessment

(WICRA) for Healthcare Settings tool can be used as an example for conducting a water-related risk assessment.

The program should also include a plan for addressing the use of water in areas of the building where water may have been stagnant for a period of time, including unoccupied

spaces, temporarily closed areas, or locations awaiting occupancy.

A Case Example: Mount Carmel Health System

The importance of these efforts is highlighted by the Legionella outbreaks that occurred within the Mount Carmel Health System in 2019. The most significant outbreak occurred at Mount Carmel Grove City, where 16 patients contracted Legionnaires' disease and one patient died. Investigations revealed that the bacteria originated from the hot water system due to inadequate disinfection before the hospital opened.

Officials confirmed that although the water lines were disinfected in February 2019, they were not re-disinfected before the hospital's official opening in late April. This lapse allowed bacteria to grow within the system. The outbreak resulted in public health orders, a wrongful-death lawsuit, and multiple negligence lawsuits filed by affected families and patients.

Identifying Vulnerable Patients and Monitoring Controls

EP 2 (D) continued | See also IC.04.01.01, EP 2

The water management program must also include an evaluation of the patient population served to identify patients who are

immunocompromised. This step is important because patients with weakened immune systems may be at greater risk from Legionella and other waterborne pathogens.

Monitoring protocols and acceptable ranges for control measures are another critical component of a successful program. Hospitals should consider incorporating basic practices for water management, including monitoring of water temperature, residual disinfectant, and pH. Protocols should specify the parameters measured, the locations where measurements are made, and the appropriate corrective actions to take when parameters are outside the acceptable range.

Managing Results and Corrective Actions

EP 3 (D) | CoPs: 482.41(d)(2) | See also PE.07.01.01, RP 1

Documentation is central to demonstrating that the program is functioning as intended. The individual or team responsible for the water management program must manage the documentation of all monitoring activities, including results, corrective actions, and procedures to follow when a test result is outside acceptable limits.

Corrective action procedures should also address situations in which a probable or confirmed waterborne pathogen indicates that action is necessary. When control limits are not maintained, organizations must

document the corrective actions taken. For additional guidance on monitoring, reporting, and investigating utility system issues, organizations should also refer to PE.07.01.01, RP 1.

Annual Review and Changes to the Water System

EP 4 (D) | CoPs: 482.41(d)(2)

Surveyors will also expect organizations to demonstrate an ongoing commitment to program effectiveness. The individual or team responsible for the water management program must review the program annually and whenever changes are made to the water system that could add risk.

This review is also required when new equipment or an at-risk water system is added that could generate aerosols or become a potential source for Legionella. This includes the commissioning of a new wing or building, as illustrated by the Mount Carmel example.

Important Guidance Notes

Joint Commission and CMS do not require culturing for Legionella and other waterborne pathogens. Testing protocols are at the discretion of the hospital unless required by law or regulation.

Organizations should also consult ASHRAE Standard 188-2018, Legionella Risk Management for Building Water Systems; the CDC toolkit, Developing a Water

Management Program to Reduce Legionella Growth and Spread in Buildings; and ANSI/ASHRAE Guideline 12-2020, Managing the Risk of Legionella Associated with Building Water Systems, for additional guidance on creating and maintaining a water management plan.

Survey Readiness Tip

This standard and its Elements of Performance (EP) will be reviewed during the document review session. Because many organizations use third-party vendors and water management plans can span hundreds of pages, organizations should clearly highlight where the plan meets each standard and EP requirement. Organizations should also remember to reference relevant S&C and QSO memos from CMS.

Acknowledgment

Thanks to Tim Markijohn, Jim Kendig, Herman McKenzie, and members of the DSSM team for creating this standard and corresponding EP.



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STRATEGIES

TO REDUCE WORKPLACE VIOLENCE IN HEALTHCARE



By Scott B. Cormier

Workplace violence can occur at any time, in any setting, and in many forms—from verbal threats to physical assault. Healthcare environments remain particularly vulnerable due to high-stress interactions, behavioral health challenges, and unrestricted public access. National data continues to show that a significant percentage of healthcare workers will experience violence during their careers.

The question is no longer **if** it will occur, but how prepared your organization is to prevent, respond to, and recover from it.

Reducing workplace violence requires more than policies or one-time training. It demands a coordinated, sustained, and system-wide approach. The following 10 strategies reflect current best practices to help healthcare organizations strengthen safety, resilience, and accountability.

1. LEAD FROM THE TOP

Effective programs begin with visible and sustained executive leadership commitment. Leaders must do more than fund initiatives; they must

actively champion safety, model expected behaviors, and integrate workplace violence prevention into organizational priorities, culture, and performance metrics.

2. ESTABLISH A MULTIDISCIPLINARY GOVERNANCE STRUCTURE

Create a formal Workplace Violence Prevention or Crisis Management Team that includes clinical leadership, security, HR, behavioral health, risk management, and external partners such as law enforcement. This team should drive policy, oversee incident review, and provide strategic guidance.

3. IMPLEMENT CLEAR, IMMEDIATE COMMUNICATION PROTOCOLS

During an incident, seconds matter. Use plain-language alerts and standardized communication protocols that are simple, direct, and actionable. Research shows that clear information reduces confusion and improves response—not panic.

4. INTEGRATE VIOLENCE PREVENTION INTO EMERGENCY OPERATIONS

Workplace violence planning should not exist in isolation. Align protocols with your Emergency Operations Plan (EOP) to ensure seamless activation of incident command when needed and consistent coordination across all hazards.

5. TRAIN THE ENTIRE WORKFORCE—NOT JUST CLINICAL STAFF

Every employee plays a role in prevention and response. Training must extend beyond clinicians to include frontline support roles such as registration, environmental services, and food service staff. Tier training across:

- Awareness and recognition
- De-escalation techniques
- Personal safety and response actions

Make training ongoing and competency based.

6. STANDARDIZE DEFINITIONS AND RESPONSE ACTIONS

Ambiguity creates risk. Clearly define key terms such as:

- Lockdown (full, partial, no entry, no exit)
- Shelter-in-place
- Evacuation
- Active threat

Ensure staff understand exactly what each term means and what actions are required in different scenarios, especially in complex, multi-building campuses.

7. PRIORITIZE PRACTICAL SKILLS AND DRILLS

Move beyond theory. Conduct regular drills and simulations that include:

- De-escalation scenarios
- Escape and evacuation routes
- Barricading and sheltering techniques

Repetition builds muscle memory and improves real-world response under stress.

8. STRENGTHEN COMMUNITY AND PUBLIC SAFETY PARTNERSHIPS

Violence response is a shared responsibility. Coordinate with local law enforcement, EMS, and neighboring healthcare facilities to align:

- Response protocols
- Communication channels
- Facility access and mapping

Pre-established relationships improve speed and coordination during real incidents.

9. USE DATA TO DRIVE CONTINUOUS IMPROVEMENT

A mature program relies on data. Track and analyze:

- Incident frequency and type
- Injury severity
- Location and timing patterns
- Near misses

Create a culture where staff feel safe reporting incidents. Use findings to refine policies, training, and environmental controls.

10. SUSTAIN AND EVOLVE THE PROGRAM

The biggest challenge is not implementation—it's long-term sustainability. Maintain momentum through:

- Regular team meetings and oversight governance
- Continuous training and refresher education
- Staff feedback mechanisms
- Ongoing policy and process updates

Workplace violence prevention must remain a living, adaptive program—not a static initiative.

FINAL THOUGHT

Workplace violence is a complex and persistent threat in healthcare, but it is also preventable and manageable with the right systems in place. Organizations that invest in leadership ownership, workforce engagement, and continuous improvement will not only reduce risk, but also strengthen trust, staff retention, and overall resilience.



Ask the **EXPERT**

The Kitchen Tracer

The Kitchen Tracer Survey Guide was originally developed several years ago by Patsy Buckberg, our very own Jim Kendig, and a military fellow to help both clinical and Life Safety Code surveyors assess kitchen areas.

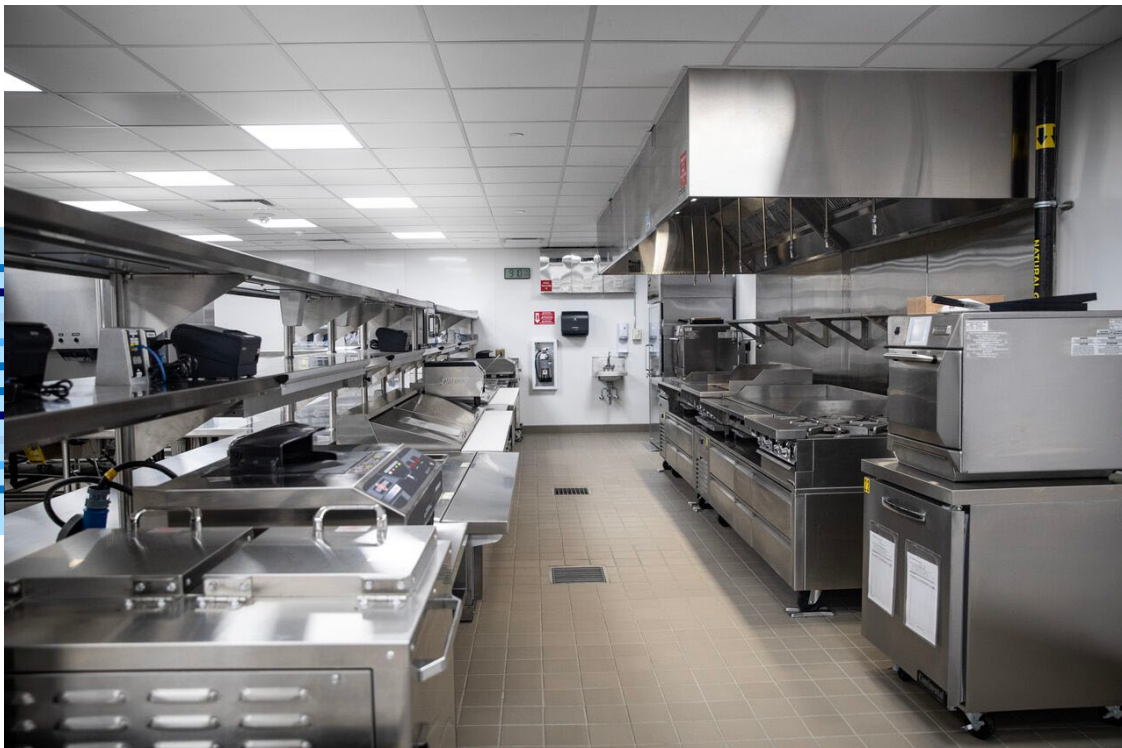
 Since the original 2016 version, the checklist has grown into a more

robust document. It's still split into two parts: the first half is evaluated mostly by the clinician, and the second half by the Life Safety Code surveyor (and it's annotated as such).

 In the field, the Life Safety Code Field Directors ensure the checklist is being used during observations.

 You can find the Kitchen Tracer Survey Guide in the Joint Commission Survey Process Guide on page 589.

 To set yourself up for success, consider using the same survey guide that surveyors use during your mock surveys!



What's the best action to take when Life Safety work orders can't be completed within 60 days?



By Ken McGraw

Over the past weeks, I have been asked a question relating to Life Safety Code (LSC) deficiencies that are not identified during an actual Joint Commission survey. These deficiencies are identified through normal operations, testing and maintenance of fire alarm, fire suppression systems, and any other type of deficiencies that could be categorized as LSC deficiencies, and cannot be corrected within 60 days of identification.

Typically, LSC deficiencies identified during an actual survey are assessed at the time of identification for any ILSM requirements, and if not corrected immediately, must be

corrected within 60 days following the last day of survey. These deficiencies are noted as Survey Related PFIs (SPFIs) and must be placed on the Statement of Conditions page, under the SPFI section for completion of a plan for improvement.

The question that has been posed to me is this: **“What about identified LSC deficiencies that are not a part of an actual survey, but cannot be corrected within 60 days. Do they fall under the same requirements as the SPFI?”**

What raised this question was a comment made by an organization where a Joint Commission LSC Surveyor asked for a listing of open Life Safety work orders looking for items exceeding the 60-day limit. It is not confirmed by the author of this article what, or if any, findings were noted relating to work orders greater than 60 days.

In the numerous Joint Commission surveys that I have been through over 37 years, and during my time spent as a Life Safety Surveyor, I have never known of a surveyor asking for a listing of open Life Safety work orders. If this truly did occur, it would be a very unusual request,

unless there was a specific reason for the request.

I didn't want to come to any conclusions on this without first contacting the Joint Commission for some level of clarification. I submitted a question to the Joint Commission for clarification and did get an immediate response:

“You can submit a non-survey related Plan for Improvement (PFI). On the Statement of Conditions page, under the SPFI section, you would create a new survey related plan for improvement.

<https://apps.jointcommission.org/SOC/Documents/SPFI%20Instructions.pdf>. They will direct you on how to complete a plan for improvement that is not survey related.”

This did not provide me with enough clarification. I asked this question to other previous surveyors. The information I received is LS Surveyors are not trained or asked to request listings of open LS work orders. Additionally, LS surveyors are not trained for this level of review since there is no requirement for this type of work order submission. It appears that if this did occur, it may have been the action of a specific

surveyor and not a normal or expected request.

What is the best action to take when LS work orders cannot be completed within 60 days?

There are only two options:

1. Complete and document a very thorough ILSM assessment of the deficiency and implement any required mitigating initiatives
 - a. Ensure any LS deficiencies that cannot be immediately corrected are assessed for any required ILSM initiatives.
 - b. This ILSM assessment and implementation must be policy driven and based upon the organization's ILSM Plan. Following your plan is essential because you will be surveyed to what your plan says.
 - c. Document all actions taken to mitigate any risks identified. Remember, Just saying that something was done is not verification, it must be documented.
2. Continue working on the corrective actions. If the corrective action cannot be completed prior to an actual survey and is cited during the

survey, create a Survey Related PFI for review and approval. If the corrective action still cannot be completed within 60 days, go through the process of requesting an extension for up to 1 year. Note: This request should be submitted at the 45-day mark to ensure sufficient time to process your request through and forwarded to CMS for review and approval.

Summary

Typically, surveyors are there to assess, provide information, and educate your facility. There are times when surveyors can be subjective as well as being consistent with the survey process and requirements as well as interpretation of the standards. I would only suggest this, if a surveyor makes a request that seems somewhat out of the normal, does not agree with a process that has made it through numerous previous surveys, I would suggest asking the surveyor to clarify the request as to the requirement and standard interpretation. Surveyors do not mind when they are asked to clarify a particular finding.

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