

Capabilities Document

Movable Medical Equipment Disinfection, Linen & Textile Management, and Commercial Healthcare Environmental Services

On January 1, 2026, environmental services staffing adequacy became a governing body accountability. Under **IC.05.01.01, EP 1**, the board must allocate human resources to mitigate infection risk, and the standard names the example itself: **“nursing and environmental services staffing must be adequate to carry out infection prevention and control activities.”** On the same date, the written management plans that let a facilities director evidence compliance with a binder were retired for hospitals and critical access hospitals. What remains is the condition of the space, the condition of the equipment in it, and the documented competency of the person who cleaned both. **That is a labor problem**, and labor is what RVP sells.

Board exposure

EVS staffing adequacy,
IC.05.01.01, EP 1

Named devices

cuffs, ECG leads, tourniquets,
oximeter probes

Orphan scope

equipment no department
currently owns

Evidence

produced at the point
of work, not stored

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Executive summary: the burden moved to labor

The 2026 reset converted a documentation burden into an operational one — and put the staffing model in front of the board.

The business case, in one element of performance

Every other argument in this document is downstream of a single requirement. Under **IC.05.01.01, EP 1**, the governing body must ensure the infection prevention and control program is resourced, including — and this is the standard's own illustration, not our gloss — “allocating human resources to mitigate infection risks and prevent transmission of infections (for example, **nursing and environmental services staffing must be adequate to carry out infection prevention and control activities**).”

EVS and equipment-cleaning headcount is no longer a budget line. It is a board exposure.

The Joint Commission has placed environmental services staffing adequacy alongside nursing staffing adequacy as a governing body infection prevention obligation. An organization cannot cut cleaning labor to a price point and treat the consequence as a vendor performance issue — the adequacy of the model is the board's exposure. RVP will not bid a model it cannot defend against this standard, and we will state the productivity basis, the equipment census, and the cleaning-time assumptions in writing.

Why the burden moved

Before 2026, physical environment compliance could be evidenced with a document. Written management plans for safety, security, hazardous materials and waste, utilities, and medical equipment were the artifact produced at survey. As of January 1, 2026, those plans are no longer required for hospitals and critical access hospitals; only the fire response plan, water management program, and emergency operations plan are still evaluated. Remove the binder and what remains is the condition of the space, the condition of the equipment in it, and the competency of the person who cleaned both. Compliance became **a state maintained continuously at the point of work**, and states are maintained by people.

We say that against our own interest, because the alternative pitch does not survive scrutiny. The 709-page Survey Process Guide is published openly, and The Joint Commission's own hospital program Field Director calls it an open-book test. Nobody should pay a vendor for access to a free document. What an organization cannot download is the trained, supervised, documented workforce that turns the open book into a passed survey. **We are not selling standards literacy. We are selling the labor that produces the evidence.**

Four scopes, one accountability

RVP delivers four capabilities that are normally split across vendors and therefore normally fall between them: **movable medical equipment disinfection, linen and textile management, commercial healthcare environmental services, and construction turnover and activation cleaning**. Each is a scope most organizations discover they do not actually own until a surveyor asks who cleans the blood pressure cuff, who verified the negative pressure in soiled textile receiving, or who signed off before the barriers came down.

For orientation: what changed structurally

Before 2026	As of January 1, 2026
Environment of Care chapter (19 standards, 189 EPs) and Life Safety chapter (24 standards, 284 EPs), plus Emergency Management	Physical Environment chapter: 8 standards, 59 EPs. Emergency Management remains a separate chapter. Total across both drops from 58 standards and 532 EPs to 21 and 90.
Approximately 1,551 hospital standards	Approximately 774 hospital standards — a reduction of roughly half.
National Patient Safety Goals (NPSG.xx)	14 National Performance Goals (NPG.xx), for hospitals and critical access hospitals. Other programs — ambulatory, behavioral health, home care, laboratory, nursing care center, office-based surgery — retain the NPSGs.
Written EC management plans for safety, security, hazardous materials and waste, utilities, and medical equipment	Not required for hospitals and critical access hospitals. Ambulatory organizations still require them. Three plans remain evaluated at survey: fire response, water management, emergency operations.
Survey Activity Guide (SAG)	Survey Process Guide (SPG) for hospital and CAH programs — 709 pages, published openly, effective January 1, 2026. SAGs remain for other programs.
Infection control cited as IC.02.02.01 and NPSG.07 series	Infection Prevention and Control chapter renumbered: IC.04.01.01 (program), IC.05.01.01 (leadership and resources), IC.06.01.01 (implementation, surveillance, environmental cleaning). Hand hygiene moves to NPG.05.03.01 . Surgical and procedural cleaning moves to LD.13.01.09 .

“All we have done is use the existing formats of our tools and change the nomenclature to reflect the new standards. What we are evaluating hasn’t changed.”

Jim Grana, Field Director, Hospital Program, The Joint Commission

The requirements did not soften. The numbering changed, the documentation wrapper came off, and the evidentiary burden moved to the point of work. Every citation in this document is drawn from a primary 2026 source and footnoted with a live URL at each section break. That is a testable claim, and we invite the test.

Sources for this section

- 2026 Hospital Survey Process Guide, The Joint Commission — Infection Prevention and Control Program Assessment Tool (pp. 605–619), source of IC.05.01.01, EP 1 as quoted. <https://digitalassets.jointcommission.org/api/public/content/64731897e3d94ca69e54042c2e27d9c6?v=19446f24>
- Joint Commission shifts to Physical Environment standards for 2026 — standard and element-of-performance counts. <https://www.compquail.com/articles/the-joint-commission-shifts-to-physical-environment-standards-for-2026>
- 2026 Hospital National Performance Goals, The Joint Commission. <https://www.jointcommission.org/en-us/standards/national-performance-goals>
- Are Joint Commission Environment of Care management plans still required? — Health Facilities Management. <https://www.hfmmagazine.com/are-joint-commission-environment-care-management-plans-still-required>
- The Survey Process Guide: your open-book test for Accreditation 360 — Healthcare Facilities Network. <https://healthcarefacilitiesnetwork.com/insights/the-survey-process-guide-your-open-book-test-for-accreditation-360>

Citation crosswalk

The retired reference, the current reference, and the exact requirement now in force.

This is the operative table in the document. If a client is comparing vendor materials, this is the page to compare.

Capability	Retired citation	2026 citation	What the 2026 requirement actually says
Environmental cleaning and surface disinfection	IC.02.02.01, EP 1–2	IC.06.01.01, EP 3	Routine and targeted cleaning as indicated by level of patient contact and degree of soiling, using an EPA-registered disinfectant. High-touch surfaces — bed rails, over-bed table, bedside commode, bathroom lavatory surfaces — cleaned and disinfected more frequently than minimal-touch surfaces.
Product use per label	IC.02.02.01, EP 2	IC.06.01.01, EP 3	Cleaners and disinfectants, including disposable wipes, used in accordance with manufacturers' instructions — dilution, storage, shelf life, and contact time.
Cleaning textiles	IC.02.02.01, EP 3	IC.06.01.01, EP 3	Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques.
Blood and OPIM spill response	IC.02.02.01, EP 1	IC.06.01.01, EP 3	Spills of blood or other potentially infectious material are promptly cleaned and decontaminated using an appropriate EPA-registered hospital disinfectant.
Hand hygiene program	NPSG.07.01.01	NPG.05.03.01, EP 1	A hand hygiene program following categories IA, IB, and IC of current CDC and/or WHO guidelines, with goals set and compliance improved against those goals.
Multidrug-resistant organism risk	NPSG.07.03.01	NPG.05.01.01, EPs 1–2	The hospital identifies risks for infection, contamination, and exposure — including CRE, <i>Candida auris</i> , norovirus, RSV, influenza, measles, and community MDRO data — and reviews those risks at least annually or when risk changes significantly.
Surgical site infection and procedural cleaning	NPSG.07.05.01	LD.13.01.09, EP 6	Horizontal surfaces damp dusted before the first procedure of the day with a clean lint-free cloth and an EPA-registered detergent or disinfectant. High-touch surfaces cleaned and disinfected between patients. Operating rooms terminally cleaned after the last procedure of the day, including weekends, and each 24-hour period during the work week, including wet-vacuuming or mopping the floor with an EPA-registered disinfectant.
Reusable noncritical device disinfection	NPSG.07.05.01 / IC.02.02.01	LD.13.01.09, EP 6	Reusable noncritical items — the standard names blood pressure cuffs, ECG leads, tourniquets, and pulse oximeter probes — are cleaned and disinfected between patients.
Clean and orderly premises	EC.02.06.01, EP 20	PE.01.01.01, EP 3	The hospital's premises are clean and orderly — an uncluttered physical environment where patients and staff can function, including storing equipment and supplies in their proper spaces, attending to spills, and keeping areas neat.
Safe furnishings and equipment condition	EC.02.06.01, EP 1	PE.01.01.01, EPs 1–2	The building is maintained for the safety and well-being of patients; furniture is safe and in good repair. Torn upholstery, exposed foam, and cracked surfaces are cited as barriers to effective cleaning and disinfection.
Chemical safety, SDS, eyewash	EC.02.02.01, EPs 1, 3, 5, 6	PE.02.01.01, EPs 1, 2, 4	Written, current hazardous materials and waste inventory; permits, licenses, manifests, and safety data sheets; policies protecting patients and staff from exposure, including precautions and PPE, and eyewash provision where the safety data sheet requires it.
Waste handling	EC.02.02.01, EP 9	PE.02.01.01, EP 6	Procedures for the proper routine storage and prompt disposal of trash and regulated medical waste.

Capability	Retired citation	2026 citation	What the 2026 requirement actually says
Corridor, storage, and sprinkler discipline	LS.02.01.10 / LS.02.01.30	PE.03.01.01, EP 3	Life Safety Code compliance: corridor clutter, door latching and undercuts, sprinkler head clearance of 18 inches, heads undamaged and clean, escutcheon plates installed.
ABHR dispenser placement	EC.02.03.05 / NPSG.07	PE.03.01.01, EP 7	Dispensers installed to protect against inappropriate access: clear of ignition sources, minimum four-foot horizontal separation, corridor clear width preserved, aggregate quantity limits per smoke compartment.
Job-specific IPC training and competency	HR.01.05.03 / IC.01.05.01	HR.11.03.01, EP 1 HR.11.04.01, EP 1	Job-specific infection prevention training with staff records confirming completion, including practical application. The standard's own example: environmental services staff must be trained in the methods and procedures for surface disinfection. Competency defined and assessed, job-specific.
Security-sensitive area access	EC.02.01.01, EP 7	NPG.11.01.01, EP 1	The hospital controls access to and from areas it identifies as security sensitive.
Clinical alarm safety	NPSG.06.01.01	<i>Not in scope</i>	This is a clinical requirement and was never environmental services scope. It has been removed from this document rather than remapped.

Scope caveat that matters commercially. The Physical Environment chapter and the National Performance Goals apply to the **hospital and critical access hospital programs only**. Ambulatory care, behavioral health, home care, laboratory, nursing care center, and office-based surgery organizations still operate under the Environment of Care structure, still maintain written management plans, and still follow the National Patient Safety Goals with a 2026 Environment of Care matrix. A vendor serving a mixed portfolio needs both vocabularies, correctly separated. RVP maintains both.

Sources for this section

- 2026 Hospital Survey Process Guide, The Joint Commission — Infection Prevention and Control Program Assessment Tool (pp. 605–619), Building Tour Guidance Document (pp. 596–604), Kitchen Tracer Survey Guide (pp. 589–595), Physical Environment Evaluation Module (pp. 250–267) and Document List and Review Tool (pp. 522–537). <https://digitalassets.jointcommission.org/api/public/content/64731897e3d94ca69e54042c2e27d9c6?v=19446f24>
- 2026 Hospital National Performance Goals, The Joint Commission. <https://digitalassets.jointcommission.org/api/public/content/8d49c3ffa9934ffda2ff83b5ad860ea7?v=aee10901>

Movable medical equipment disinfection

The standard now names the devices. There is no interpretive room left.

Movable medical equipment is the most reliably orphaned scope in a hospital. Nursing assumes environmental services owns it. Environmental services assumes clinical engineering owns it. Clinical engineering owns the calibration, not the disinfection. The equipment moves between patients, departments, and floors, and the cleaning record moves with nobody.

As of 2026 the requirement is not ambiguous. **LD.13.01.09, EP 6** states that reusable noncritical items are cleaned and disinfected between patients, and it names them: blood pressure cuffs, ECG leads, tourniquets, and pulse oximeter probes. The January 2026 *Perspectives* reinforces the point from the observation side — among the leading clinical opportunities for improvement is reducing healthcare-associated infections, with surveyors citing failure to follow manufacturer instructions for use when cleaning and disinfecting, and improper use of disinfectant wipes.

The RVP program

Element	What we do	Requirement it satisfies
Equipment census and risk tiering	Complete inventory of movable medical equipment by device class, department, and patient-contact frequency. Devices tiered by contact intensity so cleaning frequency is derived from risk rather than convenience.	IC.06.01.01, EP 3; NPG.05.01.01, EP 1
Manufacturer instructions library	Device-specific instructions for use held at the point of work — approved chemistry, wet contact time, and prohibited agents per device. Staff work from the device's own instruction, not a generic protocol.	IC.06.01.01, EP 3
Between-patient disinfection	Defined cleaning of reusable noncritical devices between patients, including the four named device types, with a visible status indicator so clinical staff can tell a cleaned device from a queued one.	LD.13.01.09, EP 6
Terminal and scheduled deep cycles	Full disinfection cycles on beds, stretchers, wheelchairs, IV pumps, workstations on wheels, and specialty equipment, on a documented rotation with condition inspection built in.	IC.06.01.01, EP 3; PE.01.01.01, EP 2
Condition and cleanability inspection	Cracked housings, torn cuffs, frayed cables, and adhesive residue identified and removed from service, because a surface that cannot be cleaned cannot be compliant.	PE.01.01.01, EPs 1–2
Clean and soiled staging discipline	Physically separated clean and soiled staging with defined traffic flow, so a disinfected device is not recontaminated in the hallway it waits in.	IC.06.01.01, EP 3
Competency validation	Direct observation of technique per device class, with named observer and date, plus PPE don and doff observation and bloodborne pathogen training at hire and at intervals.	HR.11.03.01, EP 1; HR.11.04.01, EP 1
Audit output for infection prevention	Structured cleaning and verification data delivered to the infection preventionist on a defined schedule, in a format that enters the hospital's program record.	IC.04.01.01, EP 2

Why the last row is the important one.

IC.04.01.01, EP 2 requires the infection preventionist to collaborate with all departments on competency-based training and education — and it explicitly includes **personnel providing contracted services**. The same element of performance allows auditing of adherence to infection prevention policies to be delegated to appropriate staff, provided the infection preventionist is updated on the results. That is written authorization for a contracted vendor to carry audit volume that a hospital's one or two infection preventionists cannot. It also means RVP's training and audit records are not internal paperwork — they are the hospital's compliance evidence. We format them accordingly.

Equally important is what a vendor should not claim. Reprocessing of semicritical and critical devices — high-level disinfection and sterilization — is a separate discipline with separate standards, and RVP does not represent itself as performing it. Our scope is reusable noncritical equipment and the environment. Clarity about that boundary is part of the service.

Linen and textile management

Four requirements, all verbatim. Three of them are handling discipline. The fourth is a building condition most vendors never check.

Linen is the scope where the standards are most specific and vendor practice is most casual. The 2026 requirements sit in two places: the handling and storage requirements under **IC.06.01.01, EP 3**, and one building-condition requirement under **PE.04.01.01, EP 3** that is a pressure relationship, not a cleaning task. RVP works to all four, and quotes them here so a client can verify our reading.

The requirement, as written	Cited under	How RVP delivers it
Soiled textiles are handled with minimum agitation to prevent dispersal of microorganisms into the air.	IC.06.01.01, EP 3	Trained no-shake, no-sort-at-point-of-use handling. Bagging technique observed at competency validation, not described in a binder. Staff can state why agitation matters, because the surveyor will ask the handler, not the manager.
Soiled textiles are contained in leak-proof bags or containers at the point of use. Note: Hamper covers are not required in patient care areas.	IC.06.01.01, EP 3	Correct container density and placement so bagging happens where the textile is generated. We do not over-comply by adding covers the standard does not require, and we will say so when a client's own policy exceeds the standard, so the excess is a deliberate choice rather than an unexamined habit.
Clean textiles are protected from environmental contamination during transport and storage — covered on the unit, or uncovered only in a dedicated clean storage area.	IC.06.01.01, EP 3	Covered cart discipline in transit and on units; dedicated clean storage with supplies off the floor and clear of the sprinkler plane; solid bottom shelf on supply carts. Clean linen is the most frequently mis-stored item in a hospital and the easiest finding a surveyor will ever write.
The receiving area for contaminated textiles is clearly separated from clean laundry areas and is maintained at negative pressure compared with the clean areas, in accordance with FGI construction standards in effect during the time of facility construction.	PE.04.01.01, EP 3	We verify and log the pressure relationship rather than assume it, and we escalate a failed relationship to a named facilities owner with a date, because it is a building condition we cannot correct ourselves. Note the FGI clause: the applicable edition is the one in force when the space was built, which is why a blanket claim of compliance is meaningless without knowing the vintage.

The one nobody checks.

Three of the four requirements are handling behaviors a vendor controls. The fourth — negative pressure in soiled textile receiving relative to clean areas — is a mechanical condition, cited under the Physical Environment chapter rather than infection control, and it is almost never on a linen vendor's checklist because it does not feel like linen work. It is scored anyway. RVP puts it on the rounding instrument, verifies it on a defined cadence, and reports the reading with a date.

Program scope and the contracted-services hook

IC.04.01.01, EP 5 establishes that the infection prevention program's scope covers all care, treatment, and services — and the standard's own list of examples ends with **laundry services**. Linen is not adjacent to the infection prevention program; it is inside it. The same chapter, at **EP 2**, requires competency-based training for hospital staff “and, as applicable, personnel providing contracted services,” and permits auditing of adherence to be delegated to appropriate staff provided the infection preventionist is updated on results. That is written authorization for RVP's training records and audit output to serve as the organization's compliance evidence, and we format them for that purpose rather than for our own files.

Adjacent requirement most often missed

IC.06.01.01, EP 3 also requires that **mop heads and cleaning cloths be laundered at least daily** using appropriate laundry techniques. This is a linen requirement embedded in the environmental cleaning element of performance, which is exactly why it falls between an EVS contract and a laundry contract. Under a single RVP scope it does not fall anywhere. Microfiber par levels, daily laundering, and rejection criteria for degraded textiles are managed as one system with the cleaning program they serve.

Source for this section

1. 2026 Hospital Survey Process Guide, The Joint Commission — Infection Prevention and Control Program Assessment Tool (pp. 605–619), laundry and textile requirements quoted verbatim; PE.04.01.01, EP 3 pressure relationship.
<https://digitalassets.jointcommission.org/api/public/content/64731897e3d94ca69e54042c2e27d9c6?v=19446f24>

Commercial healthcare environmental services

Medical office buildings, ambulatory sites, administrative space, and clinics.

Entrances, lobbies, and circulation

Entrance glass, mats, and thresholds; lobby seating and hard surfaces; elevator interiors and call panels; stairwells and corridors; wayfinding surfaces; floor care matched to substrate. Corridor clutter and storage discipline maintained to Life Safety Code expectations under **PE.03.01.01, EP 3**, because a corridor is a life-safety feature before it is a hallway.

Restrooms and hand hygiene infrastructure

Fixture and surface disinfection with EPA-registered product at label contact time; dispenser stocking and condition; alcohol-based hand rub dispenser placement maintained to **PE.03.01.01, EP 7**; hand hygiene product availability supporting the hospital's program under **NPG.05.03.01, EP 1**.

Clinical and exam space

High-touch surface disinfection at frequency set by patient contact and degree of soiling; exam table and chair surfaces inspected for cleanability; sharps container placement, mounting, and fill-level observation; regulated medical waste containment and prompt disposal per **PE.02.01.01, EP 6**.

Break rooms, kitchens, and food service areas

Cleanliness and pest-evidence surveillance under **PE.01.01.01, EP 3**; wet wiping cloths stored in approved sanitizing solution and washed daily; refrigerator cleaning, temperature log support, and removal of expired items; refuse handling. Where a commercial kitchen is in scope, we round it to the structure of the published Kitchen Tracer Survey Guide, including sprinkler clearance over storage racks and eyewash reach time for dishwasher decalcifying chemicals.

Chemical management and eyewash

Product rationalization to a controlled list; secondary container labeling; safety data sheet availability including a documented downtime procedure; eyewash station reach-time mapping against the published expectation — reachable within 10 seconds, approximately 55 feet, without passing through a doorway — with activation logs and unexpired solutions. All under **PE.02.01.01, EPs 1, 2, and 4**.

Floor care, project work, and specialty surfaces

Hard-surface restoration, carpet care, resilient flooring maintenance, high dusting of vents and overhead surfaces, and light fixture and diffuser cleaning — the last three matter because dust on HVAC vents and equipment is among the most frequently observed findings in the current physical environment data.

Where commercial space is scored differently

Business and ambulatory occupancies are not scored like a hospital.

The Survey Process Guide carries a separate Business and Ambulatory Occupancy Building Tour Guidance Document. Corridor clear width is 44 inches in ambulatory occupancies, and in business occupancies 44 inches only where there are 50 or more occupants, dropping to 36 inches below that. Fire extinguishers are inspected monthly, maintained annually, mounted between 4 and 60 inches off the floor and conspicuously visible. Ambulatory organizations also still maintain written Environment of Care management plans that hospitals no longer do. A vendor that applies hospital rules uniformly across a mixed portfolio will over-serve some sites and mis-serve others.

Sources for this section

1. 2026 Hospital Survey Process Guide, The Joint Commission — Business and Ambulatory Occupancy Building Tour Guidance (pp. 599–604) and Kitchen Tracer Survey Guide (pp. 589–595). <https://digitalassets.jointcommission.org/api/public/content/64731897e3d94ca69e54042c2e27d9c6?v=19446f24>
2. Joint Commission Perspectives, January 2026, Vol. 46 No. 1 — leading physical environment and clinical opportunities for improvement. <https://digitalassets.jointcommission.org/api/public/content/d5909e6a819c43f3bc08afa988e59e98?v=6d683268>

Construction turnover and activation

Two signatures are required before the barriers come down. In 42% of hospital construction projects, nobody is contractually accountable for one of them.

The Joint Commission's construction project commissioning guidance is explicit about the gate: **“An IP must sign off on the finalization of the area and the infection control risk assessment (ICRA) before the area can be reopened for services.”** Two conditions must both be satisfied before barriers are removed — the area must be inspected by infection control **and** thoroughly cleaned by environmental services. The second condition is a labor deliverable with a documented completion, and it is the one that routinely has no owner.

The upstream requirement is **PE.01.01.01, EP 1**, which requires an infection control risk assessment to define the scope of infection risk and the need for barrier measures **before a project gets underway**, and **PE.03.02.01**, which governs interim life safety measures at demolition, construction, and renovation locations. An ICRA written at the start and never operationalized at the end is the most common failure pattern in the sequence.

The size of the gap

~80% of hospital construction projects are commissioned	58% build survey-readiness into third-party contracts	42% have no contractual owner for activation readiness
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Roughly 80% of hospital construction projects are commissioned at all, which ASHE's Chad Beebe has said should be “closer to 100%,” and only 58% of organizations build operational and survey-readiness requirements into their planning, design, and construction contracts with third parties. Beebe's framing is the entire argument for buying this scope deliberately: **“You can't wait for the ribbon-cutting ceremony to learn how to operate a new facility.”**

What RVP delivers at turnover

Phase	What we do	Requirement it serves
Pre-construction	Participate in the ICRA so cleaning obligations, barrier maintenance, and the final-clean specification are defined before work begins rather than negotiated at the ribbon-cutting.	PE.01.01.01, EP 1
During construction	Maintain cleaning at barrier lines and adjacent occupied space; monitor barrier integrity, negative pressure at the work zone, and tracked debris in circulation paths; support interim life safety measure conditions.	PE.03.02.01; PE.01.01.01, EP 3
Final clean	Documented terminal clean of the entire turnover area against a written specification, with completion recorded by area, date, and technician — because “thoroughly cleaned by environmental services” is a precondition to reopening and must be evidenced, not asserted.	Commissioning guidance; IC.06.01.01, EP 3
Readiness verification	Walk the commissioning checklist items that are ours: clean linen storage covered, clean and soiled separation with separate traffic flow, supplies off the floor and at least 18 inches from the ceiling, solid bottom shelf on supply carts, sharps and waste containment in place.	IC.06.01.01, EP 3; PE.02.01.01, EP 6

Phase	What we do	Requirement it serves
IP sign-off support	Present the completed cleaning record to the infection preventionist as the evidence supporting their required sign-off, so the gate is not held open waiting for documentation that was never produced.	Commissioning guidance; IC.04.01.01, EP 2
Activation and first 30 days	Staff, train, and validate the cleaning program for the new space before occupancy, not after — including product compatibility with new finishes and equipment, which is where manufacturer instructions and new surfaces most often collide.	HR.11.03.01, EP 1; IC.06.01.01, EP 3

Why this is sold to a different buyer.

Activation readiness is priced per project, not per square foot per month, and the accountable executive is usually capital projects or facilities planning rather than support services. It is also countercyclical to routine environmental services bid pressure. If your contract for a project already underway does not name who is accountable for the final clean and the readiness evidence, that is the conversation to have before the barriers come down — not after.

Sources for this section

1. Construction Project Commissioning checklist, The Joint Commission — IP sign-off on ICRA before reopening; infection control inspection and environmental services cleaning as joint preconditions.
https://digitalassets.jointcommission.org/api/public/content/assets/1/7/05_07_construction_project_commissioning.docx
2. 2025 Hospital Construction Survey results — Health Facilities Management: commissioning rates, the 58% third-party contract figure, and Chad Beebe's comments. <https://www.hfmmagazine.com/2025-hospital-construction-survey-results>
3. 2026 Hospital Survey Process Guide, The Joint Commission — PE.01.01.01, EP 1 and PE.03.02.01.
<https://digitalassets.jointcommission.org/api/public/content/64731897e3d94ca69e54042c2e27d9c6?v=19446f24>

Evidence and reporting

The management plan requirement went away. The proof requirement did not.

Hospitals no longer keep written management plans for safety, security, hazardous materials, utilities, or medical equipment. What remains — inventories, logs, inspections, risk assessments, training records, competency validations — now stands on its own. RVP structures its contracts to generate that record as a byproduct of the work:

What we deliver	Cadence	Element of performance it supports
Equipment cleaning completion record by device and department	Continuous, reported monthly	LD.13.01.09, EP 6; IC.06.01.01, EP 3
Cleaning verification results, with re-clean documentation where verification fails	Monthly	IC.06.01.01, EP 3
Structured audit dataset formatted for the infection preventionist's program record	Monthly	IC.04.01.01, EP 2
Training matrix and competency validations with named observer and date	At hire, annually, and on process change	HR.11.03.01, EP 1; HR.11.04.01, EP 1
Chemical inventory reconciled to product in use, with SDS access verification including downtime procedure	Quarterly inventory; monthly SDS check	PE.02.01.01, EPs 1–2
Eyewash reach-time map, activation log, and annual inspection record	Weekly activation; annual inspection	PE.02.01.01, EP 4
Deficiency register with photo, date raised, named owner, and date closed	Continuous; monthly summary	PE.01.01.01, EPs 1–3
Condition and cleanability report on equipment and furnishings removed from service	Monthly	PE.01.01.01, EPs 1–2
Linen handling and storage audit, including the negative-pressure reading in soiled textile receiving	Monthly; pressure reading weekly	IC.06.01.01, EP 3; PE.04.01.01, EP 3
Project final-clean completion record by area, date, and technician, packaged for IP sign-off	Per construction turnover	Commissioning guidance; IC.06.01.01, EP 3
Mock tracer report in surveyor sequence, with corrective actions and closure	Quarterly	Cross-cutting

What we ask for in return

Direct access to the infection preventionist for audit handoff, a named hospital-side owner for conditions that are structural rather than operational, and a standing reporting slot with the committee that owns the physical environment. A vendor that reports only into purchasing can deliver clean. It cannot deliver survey-defensible.

Differentiators

- **We sell labor, not literacy.** The standards are free and public. The trained, supervised, documented workforce that turns them into a passed survey is not, and that is the only thing worth paying for.
- **Four scopes, single accountability.** Equipment, linen, building, and construction turnover under one contract. The seam between two vendors is where the uncleaned device and the unsigned final clean sit.
- **Citations current to 2026, verifiably.** Every standard in this document is footnoted to a primary Joint Commission source with a live URL. That is a testable claim, and we invite the test.
- **Program-scope literacy.** We distinguish hospital and critical access requirements from ambulatory, behavioral health, and office-based surgery requirements, because in 2026 they genuinely diverge.
- **Manufacturer instructions as the operating unit.** Contact time and approved chemistry per device, at the point of work — which is precisely where surveyors report finding the failure.
- **Evidence formatted for the client's record, not ours.** Our audit output is designed to be entered into the hospital's infection prevention program documentation.
- **Honest boundaries.** We do not claim high-level disinfection or sterilization scope. Reusable noncritical equipment and the environment is what we do, and we do not blur it to widen a proposal.

Contact and next steps

Contact	Role	Reach
Calvin Thomas IV, FACHE	Vice President of Business Development	(636) 346-5977 calvinthomasiv@rsg-solutions.com
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RVP Solutions — movable medical equipment disinfection, linen and textile management, commercial healthcare environmental services, and construction turnover and activation.

On sourcing. Every standard, element of performance, and quotation in this document is drawn from primary Joint Commission publications current as of August 2026, with full URLs below. Where a requirement is quoted, it is quoted verbatim. This revision supersedes all prior versions; citations are current to the 2026 manual.

Primary sources

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