GLOBAL ACCREDITATION AUTHORITY

Patients First. *Always.*

QUAD A Accreditation
RESOURCE GUIDE
Effective March 16, 2026

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Purpose of This Resource Guide

This Resource Guide provides operational guidance to QUAD A surveyors and accredited facilities regarding accreditation processes, survey methodologies, documentation requirements, and program policies. The guide supplements, but does not replace, the official QUAD A Standards Manuals.

Who is QUAD A?

The American Association for the Accreditation of Ambulatory Surgical Facilities (now known as QUAD A) is a nationally recognized Accrediting Organization that evaluates healthcare facilities to determine compliance with established patient safety and quality standards. QUAD A strives for the highest standards of excellence for its accredited facilities by regularly updating the requirements to promote patient safety and the delivery of quality care.

QUAD A awards each facility a three-year term of accreditation when it has determined that the survey findings are accurate, the facility has proven a commitment to provide high-quality care and services, and concludes that the facility is in compliance with all applicable QUAD A standards, Medicare Conditions for Coverage (ASC) or Conditions of Participation (OPT/RHC) as appropriate if Medicare-deemed, and state/local, and national regulations or authorities having jurisdiction.

The QUAD A Board of Directors and all committees are comprised of anesthesia providers, nurses, podiatrists, physicians and surgeons, physical therapists, and dental specialists. This group of expert clinicians develops standards and makes recommendations regarding surveyors and facilities based on years of experience in outpatient healthcare settings, as well as current industry standards and guidelines.

Optimal patient safety has always been QUAD A's guiding principle. We are proud that our standards may be considered the strongest of any Accrediting Organization, that accredits outpatient settings and providers/suppliers and is widely considered the gold standard.

We recognize, however, that these standards need to be a part of a living document. We continually re-evaluate and revise these standards considering evidence-based guidelines, medical advances, and changing legislative policies. QUAD A accreditation requires full compliance with each standard to achieve accreditation. Any deficiencies identified during survey must be corrected through an approved Plan of Correction prior to accreditation being granted.

Standards Development

QUAD A always seeks to improve and has established the plan below to develop future revisions to these standards based on information gathered during surveys conducted using this manual.

1. **QUAD A standards are updated on an approximate 3-year cycle based on:**
    a. Outcome data from the QUAD A Patient Safety Data Reporting system is evaluated and statistically analyzed to determine areas where standards can be revised or created to improve patient safety and outcomes.
    b. Standards are updated by the Standards Committee, representing subject matter experts in all areas of ambulatory medical care, each with at least 20 years' experience in outpatient surgery, anesthesia, dentistry, or nursing and clinical care, outpatient physical and occupational therapy, and rehabilitation medicine.
        i. At least every three (3) years, QUAD A standards are compared to other organizations' standards and recommendations, such as those of professional societies, including surgical, anesthesia, dental, and nursing organizations, physical therapy, or ministries, to identify the implementation of new standards and to minimize duplicative requirements.
    c. The 3-year cycle is defined as:
        i. Year one: QUAD A collects data from QUAD A surveys and updates from other organizations' standards and guidelines.
        ii. Year two: The Standards Committee revises standards based upon data collected in year one.
        iii. Year three: The updated standards are presented to the Board of Directors for consideration and approval.
2. **Standards are submitted to a medical editor for editing and to ensure clarity prior to submitting to the Board of Directors for approval.**
3. **Standard development may include internal review, validation, and stakeholder feedback prior to final approval. Pilot testing is used for new accreditation programs, not individual standards.**
    a. This allows for a comprehensive evaluation of each standard to make sure it is RUMBA (Relevant, Understandable, Measurable, Beneficial, and Achievable).
    b. If not RUMBA, the standard is revised by the Standards Committee based on input from all stakeholders.
4. **Process of adopting standards:**
    a. Data used in the development of standards is gathered.

b. The Standards Committee evaluates data and drafts proposed standards.

c. QUAD A posts draft standards and solicits feedback from US-based and international stakeholders, including societies, ministries, surveyors, and facility leadership.

d. The Standards Committee evaluates data and establishes new standards if there is a direct patient safety concern.

e. New standards are approved by the Standards Committee and submitted to the Board of Directors.

f. The Board of Directors evaluates the proposed standards and provides its approval.

g. As new standards are introduced, they are announced in QUAD A publications and incorporated into the surveyor training programs.

h. QUAD A utilizes a data-driven review process to obtain and analyze previous citations and surveyor findings and uses them to improve standards.

The planned three-year cycle of standards analysis and revision is as follows:

- **Basis:**
    - Outcome data from the QUAD A incident reporting system and onsite survey data.
    - Experience and expertise of committee members.
    - Scientific literature and comparison to standards and recommendations of subject matter experts, professional societies, and government regulators.
- **Cycle:**
    a. Year one: QUAD A collects survey and outcome data and updates from other organizations' standards and guidelines.
    b. Year two: Committee revises standards based upon data collected in year one.
    c. Year three: Updates are presented for consideration and approval.
        i. Includes editing and clarification of drafted standards.
        ii. Includes pilot testing and evaluation upon approval of drafted standards.
- **Process:**
    - Data gathered by staff.
    - Committee evaluates data and proposes drafted standards.
    - Committee posts drafted standards and solicits feedback.
    - Committee evaluates data and establishes new standards.
    - Committee approves and forwards new standards to the Board of Directors for approval.
    - New standards are implemented and incorporated into surveyor training programs.

Accreditation Definitions by Program

The QUAD A Board of Directors reserves the right to review and edit these allowable procedures that are performed in any of its accredited programs based upon differing scopes of practice standards and changing state, federal, and local laws, and regulatory requirements.

Office-Based Procedural (OBP)
The procedural facility accreditation is intended for ambulatory facilities performing procedures under sedation in which therapeutic and diagnostic procedures are carried out, which would include gastroenterologists, urologists, gynecologists, pain management physicians, and others. These procedures may include minimally invasive procedures and minor surgical procedures. (e.g. Intra-oral maxillo-facial procedures, minor urological procedures to include circumcisions, vasectomies, etc.).

Office-Based Surgical (OBS)
Outpatient surgical program designed to promote optimal patient safety in the office setting. Accredited centers must comply with standards governing professional training, operational safety and the physical layout of the center. Patients undergoing surgery in an accredited operating room should be assured the same level of care and safety preparedness as those receiving care in a hospital. Centers with nearly any surgical specialty are eligible for accreditation under this program.

Oral Maxillofacial Surgery (OMS)
Accredited oral and maxillofacial surgery facilities must meet standards written for the delivery of safe oral surgery care requiring unique anesthesia delivery and disinfection practices. This program is designed to promote optimal patient safety while meeting the specific needs of the oral surgery community.

Pediatric Dentistry (PD)
Accredited pediatric dentistry facilities must meet standards written for the delivery of safe dentistry care for children, requiring unique anesthesia delivery and focused infection control practices. Patients undergoing dental care in an accredited facility are assured the same level of care and safety preparedness as those receiving care in a hospital. This program is designed to ensure optimal patient safety while meeting the specific needs of the pediatric dentistry community.

Medical Spa (MedSpa)
This accreditation applies to a facility outside of a physician's office that provides non-surgical cosmetic medical procedures, such as neuromodulators, dermal fillers, laser, light-based, and/or other energy-based procedures.

Medicare Programs

Ambulatory Surgical Centers (ASC)
Ambulatory Surgical Centers are facilities that participate in Medicare and Medicaid programs for reimbursement. An ASC specializes in providing surgery, including certain pain management and diagnostic (e.g., colonoscopy) services in an outpatient setting. An ASC must be certified and approved to enter into a written agreement with CMS. Participation as an ASC is limited to any distinct entity that operates exclusively for the purpose of providing surgical services to patients

not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.

Outpatient Physical Therapy (OPT)
Medicare Outpatient Physical Therapy Program assesses the quality of therapeutic care in physical therapy and speech pathology clinics. These facilities may also offer occupational therapy services.

Rural Health Clinics (RHC)
Clinics located in a census tract within a non-urban designation and in a medically under-served area, or an area with a designated health professional shortage may participate in this program.

International Programs

Surgical

This accreditation program provides accreditation to both the medical community and the public that a facility meets internationally recognized standards. It ensures that patients undergoing surgery in an accredited operating room receive the same level of care and safety preparedness as those in a hospital setting. Facilities specializing in most surgical fields are eligible for accreditation under this program.

Physical Therapy

This international program evaluates the quality of therapeutic care provided in outpatient clinics specializing in physical therapy and speech pathology. The assessment process also recognizes clinics that offer occupational therapy as part of their services.

Dental

This is an accreditation program certifying to the dental community and the general public that a facility meets internationally recognized standards. This international program promotes optimal patient safety while meeting the specific needs of the dental community. Accredited clinics meet standards that are written with unique anesthesia delivery and disinfection practices appropriate to the delivery of safe dental care.

Polyclinic

This accreditation applies to freestanding outpatient clinics that provide examinations and treatments across at least two distinct specialties. These services may include diagnostics, dental care, and Traditional Complementary and Alternative Medicine (TCAM), and are provided to patients who do not require an overnight stay.

Surveyors

This section defines the expectations and requirements for all QUAD A surveyors.

Basic Surveyor Expectations

QUAD A surveyors must be organized and be prepared to conduct an accreditation survey.

- Surveyors must review all available survey preparation materials prior to arrival onsite, including previous Statement of Deficiency Report, facility applications, and publicly available facility information on the facility's website. Familiarize yourself with the program QUAD A standards and applicable local, state, and federal, provincial or national regulations.
- Familiarize yourself with the facility's location and make appropriate arrangements for a timely arrival.

QUAD A surveyors must contact the QUAD A office with questions or concerns before or during an accreditation survey.

- If the surveyor encounters any issue while onsite, the surveyor must contact the QUAD A office prior to taking any action, especially prior to concluding the survey or leaving the facility. This includes refusal of survey, wrong address, potential Immediate Jeopardy (IJ), hostile environment, suspected fraud or abuse, and a previously unidentified conflict of interest.

If the survey is scheduled to be conducted by a team of surveyors (more than one), prior to the survey, the lead surveyor must contact the rest of the team to coordinate arrival at the facility, tentative team member assignments for the survey, and to address any questions.

- The team should meet the night before or the morning of the scheduled survey before entering the facility.
- If a survey is performed by a team of surveyors, all surveyors will enter and depart the facility together unless travel logistics or scheduling requires otherwise.

During the survey, surveyors are expected to look and act professionally as representatives of QUAD A. Surveyor expectations include:

- Following QUAD A Surveyor Code of Conduct.
- Dressing professionally and respectfully (i.e., wearing your photo ID badge).
- Approaching the survey process as an educational and collaborative evaluation designed to improve patient safety while maintaining objective enforcement of accreditation standards.
- Being courteous, kind, respectful, and exhibiting excellent listening skills.
- Speaking in a calm, professional voice and posing questions to the appropriate individual(s).

- Reviewing facility files or patient records in paper or electronic format. Asking the facility to print medical records or policies for review is inappropriate.
- Surveyors must not provide consulting services, recommendations for operational changes, or advisory guidance to the facility during the survey process. The surveyor's role is limited to evaluating compliance with QUAD A standards.

Under no circumstances should a surveyor make an independent judgment to do less than the survey requirements outlined by QUAD A's survey-related policies and procedures and as described in the relevant CMS Appendix for the program being evaluated (see "Surveyor Resources").

QUAD A surveyors must adhere to post-survey requirements:

- Survey documents must be completed and returned within two business days of the survey end date.
- Surveyors must be available for at least 30 days after the survey end date for post-survey activities, including a review of the Plan of Correction (PoC) related to any noncompliance identified during a survey.
- Each surveyor must meet the requirements for annual re-approval by the QUAD A Quality Assurance Committee which includes completing required continuing education modules assigned during the year and other educational activities.

Surveyor Code of Conduct

To serve as a QUAD A surveyor, you must agree to adhere to the following code of conduct requirements:

- I agree to conduct all surveys by fair and unbiased determination of the facility in accordance with applicable standards and survey processes set forth by QUAD A.
- I agree to act and dress in a professional manner as a representative of the QUAD A accreditation program.
- I agree to disclose any real or perceived Conflict of Interest that would inhibit my ability to perform a fair and unbiased survey.
- I agree to adhere to the Code of Ethics set forth by my professional licensing body.
- I agree to disclose any professional or financial interest in a facility that I am assigned to survey.
- I agree to adhere to the responsibilities and requirements set forth in the QUAD A Surveyors Guidelines.

5. *Medicare Surveyors*: I agree that I will not disclose the date and/or time of any Medicare survey, that all Medicare surveys will be unannounced, and that I will attest to that upon submitting each Survey Report.

Surveyor Qualifications

To ensure that a surveyor is adequately qualified to perform QUAD A Medicare surveys, the surveyor must meet the following criteria:

QUAD A Medicare Health Safety Surveyors:

Ambulatory Surgical Center (ASC) surveyors must: Be a qualified practitioner able to provide documentation of current, unrestricted license as one of the following:

i. Doctor of Medicine
ii. Doctor of Osteopathy
iii. Certified Registered Nurse Anesthetist
iv. Physician Assistant
v. Registered Nurse

Rural Health Center (RHC) surveyors must be a qualified practitioner able to provide documentation of current, unrestricted license as one of the following:

i. Doctor of Medicine
ii. Doctor of Osteopathy
iii. Physician Assistant
iv. Nurse Practitioner
v. Nurse Midwife
vi. Registered Nurse
vii. Psychologist
    i. State Licensed Mental Health Professional (Social Worker, Marriage & Family Therapist, or Professional Counselor).

Outpatient Physical Therapy (OPT) surveyors must be a qualified practitioner able to provide documentation of current, unrestricted license as one of the following:

i. Physical Therapist
ii. Physical Therapist Assistant
iii. Occupational Therapist
iv. Certified Occupational Therapist Assistant
v. Speech Language Pathologist
vi. Speech Language Pathologist Assistant

1) Surveyor candidates will submit a current Curriculum Vitae that documents experience to qualify as a surveyor.
2) Sign and adhere to the initial QUAD A Surveyor Documents, including:
    b. Surveyor Attestation
    c. Conflict of interest – requires annual acknowledgement
    d. Code of Conduct
    e. Agreement to participate in annual surveyor appraisal and review process conducted by QUAD A Quality Assurance Program.
3) Attend a QUAD A surveyor training course (on-line or in-person) and pass the Surveyor training examination administered at the conclusion of each training course; documentation of completion will be kept on file at the QUAD A office.
4) Complete and pass all additional continuing education modules as assigned.
5) Successfully complete the required number of on-site training surveys accompanied by a senior surveyor. Documentation of successful completion of the training survey(s) will be maintained in the surveyor's file.

QUAD A Non-Medicare Surveyors:

1. **Surgical and Procedural surveyors**
    a. Be a qualified practitioner able to provide documentation of current, unrestricted license as one of the following:
        i. Doctor of Medicine
        ii. Doctor of Osteopathy
        iii. Physician Assistant
        iv. Registered Nurse
        v. Certified Registered Nurse Anesthetist
        vi. Doctor of Dental Surgery/Doctor of Dental Medicine
    b. Physicians must be board-certified or eligible by a certifying board accepted by QUAD A Standards.
    c. At least have two (2) years of experience working in an office-based setting.
6. **Oral and Maxillofacial surveyors**
    a. Be a qualified practitioner able to provide documentation of current, unrestricted license as one of the following:

i. Doctor of Dental Medicine (DMD) or Dental Surgery (DDS) certified or eligible for certification by the American Board of Oral and Maxillofacial Surgery (ABOMS)

7. **Pediatric Dentistry surveyors**
    a. Be a qualified practitioner able to provide documentation of current, unrestricted license as one of the following:
        i. Pediatric Dentist (DDS or DMD)
        ii. Dental Anesthesiologist
8. **Submit a current Curriculum Vitae that documents experience to qualify as a surveyor.**
9. **Sign and adhere to the initial QUAD A surveyor documents, including:**
    a. Surveyor Attestation
    b. Conflict of interest – requires annual acknowledgement
    c. Code of Conduct
    d. Agreement to participate in annual surveyor appraisal and review process conducted by QUAD A Quality Assurance Program.
10. Attend a QUAD A surveyor training course and pass the Surveyor training examination administered at the conclusion of each training course, a certificate of completion will be kept on file at the QUAD A office.
11. Complete and pass all additional continuing education modules as assigned.
12. Life Safety Code Surveyors: **Must at minimum meet one of the following:**
    a. NFPA Certified Fire Inspector I (CFI-I) possessing documentation of current certification.
    b. NFPA Certified Fire Protection Specialist (CFPS) possessing documentation of current certification.
    c. Registered Professional Engineer (PE) possessing documentation of current registration.
    d. Licensed Architectural Architect (AIA) possessing documentation of current registration.
    e. Design Professional/Engineering Intern (EI)/Architectural Associates (Assoc. AIA) working under the direct supervision of a licensed AIA or licensed PE signing and assuming the work as their own.
13. Have experience with Hospitals or Ambulatory Surgery Centers (ASC).
14. Submit a current Curriculum Vitae or Resume that documents experience to qualify as a surveyor.
15. Sign and adhere to the practices as outlined in the current contract with QUAD A.
16. Complete the online LSC surveyor course as provided by QUAD A, complete and pass the examination process, a certificate of completion will be maintained on file at the QUAD A office.

17. Complete and pass all additional continuing education modules as assigned.

Documentation of initial certification and additional continuing education modules will be maintained in each surveyor file. Evidence of certification will identify the educational course or module and date of course or certification.

QUAD A Quality Assurance Committee must verify the candidate has met the conditions outlined in the QUAD A Policy for Surveyor Qualifications and has reviewed all documentation submitted to determine certification as a QUAD A Surveyor. Final written approval by the Quality Assurance Committee Chair will be maintained in each surveyor file with the current Surveyor Certificate.

QUAD A – Accreditation Application Process

Cancellation or Refusal of Survey

Facilities may cancel a scheduled survey with written notice given at least thirty (30) days prior to the survey date and incur no additional charges.

- Any facility that cancels a scheduled survey within thirty (30) days of the survey date will incur cancellation charges. The cancellation charges consist of:

- An administrative fee (see current fee schedule).
- Any additional costs associated with the cancellation including, but not - limited to, surveyor travel and lodging, and all other related expenses

- If a facility cancels or refuses a survey after the surveyor has traveled to the survey location, the cancellation fee will include:

- An administrative fee (see current fee schedule).
- The survey fee (in addition to the original survey fee paid to QUAD A)
- Any additional cost already arranged for extraordinary costs such as expedited service or other special fees

If a facility cancels a Life Safety Code survey, the facility will be responsible for all costs incurred by the Life Safety Code surveyor.

Changing or rescheduling a survey date is a cancellation of the existing survey. The facility will be responsible for all existing survey costs, consistent with the cancellation policy. The new survey date will be subject to any fees that apply to the survey scheduled, including expedited survey fees.

Cancellations that occur within one (1) week of the scheduled survey will result in the surveyor being reimbursed the honorarium (and any costs incurred such as tickets) and the facility should be charged.

If the cancellation is over a week, the surveyor should have adequate time to rearrange their schedule, and QUAD A will not reimburse the surveyor or pay an honorarium.

QUAD A reserves the right to terminate a survey due to a lack of cooperation from the facility staff or its leadership. Termination of a survey follows the previously mentioned procedures identified in this policy.

Fees and Refund Policy

The first-year accreditation annual fee plus the initial survey fee is due with each accreditation application.

If the facility withdraws its application after it has been submitted and processed, QUAD A will refund 50% of the annual fee and 100% of the survey fee if the facility has not been surveyed. If the facility was surveyed, only 50% of the annual fee can be refunded. No refunds are issued after the facility is fully accredited.

If the facility has not confirmed a survey date within 12 months of the date of application submission, a new application and appropriate fees are required.

If a survey date is confirmed prior to the 12-month timeframe but will occur beyond that time (the confirmed survey date cannot be beyond three months after expiration), the survey cannot be postponed, rescheduled, or cancelled. If such occurs, the facility must re-apply for accreditation and re-submit the survey and annual fee. No refunds will be issued if the application expires.

Once an anniversary date is established after achieving accreditation, the facility will be invoiced six months prior to the annual anniversary date. If a facility does not pay its fees by the due date on the invoice and before the anniversary date, late fees will be applied, and other penalties will follow. If the facility's accreditation is revoked or terminated for any reason, no fees are refunded.

Waiver Requests

Waiver requests are initiated to seek approval for circumstances demonstrating equivalency with standards. The facility must indicate the standard for which it requests a waiver. QUAD A also uses waiver decisions as guidance when the committee reviews similar cases.

Typical waiver requests pertain to the following issues, outlined below:

- If a facility's local law and regulations prevent access to required QUAD A medications, the facility must present evidence of how to meet the equivalency requirement.
- Evidence of adequate sub-specialty certification in pain management. There are many variations of training and fellowships that people present in lieu of the subspecialty.
- Physicians who would like to perform cases outside their specialty who present evidence of additional training and hospital privileges in those procedures.

Waivers are not granted to exempt facilities from compliance with QUAD A standards. Waivers may be considered only when a facility demonstrates an **equivalent method of meeting the intent of a standard due to regulatory limitations or unique circumstances.**

QUAD A issued waivers may be approved for a designated period. No waiver is considered valid indefinitely and must be reviewed during the survey process. Upon survey, surveyors must ask the facility whether they have any waivers.

Types of Surveys for Scheduling

Start-up Facility Survey – Modified survey of structural accreditation standards that is conducted for facilities in states that mandate accreditation prior to operating and using anesthesia. Currently, those states include but are not limited to: FL, CA, NY, IN, KS, MA, OH, PA, NJ, and TX. QUAD A also offers these surveys to facilities that have not performed any cases in the location requested to be surveyed. Facilities may request a Start-up survey, at their discretion, when there is no state mandate.

Upon successful completion of the Start-up survey process, the facility is granted provisional accreditation for six months. Once provisional accreditation is granted, the facility may begin performing anesthesia cases. When the facility has completed the first ten (10) anesthesia cases, the facility must submit the completed Anesthesia Validation form with the ten (10) cases, with two (2) being adherent to anesthesia class. A full survey is required to be completed prior to the expiration date. Upon completing the full survey process, the facility will receive a new effective date of accreditation. This date is the date the facility demonstrated full compliance with the QUAD A Standards. If the provisional accreditation expires prior to demonstrating full compliance during the full survey, a potential gap in accreditation may occur.

When a facility is unable to perform ten (10) anesthesia cases before the expiration date or a facility is unable to complete a full survey, the facility must undergo a second Follow-up survey. QUAD A will conduct no more than two (2) Start-up surveys. If the facility is unable to perform the required number of anesthesia cases after two (2) Start-up surveys, the facility will need to initiate a new application.

Note: Deemed status cannot be recommended based on a Start-up survey. Medicare requires that a facility be in compliance with all applicable program Conditions for Coverage and Conditions for Participation before deemed status can be recommended.

Initial Accreditation Survey – This is a full survey conducted for a facility that is seeking to become accredited under a QUAD A accreditation program for the first time and is eligible for an initial survey.

For Medicare facilities only:

1. All Medicare surveys are unannounced.
2. Facilities cited for condition-level deficiencies during the initial survey will be deferred (denied) and must undergo another full initial onsite survey. These facilities are not eligible for a Follow-up survey.

3. Initial with CCN (CMS Certification Number) – This is a full survey conducted for a facility that is seeking to become accredited under a QUAD A accreditation program and is already participating in the Medicare program. Facilities cited for condition-level deficiencies during the initial survey will require a Follow-up survey to verify that the facility has achieved compliance.

Re-survey (Triennial) - This is a full survey conducted for a facility that wishes to renew its accreditation with QUAD A. Re-surveys occur on a 3-year cycle.

For Medicare facilities only: **All Medicare surveys are unannounced.**

Follow-up Surveys (All Programs)

A Follow-up survey is an abbreviated and focused survey. These are conducted for facilities:

1. Seeking reaccreditation where one or more Medicare Condition-Level deficiencies were cited during the triennial survey,
2. An Initial with CCN survey, or
3. When twenty (20) or more deficiencies were cited for any non-Medicare survey.

QUAD A requires a Follow-up survey to be conducted within forty-five (45) calendar days of the previous full or investigative survey to verify the correction of all condition-level deficiencies cited. (For Immediate Jeopardy situations, the Follow-up survey must be conducted within twenty-three (23) days of the previous survey end date). If needed, a second Follow-up survey must take place within forty-five (45) calendar days of the previous survey's end date. Facilities with Condition-Level deficiencies will not be recommended for continued Medicare deemed status until the results of the Follow-up survey confirm full compliance. QUAD A will conduct no more than two (2) Follow-up surveys (3 surveys total) concerning any single facility before reaching a final determination.

The Follow-up Survey is not intended to be a comprehensive review of compliance with all standards. In most cases, the Follow-up survey is conducted to validate that submitted corrections have been implemented by the facility. In other cases, the Follow-up survey is conducted for review of specific standards or focus by the surveyor. The surveyor has the authority to cite any observed non-compliance in the facility, even if the cited standard is not within the original scope of the Follow-up survey.

QUAD A may require a Follow-up survey for:

- Significant non-compliance with standards

- Immediate Jeopardy (Please see Policy for Management of Complaints and Adverse Incidents for details)
- Verification of Corrective Action
- Condition-Level Deficiencies (Medicare Only)

Note: Medicare facilities that are cited for Condition-Level deficiencies during a routine re-survey or an Initial with CCN survey are required to undergo an unannounced Follow-up survey within forty-five (45) days of the previous survey end date.

Note: For non-Medicare facilities, the following criteria are used when determining the need for a Follow-up survey:

Facilities cited for deficiencies that constitute significant concern due to the severity, prevalence, or nature of the deficiencies such as:

- An entire section, or more than fifty percent (50%) of one (1) sub-section, is marked as non-compliant. Standards 1-F-1 through 1-F-18, Patient Safety Data Reporting could be marked non-compliant with all standards due to failure to report. This may be considered one (1) deficiency in determining the need for a Follow-up survey. If a Follow-up survey is required, this section must be included in that review.
- Any clinical issues of a severe or pervasive nature must be reviewed by a member of the QUAD A clinical team, Accreditation Committee, or Investigative Committee.
- While there is no set number applied in all cases, as a general guide, if there are twenty (20) or more deficiencies, a Follow-up survey will normally be required. Be mindful that one (1) finding across multiple standards may be considered as one (1) deficiency (seek confirmation from management for such determination). Deficiencies that were Corrected on Site (non-Medicare only) are included in the total number of deficiencies to determine the need for a Follow-up survey.
- A history of repeat deficiencies may require a Follow-up survey to validate the Plan of Correction has been fully implemented and maintained as stated by the facility. Repeat deficiencies generally indicate a failure to fully implement and sustain compliance with previously cited areas of concern.

Complaint Survey (Investigative Survey) – Conducted when there is an immediate concern about patient safety in an accredited QUAD A facility. Investigation is a critical accreditation activity for ensuring that participating facilities continually meet all requirements. QUAD A conducts onsite investigative surveys for cases according to priority based on the issue or triage level.

Investigative Surveys are unannounced. The Surveyor(s) conducts the investigative survey using the appropriate standards manual and following any specific direction from the Investigative Committee Chair(s) or Reviewer(s). Investigative surveys are conducted for cause, with a specific area of focus. The surveyor(s) may expand the scope of a survey, based on findings, up to a full accreditation survey.

Additional Surveys during the Accreditation Term:

When changes occur within an organization, QUAD A will assess the changes via a full onsite survey. Onsite surveys will be required for the following changes:

1. Relocations
2. Program Changes
3. Providing a higher level of anesthesia
4. Addition of new specialties
5. Construction to patient care areas
6. Extension site adds (OPT only)

Changes of Ownership (CHOW): QUAD A accreditation is not automatically transferred during an ownership change, nor continued if significant organization changes have occurred. Facilities must report changes in ownership to the QUAD A office within 30 calendar days of the change. The QUAD A management team will review the reported changes and determine the need for survey.

Onsite Surveys

Each QUAD A facility is surveyed initially and at least every three (3) years thereafter. The QUAD A assigned surveyor will review any deficiencies with the Medical Director (or designee) and forward the survey results and associated documentation gathered during the survey to the QUAD A office. To be accredited by QUAD A, a facility must meet every standard. For surgical/procedural facilities, compliance must be demonstrated for the facility's identified Anesthesia Class [A, B, C-M (International facilities only), or C].

To help ensure a smooth and focused survey experience for everyone involved, we kindly ask that all participants support the process in the following ways:

- During an onsite QUAD A survey of a surgical facility, the Medical Director (or designee), an anesthesia provider, and key staff members typically work closely with the QUAD A surveyor(s). For other types of facilities, the administrator (or designee), clinical staff, and other relevant team members participate alongside the surveyor(s).

- To keep the survey process focused and productive, we ask that equipment representatives not be present during announced or unannounced surveys.

- We understand the value of having support available, and accreditation consultants are welcome to be present. However, to maintain the integrity of the evaluation, we ask that consultants observe rather than participate, remaining silent until the survey is fully completed.

- If at any point a participant's presence or behavior becomes disruptive, the QUAD A surveyor(s) may kindly request that they step away from the process. Thank you for your partnership in helping us conduct thorough and respectful surveys.

Initial Surveys

Surgical, Procedural, Pediatric Dentistry, Oral & Maxillofacial, International Surgical, and International Dental: The initial survey is performed by a surveyor or team of surveyors after the facility has performed ten (10) cases, which can be any combination of Medicare and non-Medicare procedures, in order for the survey team to review a sufficient number of clinical records and other documentation, to determine compliance.

CMS: ASC, RHC, and OPT: The initial survey is performed by a surveyor or team of surveyors after the facility has provided care for ten (10) patients, which can be any combination of Medicare and non-Medicare procedures, in order for the survey team to review a sufficient number of clinical records and other documentation, to determine compliance.

QUAD A awards each facility a three-year term of accreditation when it has determined that the survey findings are accurate, the facility has proven a commitment to provide high-quality care and services and concludes that the facility is in compliance with all QUAD A standards and Medicare Conditions for Coverage or Conditions of Participation (as appropriate), state/local, state/provincial and federal/national regulations.

Unannounced Surveys for Medicare-Deemed Facilities

QUAD A requires that all surveyors agree to conduct Medicare surveys in accordance with Section 2700A of the State Operations Manual (SOM), which states that surveys for all providers (including all types of hospitals) and suppliers (other than laboratories) are unannounced. To that end all surveyors must acknowledge their understanding of that requirement and assume all responsibility under Sections 1819(g)(2)(A)(i), 1919(g)(2)(A)(i), and 1891(c)(1) of the Social Security Act, which establish civil monetary penalties for any individual who notifies a facility of the date and or time of a survey.

i. Surveyors must agree to abide by this requirement and attest to the same in signing the Surveyor Agreement upon becoming an active surveyor.
ii. The surveyor must reaffirm that the specific survey was unannounced by signing the Surveyor Attestation, including a statement of compliance, that is required for each Survey Report submission.

Any surveyor whose file does not include a signed initial agreement to conduct all Medicare surveys unannounced, will not be activated for deployment on QUAD A Medicare surveys. Survey results that do not bear the surveyor's attestation that the specific survey was unannounced will not be considered valid, and the surveyor may not receive the honorarium for the survey and will become inactive until all Survey Reports are verified as unannounced.

Life Safety Code (LSC) Surveys

CMS requires that an independent Life Safety Code (LSC) survey in accordance with the NFPA 2012 Life Safety Codes and 2012 Health Care Facilities Codes. QUAD A will utilize either a contracted surveyor or a direct hire Life Safety Code Specialist to conduct the survey and provide a report to QUAD A. A copy of the Statement of Deficiency Report will be provided to the ASC. The ASC is responsible for correcting any deficiencies noted by the Fire Safety Specialist, who will also review any Plan of Correction submitted and make the final determination of acceptability. Please note that the ASC assumes all costs associated with the LSC survey.

When conducting the survey, the Life Safety Code (LSC) surveyor is required to consider all applicable requirements outlined in the National Fire Protection Association (NFPA) Life Safety Code (LSC), the Health Care Facilities Code (HCFC), and related reference documents.

Extension Site Surveys

CMS OPT only - OPT facilities are permitted to have extension locations as approved by CMS. QUAD A initial and triennial onsite surveys include the primary and all extension locations. Each extension location must independently meet all applicable standards consistent with the primary site.

Extension location: Refers to a location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the Outpatient Physical Therapy facility (OPT). The extension location should be located sufficiently close to share administration, supervision, and services with the primary site and any other extension locations in a manner that renders it unnecessary for the extension location to independently meet the Conditions of Participation (CoP) as an OPT.

All sites (primary and extension locations) combine to comprise a single unit (an OPT) for deeming purposes. A deficiency citation at any site reflects as a deficiency for that standard for the entire OPT operating under a single CMS Certification Number (CCN). Non-compliance with standards at any single location jeopardizes the certification of the entire OPT (all associated locations). If an OPT that is already deemed applies to add an extension site and the extension site fails to comply with all applicable standards, QUAD A will deny the addition of that site. One (1) Statement of Deficiency Report that contains the primary and extension site survey results will be generated by QUAD A.

OPTs seeking new (initial) or continued participation via deemed status may apply to add extension locations with the QUAD A accreditation application. In these cases, all extension locations will undergo an on-site survey, along with the primary site.

Note: All extension site additions must receive an enrollment approval via the CMS 855 process (PECOS)

Performance of Onsite Surveys

This section defines the process that the QUAD A survey team must use for completing an onsite survey. Utilization of this process is the minimum expectation of a surveyor. Some survey teams may review additional files or materials if a determination of compliance cannot be made from using the minimum set by the QUAD A standards or if noncompliance requires additional investigation.

QUAD A requires 100% compliance with each standard to become and remain accredited. There are no exceptions. Because QUAD A requires 100% compliance with all requirements prior to attaining accreditation, facilities who achieve accreditation are not required to publicly post their survey performance data. If accreditation has been conferred and a facility possesses a valid QUAD A accreditation certificate, it is because the facility has demonstrated 100% compliance with applicable standards, including providing evidence of having corrected any cited deficiencies.

The Medical Director or Outpatient Physical Therapy Administrator must attest that the facility meets all local, state/provincial, and federal/national and regulatory requirements, since such governmental regulations may supersede QUAD A standards. Please note, however, that the stricter requirement always applies, whether it is the federal/national, local, state/provincial, or QUAD A standard. The facility is required to annually submit a signed Medical Director's Responsibilities & Attestation (CMS OPT only – Clinic Administrator's Responsibilities & Attestation) to the QUAD A office.

It is critical that all surveys are conducted according to the QUAD A survey guidelines. Survey findings must comply with the instructions for writing deficiency reports (and the CMS **Principles of Documentation**, as appropriate), in order for QUAD A to determine that an adequate survey has been performed, and survey findings are complete.

To ensure uniformity of the QUAD A survey process and standards compliance, QUAD A has established this pre-amble to our current standards as a guide for surveyors and facilities. QUAD A surveys must be conducted in a consistent manner to ensure a fair and unbiased evaluation for each survey performed regardless of accreditation program, CMS, local regulations (as appropriate), or geographic location.

QUAD A is committed to conducting thorough, accurate, and standardized surveys. Surveys must include a review of the facility's physical plant, policies, procedures, patient records, personnel records, and

interviews of key staff and patients. Survey findings are a collaborative effort of the entire survey team. Final determinations of surveyor findings require discussion between team members to establish and indicate surveyor evidence and appropriate citation level as defined by QUAD A.

Surveyor(s) should attempt to build consensus about their findings among the team. However, the lead surveyor is ultimately responsible for determining the appropriateness of the survey findings. When necessary, the team leader will contact the QUAD A Clinical Review Analyst while at the facility if additional guidance is needed. For all survey reports, a clinical analyst reviews all surveyor findings for accuracy before the facility receives its final Statement of Deficiency Report.

Sample Accreditation Survey Agendas — Medicare and Non-Medicare Surveys

Agenda: Ambulatory Surgical Center				
		Life Safety Surveyor		Survey Activity - (may occur on a separate day)
		8:00 AM	12:30 PM	Life Safety Code® Building Assessment
Team Leader		Surveyor #2		Survey Activity
7:45 AM	8:00 AM	7:45 AM	8:00 AM	Arrival to the Organization and Introductions
8:00 AM	9:00 AM	8:00 AM	9:00 AM	Opening Conference and Orientation to the facility
9:00 AM	9:30 AM			Basic Mandates
9:30 AM	10:00 AM			Facility Layout and Environment Tour
10:00 AM	11:00 AM			Physical Environment Review
11:00 AM	12:00 PM			Review of Clinical Records
		9:00 AM	11:00 AM	Case Tracer and Observation of Care
		11:00 AM	11:30 AM	Review of Medications
		11:30 AM	12:30 PM	Infection Control Practices & Policies Review
12:00 PM	12:30 PM			Equipment Review
12:30 PM	1:00 PM	12:30 PM	1:00 PM	Survey Team Lunch
1:00 PM	1:30 PM			Safety Review
		1:00 PM	2:30 PM	Emergency Procedures Review & Emergency Preparedness
1:30 PM	2:00 PM			Governing Body Review
		2:30 PM	3:00 PM	Quality Assessment/Quality Improvement/Risk Management Review
2:00 PM	3:00 PM			Review of Personnel Records
3:00 PM	4:00 PM	3:00 PM	4:00 PM	Team Meeting / Documentation of Findings
4:00 PM	4:30 PM	4:00 PM	4:30 PM	Exit Conference

Agenda: Dental, OBS, OMS, Procedural, Surgical		
Survey Activity		
7:45 AM	8:00 AM	Arrival to the Organization and Introductions
8:00 AM	8:30 AM	Opening Conference and Orientation to the facility
8:30 AM	9:00 AM	Basic Mandates
9:00 AM	9:30 AM	Facility Layout and Environment Tour
9:30 AM	10:00 AM	Physical Environment Review
10:00 AM	10:30 AM	Review of Clinical Records
10:30 AM	11:00 AM	Review of Medications
11:00 AM	11:30 AM	Equipment Review
11:30 AM	12:00 PM	Safety Review
12:00 PM	12:30 PM	Survey Team Lunch
12:30 PM	1:00 PM	Infection Control Practices & Policies Review
1:00 PM	1:30 PM	Emergency Procedures Review
1:30 PM	2:00 PM	Governing Body Review
2:00 PM	2:30 PM	Quality Assessment/Quality Improvement/Risk Management Review
2:30 PM	3:30 PM	Review of Personnel Records
3:30 PM	4:00 PM	Team Meeting / Documentation of Findings
4:00 PM	4:30 PM	Exit Conference

Agenda: Outpatient Physical Therapy		
Survey Activity		
8:00 AM	8:15 AM	Arrival to the Organization and Introductions
8:15 AM	8:30 AM	Opening Conference and Orientation to the Facility
8:30 AM	9:00 AM	Personnel Qualifications Review
9:00 AM	9:30 AM	Administrative Management
9:30 AM	10:00 AM	Plan of Care and Physician Involvement Review
10:00 AM	10:30 AM	Physical Therapy Services Review
10:30 AM	11:00 AM	Occupational Therapy Services Review
11:00 AM	11:30 AM	Speech Pathology Services Review
11:30 AM	12:00 PM	Rehabilitation Program
12:00 PM	12:30 PM	Survey Team Lunch
12:30 PM	1:00 PM	Arrangements for Services to be Performed By Other Than Salaried Organization Personnel
1:00 PM	1:30 PM	Clinical Records
1:30 PM	2:00 PM	Physical Environment
2:00 PM	2:30 PM	Infection Control
2:30 PM	3:00 PM	Program Evaluation
3:00 PM	3:30 PM	Emergency Preparedness Review
3:30 PM	4:00 PM	Team Meeting / Documentation of Findings
4:00 PM	4:30 PM	Exit Conference

Agenda: Rural Health Clinic		
Survey Activity		
8:00 AM	8:15 AM	Arrival to the Organization and Introductions
8:15 AM	9:00 AM	Opening Conference and Orientation to the Facility
9:00 AM	9:30 AM	Physical Plant and Environment Review
9:30 AM	10:00 AM	Organizational Structure Review
10:00 AM	11:00 AM	Staffing and Staff Responsibilities
11:00 AM	12:00 PM	Provision of Services Review
12:00 PM	12:30 PM	Survey Team Lunch
12:30 PM	1:30 PM	Program Evaluation Review
1:30 PM	2:30 PM	Emergency Preparedness Review
2:30 PM	3:30 PM	Patient Clinical Records Review
3:30 PM	4:00 PM	Team Meeting / Documentation of Findings
4:00 PM	4:30 PM	Exit Conference

Please take note that the timeframes for each survey activity listed are estimates that surveyors may use as a reference. Additionally, the order of survey activities can be rearranged based on patient care and availability of staff provided that the integrity of the survey process is maintained.

Sample MedSpa Survey Agenda

Time	Agenda Item	Duration	Purpose / Key Activities
8:00 AM	Opening Conference	30 min	Establish rapport & review survey process. Discuss state requirements (if applicable). Verify risk stratification classification. Attendees: Med. Director, Manager, key staff.
8:30 AM	Facility Tour & Environment of Care	45 min	Observe safety, workflow, and infection control. Check treatment rooms, medication preparation area, emergency equipment, and medication storage.
9:15 AM	Direct Observation of Patient Care	60 min	Critical: Observe 1-2 patient interactions. Focus: Consent process, positive patient ID verification, infection control (hand hygiene, clean technique), patient rights, clinical technique, procedures performed aligned with risk stratification, and real-time documentation (may include patient interview).
10:15 AM	Document Review - Part 1	75 min	Review clinical records (5-8 patients for simple relevant history or H&P as required by risk stratification, consent, photos, notes) and personnel files (licenses, certifications).
11:30 AM	Lunch / Surveyor Work Period	30 min	Surveyor's private time for note consolidation and preparation for afternoon.
12:00 PM	Document Review - Part 2	60 min	Review Medical Director requirements, QA/PI records, key Policies & Procedures, device maintenance logs.
1:00 PM	Staff Interviews	45 min	Interview clinical and administrative staff (individually/small groups) to assess knowledge of protocols, emergencies, and roles.
1:45 PM	Surveyor Private Analysis & Report Prep	45 min	Finalize findings, complete score sheets, and prepare exit conference summary.
2:30 PM	Exit Conference Briefing	15 min	Optional: Private preview of key findings with Med. Director/Manager for clarity.
2:45 PM	Formal Exit Conference	15 min	Present summary of strengths and findings, explain next steps in accreditation process, and conclude survey.

Note: The times and sequence below are guidelines. The actual flow of the agenda may vary based on patient schedules, staff availability, and facility operations. The surveyor must maintain flexibility while ensuring all key components are addressed.

Onsite Survey Overview

The following has been developed to assist facilities in becoming more familiar with the accreditation process, identify key staff members for participation, and prepare your facility for the scheduled onsite survey.

Review the physical layout, clinical staff size, staff credentials, and requirements for clinical record review. Take note of any questions or concerns you have and be prepared to review any concerns with the facility staff. A thorough review of the survey documentation will help prepare the surveyor to conduct a detailed and efficient survey.

QUAD A requires surveys be conducted in a standardized and thorough manner. The surveyor is expected to be collaborative and respectful with their fellow surveyors and facility staff.

The following procedures must also be utilized during the survey process:

- The surveyor must plan to be at the survey site to allow for adequate surveyor hours to complete the survey. The survey team should plan to enter the facility as the facility is opening.
- Make travel arrangements flexible enough to consider that additional hours may be required to complete the onsite survey, in collaboration with QUAD A approval. It is not appropriate to rush through aspects of the survey process due to inappropriately scheduled travel arrangements. There must be sufficient time allowed to complete the survey as required by QUAD A policies and protocols.

Upon arrival, the survey team should inform the facility they have arrived to conduct a survey of the facility (all locations) and request that the Medical Director be notified. Ask the facility to provide a dedicated, private, and secure area for the survey team to review materials and complete the survey report.

Entrance conference should include:

- Survey purpose
- Survey scope
- Survey methodology
- Case tracer expectations
- Documentation review
- Exit conference expectations

Prior to beginning the survey activities, the survey team should confirm the following items during the entrance conference with the Medical Director (or designee) and key staff, as identified by the facility, to:

i. Introduce surveyor(s) and their background.
ii. Confirm the type of survey being conducted (Initial, Re-survey, Follow-up, Complaint, etc.).
iii. Request a dedicated workspace for the survey team.
iv. Explain the survey process and methodology.
    a. Non-Medicare surveys - Point out that deficiencies corrected during the survey must be cited as deficiencies, although if appropriately corrected in the presence of the survey team they may be noted as "Corrected on Site" (depending on nature and severity of deficiency).
    b. Medicare surveys - Point out that all instances of noncompliance are considered deficiencies and will appear in the final survey report. A comprehensive Plan of Correction will be required for all deficiencies cited during the survey even if Corrected on Site.
    c. Components of survey:
        i. Familiarization Tour: There will be familiarization walkthrough of the facility including, but not limited to, the reception and waiting areas, the business office, lavatories, medication areas, exam and consultation rooms, prep area, procedure/operating room(s), recovery rooms, and discharge area.
        ii. Request any QUAD A or CMS approved waivers.
        iii. Safety of Operating Room (OR) and Recovery Room Environment: The surveyor will concentrate on the equipment, medication, and supplies in the operating room and recovery room(s).
        iv. General Safety in the Facility: The surveyor will review documentation, including the safety manual, emergency protocols, transfer agreement (if required), hazardous waste protocols, IV fluids, and medication management and storage.
        v. *CMS ASC only* – Case Tracer – the observation of a surgical case: registration, pre-operative to Post Anesthesia Care Unit (PACU) to discharge.
        vi. Document Review: The surveyor(s) will review clinical records, personnel files, manuals, policy and procedures, peer review documentation, meeting minutes, Patient Safety Data Reporting (PSDR) records, and organizational documents.
        vii. Survey Findings: The surveyor will enter all survey findings in the survey app. For any finding of noncompliance with a standard that remains deficient since the previous triennial survey, please enter the following statement in the: This is a repeat deficiency.
        viii. Exit Interview: The surveyor will review the survey process in an exit interview with the Medical Director and key staff with discussion of areas of deficiency and suggestions for improvement.

v. Request a Registered Nurse or facility supervisor/administrator to accompany the surveyor(s) during the survey. Request that a staff member be appointed to assist the survey team as needed. It may be necessary for that staff member to guide surveyor(s) through patient charts or electronic medical records and policies.

vi. Conduct the facility walkthrough. If the facility staff have already gathered their policies and procedures, the survey team may begin the walkthrough of the facility. If not, the survey team should request that the documents be pulled while the survey team conducts the walkthrough.

vii. Ask that patients undergoing care in the facility be made aware that a QUAD A (accreditation) survey is being performed by QUAD A surveyor(s). Facility staff must obtain consent from the patient when care will be observed as part of the survey process.

Once the entrance conference has concluded, the survey team should:

a. Perform the walkthrough of the facility.
    a. If the survey is conducted by multiple surveyors, the full survey team will then meet to decide how the survey will be conducted.
    b. The lead surveyor can adjust the assignments for each member of the team.

b. Perform a thorough and unbiased evaluation of the facility by observation, staff and patient interviews, document and file review, and utilization of the materials provided.

Important for Medicare: *Each standard must be marked compliant or deficient in the survey app. If you need additional information to determine whether the facility is in compliance with the Standards, refer to our "Surveyor Resources" for web links to access the complete CMS Interpretive Guidelines.*

Conducting Patient and Staff Interviews Medicare and non-Medicare Surveys:

a. For all interviews, surveyors must use open-ended probing questions, not "Yes" or "No" inquiries.
b. Interview patients about their care, objectives of treatment, knowledge and understanding of treatment, post-treatment care and patient responsibilities, discharge planning, and rights.
c. Interview the staff about their knowledge of patient care needs, their assigned patients and responsibilities, and their knowledge of facility policies and procedures.
d. There are elements related to each standard or condition that the surveyor might need to discuss with the administrator, facility director, or Medical Director depending on the program.
e. Surveyors must obtain information from other key personnel who are responsible for the delivery of patient care, treatment, or services.

f. Staff interviews are geared to the appropriate personnel to elicit information that demonstrates their knowledge of the facility's policies and procedures.

c. Observations of noncompliance must be verified by a staff person from the facility and included in the deficiency statement. In addition to making a clearer deficiency statement, this assures that the clinical staff are aware of the findings as they are observed, so that there are no surprises at the end of the survey.

d. Once the survey process is complete, the surveyor should enter all findings in the survey app. The surveyor must complete all mandatory survey report forms and adequately and appropriately document the survey findings according to QUAD A requirements.

All surveyors, upon completion of the survey, conduct an exit interview with the Medical Director (or designee) and key staff. Review all preliminary findings and observations. Clearly indicate that the survey team does not make accreditation decisions. The final accreditation determination is made by QUAD A.

- Inform the facility that they:
  - Will receive a survey report from the QUAD A office within ten (10) business days from the end date of the survey.
  - Will be required to submit an acceptable Plan of Correction (PoC) for any deficiencies within ten (10) calendar days of QUAD A issuing the survey report.
  - Will be required to provide evidence that deficiencies have been corrected within thirty (30) calendar days of QUAD A issuing the survey report.
- Complete all surveyor documentation and return all survey documentation materials electronically within two (2) calendar days of completing the survey. Questions regarding documentation requirements may be directed to the QUAD A Accreditation at 1-888-545-5222.

***Please note*:** All deficiencies must be cited even if the facility corrects a deficiency during the onsite survey. For non-Medicare surveys, the surveyor(s) will document that the deficiency was Corrected on Site upon writing the SOD. Deficiencies noted as Corrected on Site will still require the facility to submit a Plan of Correction (PoC) and Evidence of Correction (EoC). Corrected on Site is not applicable to the Medicare surveys and language should not appear in the SOD that the facility corrected a deficiency onsite. Surveyor(s) must follow the CMS Principles of Documentation to document every deficiency.

Upon receipt of the survey report, the QUAD A office may contact the surveyor(s) for additional information or clarification, if needed. Surveyors must provide immediate responses to post-survey questions as QUAD A must submit the survey findings to the facility within ten (10) business days from the end date of the survey. Please note, surveyor honorariums will be held until a complete and accurate survey report is established.

How to Conduct the Review of Clinical Records

Clinical record review is conducted as part of the survey process. Surveyor(s) must ensure that a random sample of clinical records is reviewed.

The following criteria must be met when performing clinical record review during an onsite survey:

1. The facility is required to produce a log or other record of closed cases for the previous six (6) month period and the lead (or assigned) surveyor will select a sample of clinical records to review. Please note: In all surveys, the surveyor must make the sample record selections. It is not appropriate to allow facility staff to select the sample records to be reviewed.
2. Sample size - surveyors may increase the sample size if initial findings suggest systemic deficiencies.
    i. CMS ASC, Surgical, Procedural, OMS, Pediatric Dentistry, International Surgical, International Dental and Polyclinic:
        1. **High-volume facilities:** If the facility performs more than 50 cases per month on average, you will need to review a minimum of **20 records**.
        2. **Lower-volume facilities:** If the facility averages 50 or fewer cases per month, you may review a minimum of **10 records**.
    ii. The total number of records within the six-month case period must be noted on the review form. The average monthly case volume must be noted on the electronic survey record.
    iii. The sample must include a representative sampling of procedures and surgeries conducted, providers performing procedures and surgeries, various anesthesia types (as appropriate), and adverse events, including deaths, unanticipated transfers, and post-operative infections.
    iv. *All CMS ASCs must have begun treating patients and are currently treating patients to enroll in the program.*
    b. CMS RHC: The minimum number of records selected for review is twenty (20) for a clinic with a monthly case volume exceeding fifty (50) patients, and ten (10) for lower volume clinics and initial (Start-up) surveys.
        - *Please note: The number of records reviewed should be determined by case volume, not patient visits.*
        - The total number of records within the six-month case period must be noted on the worksheet/portal.
        - The sample must include a representative sampling of all services provided, clinicians providing the services, and open and closed records.
        - *All RHCs must have begun treating patients and are currently treating them to enroll in the program.*

- **CMS OPT:** The organization maintains clinical records on all patients in accordance with accepted professional standards, and practices. The clinical records are completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.
- Sample a minimum of twenty-five (25) clinical records, representing both the organization's current roster of patients, as well as records from discharged patients, from the past six (6) months. The sample must include records from both the primary site and any extension locations.
- "Case" – The term "case" in this policy is used interchangeably with the term record and is defined as unique patient admissions, including all of the treatments, visits, and diagnosis across all services between a single admission and discharge. Even if an admission includes treatments in multiple services that are stored in separate files, they are considered one (1) case for the record review process. However, if the same patient has been treated as part of multiple admissions, each separate admission is considered a case.
- The number of records reviewed should be determined by case volume not patient visits. The total number of records within the six-month case period must be noted on the review form to establish the monthly average.
- *All OPTs must have begun treating patients and are currently treating patients in order to enroll in the program.*
- The selected records to be reviewed should include a sample from each therapist and discipline Physical Therapist, Occupational Therapist, Speech Language Pathologist (PT, OT, SLP) as offered at the site. Include in the sample those patients whose treatment are/were provided by a contracted employee, to ascertain whether evaluations, plans of care, progress notes, and other pertinent clinical material are present and that the clinical records for all patients are maintained on the premises of any location at which services are rendered.

3. A sample of both open and closed cases must be reviewed.
    - Non-Medicare Surgical/Procedural Facilities - An open case is defined as a patient that is being treated on the day of the survey.
    - *CMS ASC only* e case that was observed on the day of survey must be included in the clinical record review sample.
    - *RHC & OPT only* – An open case is defined as an active patient who is currently under the care of the facility.

4. The sample selected must represent a cross section of the cases performed at the facility.
    a. Medicare facilities – The sample selected must include both Medicare beneficiaries and non-Medicare patients.

If deficient practices are noted during the records review, the survey team should request additional record samples to substantiate the finding(s) documented from the initial sample. If the team reviews additional records, the team must include those reviews and document every record that was included in the sample review.

- **Medicare only**: If an egregious number of deficient practices are noted, the survey team must at least document their consideration of whether the deficiencies constitute Condition-Level noncompliance.

The Clinical Record Review Worksheet is a part of the official survey documentation provided to the survey team by QUAD A. The review form must be completed for all records that are reviewed with the findings noted appropriately. This worksheet contains the required elements which must be present in each clinical record. As needed, surveyors should use the blank rows at the end of the worksheet to add facility-specific requirements based on facility policies related to clinical records.

Each record reviewed must be scored for each standard element on the worksheet:

1. Choose "NO" from the drop-down if the required element is not present in the record (Deficient).
    a. Add up the number of "N" responses over the total number of records reviewed for the final record score (e.g., 3 (deficient)/10 (reviewed)).

2. Mark "N/A" if the required element does not apply to the record being reviewed.
    a. Each "N/A" score requires an explanation in the comment section for that standard.
    b. "N/A" should only be used for requirements that are truly conditional such as if a male patient does not require a pregnancy test, or per facility policy a 20-year-old patient with no pre-existing conditions does not require a pre-operative EKG/other testing.
    c. "N/A" is not appropriate for instances in which the facility chooses not to collect a certain piece of information. In this case, the appropriate standard must be marked deficient if evidence of compliance cannot be provided during the time of the survey.

How to Conduct the Review of Personnel Records

The facility must produce a complete list of all employees, including contract and PRN staffers, surgeons/proceduralists who are owners, etc. The surveyor(s) should review the list for accuracy at the beginning of survey activities and must ensure that a random sample of clinical personnel records are reviewed.

Qualified personnel providing services at ASCs, OPTs, and RHCs, and non-Medicare programs, must be licensed, registered, or certified (when licensure, registration or certification is applicable). This includes personnel providing services directly or under arrangement.

Review the organization's personnel records for evidence of current licensure or registration of personnel (e.g., wallet size identification cards sometimes made available). Where personnel are required to be licensed, but are not licensed, notify the appropriate State licensing body. If extension locations are located in other States, ensure that personnel who are providing services are licensed in the State in which the services are provided. Generally, licenses or registration certificates are located in credential files or posted in the facility or located on office walls.

The minimum number of records selected for review is fifty percent (50%) of the total number of clinical personnel. (See Glossary for QUAD A's definition of "Clinical Personnel".) *For ASCs, OPTs, and RHCs, and non-Medicare programs,* the licensure of all clinical personnel (required to be licensed under State/local laws or regulations) must be reviewed for verification of appropriate documentation. The total number of clinical personnel and personnel records reviewed must be documented on the form to ensure adherence to the policy. For example: in a facility with ten (10) surgeons, four (4) anesthesia professionals, and twenty (20) licensed nurses, the personnel worksheet should reflect a thorough review of seventeen (17) staff members followed by a validation of current licensure for the additional fourteen (14) licensed staff members.

If deficient practices are noted during the record review, the survey team should request additional records to substantiate the findings documented from the initial sample. If the survey team reviews additional records, they must document every record that was included in the sample review. For example: when a facility is notified that evidence of current licensure is missing in a personnel file, and later, evidence of current licensure is provided to the survey team, the findings must be cited to note a breakdown in the organizational process to monitor licensure. If a facility has five (5) or fewer staff members, all five (5) records must be reviewed.

- **Medicare only**: When multiple deficient practices are noted, the survey team must at least document their consideration of whether the deficiencies constitute Condition-Level non-compliance.

The Personnel Record Review Worksheet is part of the electronic survey documentation in the survey app provided to the survey team by QUAD A. The review form must be completed for all records reviewed with findings noted appropriately.

- At the top of the worksheet, please indicate the clinical personnel breakdown by type and number of providers.

- This worksheet contains the required elements that must be present in each personnel file.
- As needed, surveyors should use the blank rows at the end of the worksheet to add facility-specific requirements based on facility policies related to personnel files.

Each record reviewed must be scored for each standard element on the worksheet.

1. Choose "NO" from the drop-down if the required element is not present in the record (Deficient).
    a. Add up the number of "N" responses over the total number of records reviewed for the final record score, e.g., 3 (deficient) /10 (reviewed).

2. Mark "N/A" if the required element does not apply to the record being reviewed.
    a. Each "N/A" score requires an explanation in the comment section for that standard.
    b. "N/A" should only be used for requirements that are truly not applicable, such as if a State does not require a License for certain professionals.
    c. "N/A" is not appropriate for instances in which the facility chooses not to collect a certain piece of information. In this case, the appropriate standard must be marked deficient if evidence of compliance cannot be provided during the time of the survey.

How to Conduct a Case Tracer

CMS ASC only - CMS requires surveyors to observe at least one (1) procedure during the Medicare ASC survey process, referred to as the "case tracer." The following information is a guideline for QUAD A Medicare surveyors to use in completing the case tracer requirement as a part of a Medicare survey.

At the beginning of the survey, the lead surveyor must select one (1) or more surgical cases for observation during the survey. Surgical patients remain in the facility up to a maximum of twenty-four (24) hours; therefore, following individual cases from start to recovery or discharge is an effective tool for assessing the facility's compliance with all QUAD A standards. The number of cases selected will depend on the size of the survey team, the scheduled length of the survey, and the expected duration of the surgical case. Depending on the timing of the case selected, a surveyor may begin a case observation immediately. For larger facilities (i.e., those with more than two (2) operating or procedure rooms, or for multi-specialty facilities), surveyors should consider observing two (2) cases.

In following the case(s) surveyors will look for evidence of compliance related to various QUAD A requirements, including, but not limited to, infection control, physical environment, medication administration/safety, assessment of anesthesia and procedure risk as well as the required preoperative update assessment of changes from the history and physical, provision of surgical and anesthesia services, post-surgical assessment, recovery from surgery and anesthesia, and discharge orders.

Case Selection:

- Obtain the day's surgery schedule from the facility.
- Guidelines for selecting the patient to follow:
    - Choose a more complex case, based on the type of procedure, higher level of anesthesia, patient age, or patient co-morbidities.
    - Avoid selecting a case where surveyors anticipate that patient modesty concerns may make it harder to obtain the patient's consent.
    - To make efficient use of onsite time, avoid selecting a case where the surgical time is expected to exceed ninety (90) minutes unless there are no shorter cases scheduled on the survey day.

- Surveyor(s) are required to follow at least one (1) patient through registration, pre-operative, surgery, post-operative, and discharge.
    - If the surgery runs longer than ninety (90) minutes, the surveyor can opt to be present at the beginning of the procedure, then may conduct other survey duties as long as the surveyor is present when the facility transfers the patient to post-operative.
    - It may be useful for a surveyor to remain in the OR after the patient leaves to observe how the OR is cleaned and prepped for the next case.

- If multiple surveyors are present, they should arrange for one (1) surveyor to remain with the patient to observe post-operative care while a different surveyor remains in the OR.
- If the survey is performed by a solo surveyor, observation of OR room turnover or room set-up may not be possible until after the observed patient has been discharged.

Patient's Right to Refuse:

- It is the responsibility of the facility staff to obtain patient consent to allow surveyor(s) to observe the surgery.
- The patient has the right to refuse, and another surgery/patient should be selected if consent cannot be obtained for the first selection by the surveyor.

Facility's Right to Refuse:

- If the surgeon refuses to allow the surveyor(s) to observe the surgery, the Medical Director should be notified.
- Failure to allow the surveyor(s) to perform the case tracer by the facility staff must be documented in writing by the survey team and signed by the Medical Director. If the Medical Director is not onsite, a designee can sign but the Medical Director's awareness must be documented and initialed by surveyor(s) and facility staff.
- The lead surveyor should inform the Medical Director that failure to allow the survey team to complete all segments of the survey; including the case tracer, will result in denial of accreditation. Facilities will be invoiced according to the QUAD A Cancellation Policy.
- Surveyors must contact QUAD A for additional guidance.

Performance of the Case Tracer:

- *Please note*: Throughout the survey and while observing a procedure for the case tracer, maintain an open dialogue with staff, but be aware that you are there to observe, not advise, or critique. It is not appropriate to delay or stop a procedure unless you become aware of an Immediate Jeopardy (IJ) issue that may risk the patient's safety.
- The surveyor must follow the patient starting with patient registration, pre-operative preparation and assessment and concluding with the patient's discharge (if discharge is delayed, observation may conclude in post-anesthesia recovery).
- The case tracer is meant to observe and evaluate for compliance with multiple standards.
    - Observe for compliance with standards throughout the case, particularly transition points.

  - Observe the environment, staff interactions, patient safety practices, medication labeling (on or off the surgical field) and medication security, and infection prevention and control practices.
- Interview patient and/or patient's family member about patient care, knowledge of their surgery or procedure, post-operative care, discharge planning, and their privacy and patient rights.
- Interview clinical staff caring for the patient about their knowledge of the patient and care needs, their assigned patients and responsibilities, and their knowledge of the policies and procedures relating to the pre-operative, intra-op, and post-operative periods.

Completing the Case Tracer Template:

- Include required information as collected during the performance of the case tracer.
- Document all findings observed during the case tracer procedure even if those findings do not conform to the template.
- Share findings with other survey team members and cross verify information as appropriate.

Completing Observation of Care:

1. *Please note*: Observation of Care is not peer review; the surveyor does not evaluate surgical techniques, procedural decisions, or clinical judgment. It is meant to be a fluid process where the surveyor observes portions of the care in real time, not a case tracer where one patient is followed from registration through discharge, as in a Medicare facility.
2. Observations may include full **procedural** or **surgical** observations, examples are as follows, but not limited to:
    a. Patient Identification – Verifying correct patient identification before procedures.
    b. Time-Out Process – Confirming procedural pauses for safety checks.
    c. Handoff Communication in PACU – Assessing how patient information is transferred during care transitions.
    d. Infection Control and Sterilization – Evaluating hand hygiene, high-level disinfection, and cleaning protocols.
    e. Room Turnover Procedures – Monitoring efficiency and cleanliness between procedures.
    f. Medication Management – Validating proper labeling, administration, and storage.
    g. Discharge Process – Confirming safe and effective patient release practices.

Submitting Survey Documentation

QUAD A only accepts survey findings and documentation on official QUAD A *forms [in the official QUAD A survey app]*. Any surveyor-created materials submitted may be considered supplemental to, or supportive of, official documentation, but do not independently constitute submission of a surveyor's report.

All survey documentation must be submitted in electronic form, no later than two (2) business days after the survey end date.

Surveyors must be available for QUAD A staff support functions for up to thirty (30) days after the survey end date. (Available means you must be able to correspond with the QUAD A office for questions, and revisions to a statement of deficiency). If you will not be available during the thirty (30) days following the survey date, do not accept the survey assignment, or if something unexpected comes up, please contact the Scheduling department for reassignment.

The QUAD A staff may not revise surveyor documentation other than to make spelling or grammatical corrections. Statements of Deficiency (SOD) must be completed according to the CMS Principles of Documentation.

How to Write a Statement of Deficiency (SOD)

Each numbered standard must have a response as appropriate per facility program and class. During the onsite survey, the surveyor(s) maintains a record of the standards for compliance and marks each standard as Compliant, Deficient, Corrected on Site, or Not Applicable. If a standard for the class (A, B, C-M, or C) does not apply to the identified class of the facility, indicate such by marking N/A on the answer sheet. Please note: C-M is only applicable in the international accreditation surgical programs.

All "Deficient" answers should be discussed with the Medical Director and/or designee, and the surveyor(s) should discuss the findings clearly (recommendations for corrective actions should not be included in the SOD report).

For each requirement marked deficient, the surveyor will document the specific findings including the following:

- An explicit statement that the requirement was "NOT MET."
- The factual evidence to support the deficiency.

If a standard does not apply to the situation in the facility, the surveyor must indicate such by selecting "N/A." For every "N/A," there **must** be an explanation noted by the surveyor to justify that response.

A Statement of Deficiency (SOD) must be completed for each deficient standard. This SOD must be submitted in the QUAD A approved format. Keep in mind the facility will use the SODs for reference in providing an acceptable Plan of Correction (PoC) for each deficiency.

The SOD must clearly and legibly explain how the facility failed to comply with the requirements directly, not how it failed to comply with any guidelines for the interpretation of those requirements. A comprehensive SOD must include the facts and findings relevant to the deficient practice, must illustrate the entity's non-compliance with the requirement, and must answer the questions: Who, What, Where, When, and How.

Sufficient supporting detail must be included, such as:

a. An explicit statement that the requirement was "NOT MET".
b. The language from the standard, which specifies the aspect(s) of the requirement with which the facility was non-compliant.
c. The actual deficient practice statement, which includes:
    a. The specific action(s), error(s), or lack of action (deficient practice),
    b. Outcome(s) relative to the deficient practice or the number of deficient cases relative to the total number of such cases,
    c. The identifier of the individuals or situations referenced in the extent of the deficient practice, and
    d. The source(s) of the information through which the evidence was obtained.
d. The relevant facts and findings relevant to the deficient practice, which answer the questions: who, what, where, when, and how. These facts and findings illustrate the facility's non-compliance with the requirement or regulation.

Wherever possible, supply a numerator and denominator to demonstrate how systemic or prevalent a deficiency is, for example, "Four (4) of six (6) clinical records failed to include an informed consent." When referring to "subsets" of applicable records or files, ensure that the appropriate "universe" is included as the denominator. For example, the survey team reviewed twenty (20) records in total, six (6) of these records were discharge records. When reviewing compliance with discharge orders, the total "universe" of applicable records would be "six" (6).

Refer to the QUAD A/CMS Principles of Documentation for further detailed instructions.

If, at any time, a surveyor is unsure of compliance/non-compliance during the survey or the extent to which the non-compliance may exist, surveyors should contact the QUAD A office to discuss the findings.

Surveyors must submit the completed survey materials electronically to the QUAD A office within two business days of completion of the survey (survey end date). Once reviewed and processed, QUAD A sends a deficiency report to the facility. The facility must provide its PoC for each deficiency and submit Evidence of Correction (EoC) to be reviewed by the QUAD A Accreditation Committee.

Egregious noncompliance that poses an immediate threat to patient safety must be reported immediately to a QUAD A member of the clinical team at 1-847-775-1970 while the surveyor is onsite.

Complete honorarium and expense report in Concur, upload all receipts, and submit to the QUAD A office for processing within ten (10) calendar days of the survey

Medicare ASC, OPT, RHC only:

When writing each SOD, consideration needs to be made to determine whether the found deficiency's level of non-compliance should be cited at the Standard or Condition-level. Unless the QUAD A standard is tied to the CMS Condition-level deficiency, then the default is Standard level deficiency. If a Standard level deficiency or a collection of Standard level deficiencies rises to the severity of a Condition, then the related Condition-level deficiency must be cited. All appropriate deficiencies must be cited including the Condition-level deficiency and all related Standard level deficiencies.

Condition-level noncompliance is defined as substantial noncompliance that limits the facility's capacity to furnish adequate care or potentially adversely affects the health and safety of patients. If Condition level noncompliance is found, Follow-up survey(s) are required to ensure compliance before the facility can be recommended or approved for accreditation.

Observations of Condition level noncompliance are made according to the scope and severity of the noncompliance noted. This could be related to multiple related standards noted to be out of compliance, or a single standard in which the noncompliance is so pervasive, or content is so severe, that a Condition level citation is warranted. The Condition-level citation includes deficient practice statements and findings to support the determination of noncompliance.

If the current noncompliance is identified as a Repeat Deficiency, this is a primary indicator of a systemic failure and must trigger an immediate evaluation for escalation to a Condition-level citation. A pattern of uncorrected problems demonstrates the facility's inability to maintain compliance with the overarching Condition.

Example of a Statement of Deficiency (SOD)

Statement of Deficiency

Official Forms Only Please

Facility ID: 1234 Surveyor: I.M. Surveyor, RN Date: 12/12/2025

☐Condition Level Deficiency

☒Standard #: 14-G-4 Standard Level Deficiency

Instructions:

Include the facts and findings relevant to the deficient practice must answer the questions: who, what, where, when, and how. Illustrate the entity's noncompliance with the requirement. The deficiency citation must explain how the entity fails to comply with the regulatory requirements, not how it fails to comply with the guidelines for the interpretation of those requirements. Refer to the CMS Principles of Documentation for further instruction.

This standard was NOT MET as evidenced by... *(Describe the deficient practice and identify relevant findings and facts that substantiate the failure of compliance.)*

The facility failed to document physical examinations and laboratory tests as required and per clinic policy.

-Documentation of physical examinations were missing in 4/20 clinical records reviewed. Deficient records included: Patients #2, #6, #9 and #11.

-Documentation of laboratory test results were missing in 2/6 applicable records reviewed. Deficient records included: Patients #7 and #17.

During staff interviews at 10:45am, the Clinic Manager verified that the clinic policy was to document physical examinations on every patient and that laboratory results must be documented in the clinical record upon receipt. It was further verified that the laboratory results for:

- Patient #7 was received on 12/27/2025, but as of 01/27/2026, they had not yet been placed in the record.
- Patient #17 was received on 01/03/2026, but as of 01/27/2026, they had not yet been placed in the record.

Example Statement of Deficiency (SOD) (Back-Up Documentation System)

ID	Standard	Score	Findings/Comments
14-G-4	For each patient receiving health care services, the clinic or center maintains a record that includes reports of physical examinations, diagnostic and laboratory test results, and consultative findings.	☐Compliant ☒Deficient	This standard was not met as evidence by the following: The clinic failed to document physical examinations and laboratory tests as required and per clinic policy. Documentation of physical examinations were missing in 4/20 clinical records reviewed. Deficient records included: Patients #2, #6, #9 and #11. Documentation of laboratory test results were missing in two of six applicable records reviewed. Deficient records included: Patients #7 and #17. During staff interviews at 10:45am, the Clinic Manager verified that the clinic policy was to document physical examinations on every patient and that laboratory results must be documented in the clinical record upon receipt. It was further verified that the laboratory results for: • Patient #7 were received on 12/27/2024, but as of 01/27/26, they had not yet been placed in the record. • Patient #17 were received on 01/03/2026, but as of 01/27/2026, they had not yet been placed in the record.

ADVERSE SURVEY FINDINGS: FRAUD & ABUSE

Policy for Reporting Fraud, Abuse, or Suspicious Activities

QUAD A surveyors who suspect or find evidence of fraud, abuse, and/or suspicious activity while performing an accreditation survey, should notify the QUAD A office of their findings during the survey. The Statement of Deficiency report must be submitted electronically within two (2) days of the last date of the survey and include all documented evidence of such suspected fraud, abuse and/or suspicious activity to info@quada.org, Attention: QUAD A Accreditation Manager.

If this is a Medicare-deemed facility, all reports submitted will be forwarded within two (2) business days of receipt to the CMS Center for Program Integrity (CPI) and a copy to the appropriate CMS Survey and Operations Group (SOG) Location that presides over the location of the surveyed facility.

How to Report Fraud and Abuse

When reporting suspected fraud and abuse (including Medicare related fraud and abuse), please include as much of the following information as possible:

- The provider's name and any identifying number you may have.
- The item or service you are questioning.
- The date on which the item or service was supposedly furnished.
- The amount approved and paid by Medicare, if applicable.
- The date of the explanation of benefits.
- The name and Medicare number of the person who supposedly received the item or service, if applicable.
- The reason you believe Medicare should not have paid, if applicable.
- Any other information you may have showing that the claim for the item or service should not have been paid by Medicare, if applicable.

Immediate Jeopardy

An Immediate Jeopardy (IJ) represents a situation in which a facility's noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment, or death. These situations must be accurately identified by surveyors, thoroughly investigated, and resolved by the facility as quickly as possible. An Immediate Jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm.

There are three (3) key components that are essential for surveyors to use in determining the presence of IJ. These components include:

- **Noncompliance**: An entity has failed to meet one (1) or more federal health, safety, and/or quality regulations,

AND

- **Serious Adverse Outcome or Likely Serious Adverse Outcome**: As a result of the identified noncompliance, serious injury, serious harm, serious impairment, or death has occurred, is occurring, or is likely to occur to one (1) or more identified recipients at risk,

AND

- **Need for Immediate Action**: The noncompliance creates a need for immediate corrective action by the facility to prevent serious injury, serious harm, serious impairment, or death from occurring or recurring.

If IJ is suspected or found during a survey, the surveyor must call the QUAD A office during the survey to alert QUAD A of the situation and to allow QUAD A to provide appropriate guidance. It is the surveyor's responsibility to identify the potential for IJ while performing the survey.

IJ points of contact at the QUAD A Office:

- Please call the QUAD A office (847-775-1970), request to speak to a member of the clinical team and mention that you have found a potential "Immediate Jeopardy situation."

CMS Appendix Q - Immediate Jeopardy

Immediate Jeopardy Reporting Template Instructions

Survey teams must use the Immediate Jeopardy (IJ) Template to document evidence of each component of IJ. This template can be found with the survey materials and is to be provided to the QUAD A office with the rest of the onsite survey materials.

Instructions: The survey team must use evidence gathered from observations, interviews, and record reviews to carefully consider each component of IJ outlined in the left-hand column of this template. For an IJ to exist, the survey team must answer "Yes" to all three (3) components and provide a preliminary fact analysis in the right-hand column to support their determination. Use one (1) IJ template for each issue/scenario/situation being considered at IJ level.

For the purpose of completing this template, the following definitions apply:

- Likely/Likelihood means the nature and/or extent of the identified noncompliance creates a reasonable expectation that an adverse outcome resulting in serious injury, harm, impairment, or death will occur if not corrected.
- Noncompliance means failure to meet one (1) or more federal health, safety, and/or quality regulations. Please note, QUAD A reserves the right to apply the same criteria to non-Medicare surveys.
- Recipient at Risk is a recipient who, as a result of noncompliance, and in consideration of the recipient's physical, mental, psychosocial or health needs, and/or vulnerabilities, is likely to experience a serious adverse outcome.
- Serious injury, serious harm, serious impairment, or death are adverse outcomes which result in, or are likely to result in:
    - Death, or
    - A significant decline in physical, mental, or psychosocial functioning, (that is not solely due to the normal progression of a disease or aging process), or
    - Loss of limb, or disfigurement, or
    - Avoidable pain that is excruciating, and more than transient, or
    - Other serious harm that creates life-threatening complications/conditions.

*NOTE: IJ does not require serious injury, harm, impairment, or death to occur. It is sufficient that non-compliance makes serious injury, harm, impairment, or death likely to occur to one (1) or more recipients.

Immediate Jeopardy (IJ) Template: Guidance for Surveyors

The Immediate Jeopardy Template is our standardized tool designed to help you document IJ findings thoroughly and consistently. It serves two important purposes: ensuring all evidence is captured in one place, and clearly communicating the finding to the facility. Here's how to use it effectively.

Documenting the Finding

When completing the template, your goal is to build a clear and complete picture of the situation. Populate each section with specific, factual information drawn from your survey activities:

- Observations: Note times, locations, and specific details of what you observed.

- Interviews: Include summaries of conversations, with staff names/titles and relevant quotes.
- Record Reviews: Reference specific policies, logs, or clinical notes that support the finding.

Communicating the Finding and Next Steps

Once you have confirmed an Immediate Jeopardy situation, prompt action is essential. Here is the process to follow:

1. Notify the Administrator
    - Verbally inform the facility administrator that an Immediate Jeopardy finding has been identified.
    - Provide the completed IJ Template as formal written notice of the finding.
2. Request a Removal Plan
    - Require the facility to submit a written, time-specific plan of correction.
    - Clearly communicate that the plan must address how the facility will immediately stop the harm and implement measures to prevent it from recurring.

Immediate Jeopardy Removal Plans: What Surveyors Need to Know

A Removal Plan is the facility's formal, binding commitment to eliminate an Immediate Jeopardy situation. Your role is to ensure the plan is specific, actionable, and verifiable. Here is what to look for:

What an Effective Removal Plan Must Include

1. Specific Corrective Actions

The plan must clearly describe exactly how the facility will:

- Stop active harm immediately (examples: reassigning staff, removing equipment from service, discontinuing unsafe practices)
- Protect all at-risk patients while corrective actions are underway (examples: implementing one-to-one monitoring, isolating affected patients, suspending certain procedures)

2. A Clear and Realistic Timeline

The plan must include a firm deadline by which all threats will be fully abated. Vague timelines are not acceptable—look for specific dates and times.

Documentation Standards

The written plan should:

- Use active voice that clearly states who will do what and by when (correct: "We will implement X by Y date"; avoid: "Staff will be reminded")
- Be signed by the Administrator as a legally binding commitment

Surveyor Verification: What to Do Next

Once the facility submits its plan, onsite validation is required. Do not simply accept future promises. Verify that:

- Corrective actions have already been initiated at the time of your review

- Staff can demonstrate new protocols and articulate the changes
- Evidence shows that at-risk patients are currently protected

Example of Strong Language in a Removal Plan:

"Effective immediately, all diabetic patients will have blood glucose checks verified by two nurses. Full staff training on this protocol will be completed by 5 PM today."

Quality Assurance (QA) Committee

The Quality Assurance (QA) Committee's role is to perform ongoing evaluations of surveyors' performance to ensure all surveyors conduct thorough and accurate surveys each time they survey a facility. The surveyor evaluation process is standardized, so all surveyors are fairly evaluated using the same criteria.

The QA Committee consistently evaluates its surveyors through an ongoing quality assurance process that incorporates facility feedback, objective performance metrics, and random validation observation surveys.

Annual Evaluation of Surveyors

The QA Committee is charged with the annual review of individual surveyors and required to complete an analysis of their performance and provide their recommendation for continued certification of each QUAD A surveyor.

The annual review of surveyors by the QA Committee includes the following:

- Summary report of facility evaluations
- Continuing education
- Performance review (surveys, survey requests turned down, punctuality, survey documents, etc.)
- Complaints
- Validation Observation Survey Reports (if applicable)
- Adherence to all QUAD A surveyor policies including but not limited to:
    a. Basic surveyor expectations
    b. **Surveyor Code of Conduct**
    c. Unannounced survey policies
    d. Conflicts of Interest
    e. Confidentiality
- Additional information provided to the committee by QUAD A staff or other sources if pertinent to the annual review process.

A copy of the QA Committee annual surveyor review and any corrective action taken will be maintained in each individual surveyor file.

Surveyor Assessment by Facility

At the conclusion of a routine survey, the facility is asked to provide feedback specific to surveyor performance and survey experience. This feedback is taken into consideration by the QA Committee when annually reviewing each surveyor or if a specific complaint is filed.

a. The QA Committee assesses surveyor performance to drive individual surveyor improvement and overall program enhancement.

- Surveyor performance is analyzed using performance metrics to identify opportunities for improvement relative to specific surveys, and
- Surveyor performance is analyzed using performance metrics to identify opportunities for improvement relative to trend analysis to capture more subtle, long-term performance concerns.

b. The Surveyor Performance Evaluation contains three sections:

- Section 1: The surveyor's depth of familiarity with standards are scored using a 1-5 scale.
- Section 2: The surveyor's performance of the essential functions of a survey are scored on a "Y/N" (Yes/No) basis.
- Section 3: The surveyor's time spent onsite, and narrative feedback provided by the facility are noted.

c. Scores may initiate a more detailed examination.

d. Surveyor violations can include:

- If the surveyor violates a single established scoring metric during a survey, the QA Committee examines the surveyor for a trend of violations over subsequent periods.
- If a survey violates more than one (1) established scoring metric during a survey, the QA Committee initiates a review of the surveyor's performance which may include document review, interviews with the surveyor or other team members and may result in remedial action or removal from the program.

Complaints Against Surveyors

All complaints against a surveyor's performance or conduct are taken seriously and will be reviewed by the appropriate QUAD A personnel. It is the responsibility of the facility to report any complaint against a surveyor to QUAD A.

- All complaints against a surveyor's performance or conduct must be made to QUAD A in writing to the Surveyor Relations Manager's attention.
    - Email is preferred.
- The Surveyor Relations Manager will review all complaints. If the nature of the complaint compromises patient safety or the quality of the facility's survey, the Surveyor Relations Manager will escalate the complaint to senior management who will determine the need to include the QA Committee for their review and counsel for action accordingly.
- A survey resulting in a complaint against the surveyor that was determined to be valid and of sufficient gravity to warrant invalidation of the survey results, will be scheduled for reassessment by another surveyor. Surveyors receiving complaints that invalidate surveys will be notified within three (3) business days that a complaint was received, and the nature of the complaint. All surveyors will have the opportunity to respond to any complaints before any punitive action takes place.
- The costs associated with the reassessment of any facility due to a complaint will be absorbed by QUAD A, only if the written complaint report was received by the end of the third QUAD A business day (4:30 pm Central Standard Time) following the incident.
- Any surveyor whose conduct was determined to warrant invalidation of survey results may not receive an honorarium.
- Surveyors who are the subject of complaints based upon performance may be required to undergo retraining before being assigned to subsequent facility surveys.
- All records of complaints and the results of each review process will be maintained in the associated surveyor and facilities files by the QUAD A staff member responsible for maintaining the surveyor and facilities files, respectively.

Review of Complaints Against Surveyors

In reviewing a complaint against a surveyor, a rotating three-member review team is selected from the QA Committee members to review the complaint as communicated by the Surveyor Relations Manager. The review team will determine if the results of a complaint invalidate the survey and if any action should be taken against the surveyor.

Each QA Committee team review may result in one (1) of the following determinations with regard to the surveyor's status:

- *Active:* Surveyor is eligible to conduct onsite surveys.

- *Inactive-Training:* Surveyor will become eligible to conduct surveys upon completion of training in an area determined to be adversely affecting performance.
- *Inactive:* Surveyor will become eligible to conduct surveys upon completion of some activity determined by the QA program review team necessary to resolve the deficiency in conduct or performance.
- *Deactivated:* Surveyor is permanently ineligible to conduct surveys.

CONFLICT OF INTEREST (COI)

QUAD A is committed to maintaining the integrity of its accreditation process and to maintaining public confidence in its accreditation decisions. Therefore, it has always been and continues to be important to identify and address actual or potential conflicts of interest that might improperly affect the decisions of individuals involved in the accreditation process, including surveyors who conduct surveys of facilities seeking QUAD A accreditation. It is also critical to maintain the confidentiality of the accreditation process and to assure information obtained during the conduct of a survey is not disclosed to third parties not involved in the accreditation process.

Definition of a Conflict of Interest

A conflict of interest is defined as an interest or relationship, including financial and consulting relationships, held, or maintained by a surveyor that could influence the surveyor or be perceived as influencing the surveyor to act for the surveyor's personal benefit or contrary to the goal of QUAD A to conduct fair, impartial and unbiased surveys of facilities seeking accreditation.

Conflicts of interest are not confined to financial or economic interests but include relationships or affiliations with organizations with competing or conflicting goals and personal and professional relationships.

All decisions as to whether a surveyor's interest or relationship constitutes a conflict of interest or the appearance of a conflict of interest shall be made by QUAD A.

Surveyor's Duty to Disclose Conflicting Interests

Each surveyor shall disclose all actual or potential conflicts of interest that could influence or be perceived to influence the surveyor's decision-making process. Sources of possible conflicting interests include, but are not limited to, a consulting, investment or other commercial relationship with a company providing goods and services to QUAD A accredited facilities; consulting relationships with QUAD A accredited facilities; or a financial interest or practice position in an accredited facility that may compete with the surveyed facility. The foregoing examples are illustrative and should not be considered the only interests which might give rise to a conflict.

Each surveyor will be required to sign and submit to QUAD A's Surveyor Relations Manager not less than annually the Surveyor Conflict of Interest Disclosure and Confidentiality Statement (the "Statement"). Failure or refusal to sign and submit the Statement will automatically disqualify an individual from serving as a surveyor. The Board of Directors of QUAD A may from time to time amend the content and form of the Statement. The Statement will be kept confidential except for review by the President and Executive Director of QUAD A who shall in turn maintain the confidentiality of the information contained in the Statement.

It is critical to maintain the confidentiality of the accreditation process and to ensure that information obtained during a survey is not disclosed to third parties not involved in the accreditation process.

How to Report an Identified Conflict of Interest

QUAD A Surveyors must sign and submit a *Conflict of Interest Agreement and Attestation* in order to become an active surveyor. For a submitted report to be considered valid by QUAD A, the surveyor must also sign the report/submission form including clauses certifying that the specific survey was conducted in accordance with the QUAD A Conflict of Interest Policy.

In the event that a surveyor becomes aware of a Conflict of Interest as defined in the QUAD A Conflict of Interest Policy before conducting the survey, the surveyor must report the Conflict of Interest in writing to QUAD A prior to traveling to the survey site but no later than the close of the second QUAD A business day (4:30 pm Central Standard Time) following discovery; if a Conflict of Interest is discovered while carrying out, or after completing the survey, the surveyor must stop any in-progress surveys and notify QUAD A immediately by telephone so the facility can be assigned a new surveyor.

- Email submissions are preferred.
- Notification of a Conflict of Interest must contain the classification of the conflict, either professional, financial, or personal.
- Surveyors must submit the nature of the conflict as being either with personnel of the facility or with the organization.

Resolving Conflicts of Interest

Any report of a Conflict of Interest will be reviewed by QUAD A's Director of Accreditation and the survey will be reassigned as appropriate. Any completed or partially completed surveys will be invalidated and a new survey scheduled at the expense of QUAD A. By the close of business, on the day QUAD A receives the Conflict of Interest report, the QUAD A staff member responsible for surveyor and facilities records will enter the report in the surveyor and facility's file. In the event that reassignment is necessary, the staff member will begin the process of reassigning the facility to a new surveyor immediately. If this involves a Medicare survey, the staff member will notify CMS upon confirmation of the reassignment of the facility to a new surveyor and any changes to the date and time at which the survey will be carried out.

The maintenance of Conflicts of Interest records in the surveyor and facility's file is not to be interpreted as a punitive measure. This will allow for more efficient assignment of facilities over time and should reduce the instances of future surveyor Conflicts of Interest.

Logging the classification and nature of a Conflict of Interest will also help the staff to identify when a conflict no longer exists, and a surveyor becomes eligible to conduct a survey on a particular facility.

Post-Survey Processes

Disputes

In case of a disputed finding/citation, the facility must supply a response that includes a description of why it is in compliance, the evidence of that compliance, and why it was not provided to the surveyor(s) during the onsite survey. The Accreditation Committee will review the response and may determine the facility is still deficient with the Standard(s); or the facility has demonstrated it was in compliance with the Standard(s) at the time of the survey; or may order a re-survey of the facility.

Policy for Plan of Correction Review by Surveyors

When deficiencies are cited in the survey report, QUAD A requires t that the surveyor(s) review the Plan(s) of Correction prior to approval to ensure the corrections are adequate, address every deficiency cited, and are appropriate. If the surveyor deems the Plan of Correction insufficient, the surveyor can return the PoC to the facility to make changes to meet compliance requirements.

Self-Surveys

Accredited facilities must perform a Self-Survey review of their compliance with all QUAD A standards annually prior to the annual expiration date of its accreditation in each of the two (2) years between QUAD A onsite surveys. The Self-Survey documentation must be retained for a minimum of three (3) years and include:

1. A completed Self-Survey checklist.
2. A Plan of Correction for any standard identified as non-compliant.

- Evidence that each Plan of Correction has been carried out to establish compliance with standards.
- Evidence that findings from the Self-Survey have been reviewed, included in the facility's Quality Improvement Plan, and discussed in the facility's Quality Improvement meetings.

The Medical Director is required to provide QUAD A with a signed attestation that they have completed the Self-Survey and all related activities. During the onsite reaccreditation survey, the surveyor will assess compliance by reviewing these documented Self-Surveys, Plan of Correction, and Evidence of Correction.

A facility’s QUAD A accreditation remains valid if it continues to comply with every standard for its program and facility anesthesia class. Deficiencies should be noted by the facility as appropriate during this Self-Survey process, and a subsequent Plan of Correction must be provided with Evidence of Corrections.

Adverse Accreditation Actions

Emergency Suspension

QUAD A may place a facility on an emergency suspension status upon receiving information that a state medical or other specialty board has taken action or begun formal proceedings which may result in it taking action against a license held by any physician and surgeon operating at the facility, or the QUAD A Board of Directors determines that the facility no longer meets the QUAD A standards for accreditation. The emergency suspension status will remain in such status pending an expedited onsite investigation and hearing conducted in accordance with QUAD A procedures as outlined in the QUAD A Terms & Conditions.

Denial or Loss of Accreditation

QUAD A may deny or revoke accreditation of a facility if the facility fails to satisfy every standard as applicable to the QUAD A Program and/or Anesthesia Class (as applicable). Additionally, QUAD A may deny or revoke the facility's accreditation if the facility fails to report the scenarios below to the QUAD A office.

If any medical professional providing services at the facility:

- Has had their privileges restricted or limited due to lack of clinical competence, ethical issues, refusal to take emergency call, or professional problems other than perceived or real economic competition.
- Has been found to be in violation of the Code of Ethics of any professional society or association for which they are a member.
- Has had their right to practice limited, suspended, terminated, or otherwise affected by any state, province, or country, or if they have been disciplined by any professional licensing authority.
- Non-reporting of any of the above to QUAD A.

Probation

An adverse accreditation decision under which the facility must comply with policies and timeframes set by QUAD A or correct any outstanding deficiencies. Failure to comply with standards, timeframes, policies, or terms results in termination of accreditation. Upon completing the probationary period, the facility must successfully remedy the outstanding request to have the probation lifted. Failure to do so may result in termination of accreditation. Facilities may continue their normal operations while on probation.

Investigations

QUAD A has the authority to investigate allegations that, if substantiated, would result in noncompliance with QUAD A standards, including the Medicare Conditions for Coverage, and Conditions for

Participation, where appropriate. All investigative surveys will be conducted unannounced. Refusal of an investigative survey will result in revocation/termination of the facility's accreditation.

Allegations or findings that fall outside of the QUAD A scope of authority are referred to the appropriate federal, state, and/or local agency or Authority Having Jurisdiction. When QUAD A becomes aware that an agency or other body is also conducting an investigation of a facility, QUAD A will coordinate with that office to reduce duplicative work and avoid compromising either or both investigations. However, QUAD A reserves the right to conduct an investigative survey should it be made aware of any serious allegations of non-compliance, irrespective of any other agency's concurrent survey or investigative process, which may be ongoing.

GLOSSARY: Outpatient Physical Therapy (OPT)

Adequate: sufficient; is meant to encompass size, space, maintenance, cleanliness, free of clutter, lighting, appropriately equipped, etc., freedom from clutter, lighting, and appropriate equipment.

Clinic Administrator: is responsible for the internal operation of the facility in accordance with written policies. A qualified Clinic Administrator is designated by the facility's governing body [CMS §485.705(c)(1) and §485.709(b)].

Clinical Personnel: refers to all personnel who are involved in the furnishing of outpatient physical therapy, occupational therapy, and speech-language pathology services directly by or under arrangements with an organization. Including, but not limited to, physical therapist, physical therapist assistant, occupational therapist, occupational therapist assistant, speech-language pathologist, social worker, etc.

Extension Locations: a location or site from which a rehabilitation agency provides services within a portion of the total geographic area served by the primary site. The extension location is part of the Outpatient Physical Therapy (OPT). The extension location should be located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the extension location to independently meet the Conditions of Participation (CoP) as an OPT.

Primary Sites: A rehabilitation agency/OPT must provide services at its approved primary site (the site that was issued the CCN). Note: The OPT may apply to CMS for approval of another location near the primary site for the purpose of providing additional access to care. These locations are known as “extension locations.”

Qualified Physical Therapist: a person who is licensed as a physical therapist by the State in which practicing and (1) has graduated from a physical therapy curriculum approved by the American Physical Therapy Association or by the Council on Medical Education and Hospitals of the American Medical Association, or jointly by the Council on Medical Education and Hospitals of the American Medical Association and the American Physical Therapy Association; or (2) prior to January 1, 1966: (a) was admitted to membership by the American Physical Therapy Association; or (b) was admitted to registration by the American Registry of Physical Therapists; or (c) has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education; or (3) has 2 years of appropriate experience as a physical therapist and has achieved a satisfactory grade on a proficiency examination approved by the Secretary, except that such determinations of proficiency shall not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or (4) was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and

direction of attending and referring physicians; or (5) if trained outside the United States: (a) was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; (b) meets the requirements for membership in a member organization of the World Confederation for Physical Therapy; (c) has 1 year of experience under the supervision of an active member of the American Physical Therapy Association; and (d) has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

Qualified Speech Pathologist: a person who is licensed, if applicable, by the State in which practicing: (1) is eligible for a certificate of clinical competence in speech pathology granted by the American Speech and Hearing Association under its requirements in effect on January 17, 1974; or (2) meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Rehabilitation Agency (also referred to as an Outpatient Physical Therapy): an agency which provides an integrated multidisciplinary program designed to upgrade the physical function of disabled individuals by bringing together as a team specialized rehabilitation personnel. At a minimum, it must provide physical therapy or speech pathology services, and a rehabilitation/OPT program which, in addition to physical therapy or speech pathology services, includes social or vocational adjustment services.

Supervision: Authoritative procedural guidance that is for the accomplishment of a function or activity and that—

A. Includes initial direction and periodic observation of the actual performance of the function or activity; and
B. Is furnished by a qualified person—
    - Whose sphere of competence encompasses the particular function or activity; and

    Who (unless otherwise provided in this subpart) is on the premises if the person performing the function or activity does not meet the assistant-level practitioner qualifications specified in § 485.705.

Surveyor Resources

Additional training modules can be found on the QUAD A Learning Management System (LMS)

CMS Principles of Documentation (*adopted from The Centers for Medicare and Medicaid Services*)

Appendix E CMS State Operations Manual (OPT): OPT Guidance

Appendix G CMS State Operations Manual (RHC): RHC Guidance

Appendix L CMS State Operations Manual (ASC): ASC Guidance

Appendix Q CMS State Operations Manual (Immediate Jeopardy): IJ Guidance

Appendix Z CMS State Operations Manual (Emergency Preparedness): EPP Guidance