GLOBAL ACCREDITATION AUTHORITY

Patients First. *Always.*

Accreditation Resource Guide Effective February 1, 2024

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Who is QUAD A?

The American Association for the Accreditation of Ambulatory Surgical Facilities, (AAAASF), is an accrediting organization with programs certifying to the medical community and the lay community at large that a facility meets recognized standards. The accreditation program is operated by clinical professionals who set and evaluate the standards under the direction of a Board of Directors. QUAD A strives for the highest standards of excellence for its accredited facility by regularly updating the requirements for 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 or Conditions of Participation (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, and dental specialists from several countries. This group of expert clinicians develops standards and makes recommendations on the status of surveyors and facilities based on their years of experience practicing in the outpatient setting. This program is peer-based designed, and administered by medical, dental, and other healthcare professionals.

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 that many consider them to be the gold standard.

We recognize, however, that they need to be part of a living document, and we continually re-evaluate and revise these standards in light of evidence-based guidelines, medical advances, and changing legislative policies. The QUAD A accreditation programs require 100% compliance with each standard to become and remain accredited. There are no exceptions.

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 therapies, and rehabilitation medicine.
    c. At least every three 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.
    d. 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 for approval.
3. Standard development includes pilot testing and evaluation upon approval of draft.
    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:

1. Basis:
    a. Outcome data from the QUAD A incident reporting system and onsite survey data.
    b. Experience and expertise of committee members.
    c. Scientific literature and comparison to standards and recommendations of subject matter experts, professional societies, and government regulators.
2. 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.
3. Process:
    a. Data gathered by staff.
    b. Committee evaluates data and proposes drafted standards.
    c. Committee posts drafted standards and solicits feedback.
    d. Committee evaluates data and establishes new standards.
    e. Committee approves and forwards new standards to the Board of Directors for approval.
    f. New standards are implemented and incorporated into surveyor training programs.

Procedures by Program

The QUAD A Board of Directors reserves the right to review and edit these allowable procedures at any time based upon differing scopes of practice standards and changing state, federal, and local laws, and regulatory requirements.

Procedural Accreditation

Accreditation under the QUAD A office-based procedural (OBP) standards is intended for ambulatory facilities performing procedures under moderate, deep sedation, major upper or lower extremity neuraxial, or general anesthesia in which diagnostic, and/or therapeutic procedures are performed. This includes the following physicians: gastroenterologists, urologists, gynecologists, pain management, vascular, cardiologists, interventional radiologists, podiatrics, ophthalmologists, and nephrologists. These procedures may include minimally invasive procedures and minor surgical procedures (e.g., intra-oral minor to include circumcisions, vasectomies, etc.). Examples of procedures that are under the OBP accreditation program may include but are not limited to the following:

Circumcisions	Rhinoplasty
Colonoscopy	Upper endoscopy
Lithotripsy	Urological procedures
Mammoplasty	Upper endoscopy
Maxillofacial procedures – reconstruction of the face, hard and soft tissues of the oral and maxillofacial region	Vascular access related procedures
Nerve blocks	Vasectomies
Nail avulsion	

Pediatric Dentistry

The following list of pediatric dentistry procedures are permitted under this current version of the QUAD A Pediatric Dentistry Standards.

Dentoalveolar	Trauma
• Dental Restorations	Hard and Soft Tissue Trauma
• Pulpal Treatment	Lacerations
• Soft Tissue Graft	Hard Tissue Dental Fractures including Alveolus
• Frenuloplasty	Pathology
• Frenectomy	Hard and Soft Tissue
• Extractions o Simple o Complex	Management of Odontogenic Infection
Space Maintenance	Soft and Hard Tissue Biopsy

Oral & Maxillofacial Surgery (OMS)

The following list of OMS office-based procedures are permitted under this current version of the QUAD A Oral & Maxillofacial Standards.

Dentoalveolar	*Trauma*
Extractions – simple and complex	Hard & Soft Tissue Trauma
Alveolectomy/Alveoplasty	Lacerations
Periapical Surgery (Apicoectomy)	Fractures – Closed and Open Reduction
Hard & Soft Tissue Grafting	Dental including Avulsion
Harvest & Placement	Pain Management – head and neck
Local and Distant	
Xenograft	Orthognathic & Esthetic
Allograft	Alloplastic Implants
Autograft	Sliding Genioplasty
Placement of Dental Implants	Removal of Hardware
	Aesthetic procedures as delineated by State-designated Scope of Practice[1]
Pathology	
Hard & Soft Tissue Biopsy and Excision	
Salivary Duct and Gland	
Odontogenic and Non-Odontogenic Lesions of the Jaws	
Sinus & Nose	
Grafting	
Closure of Oro-Antral and Oro-Nasal Communication	
Caldwell-Luc	
Management of Infections	
Hard & Soft Tissue	
Odontogenic	
TMJ Arthrocentesis and Arthroscopy	

Any other procedure as encompassed by the American Dental Association's definition of the specialty of Oral and Maxillofacial Surgery, subject to that which is allowed under a state's legally defined scope of practice for either dentistry or Oral and Maxillofacial Surgery.

[1] The aesthetic procedures performed by Oral & Maxillofacial surgeons that are permitted by state and federal regulations and laws, and are also performed by Board Certified Plastic Surgeons, Otolaryngologists, and Dermatologists must follow the applicable standards.

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.

- Review all material prior to going onsite.
- Familiarize yourself with applicable QUAD A standards and applicable local, state, and federal, 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, during, and after the 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 not previously identified 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 arrive at and depart the facility together.

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.
- Being educational, not punitive.
- 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.

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 Plans 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, I agree to adhere to the following code of conduct:

1. 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.
2. I agree to act and dress in a professional manner as a representative of the QUAD A accreditation program.
3. I agree to disclose any real or perceived Conflict of Interest that would inhibit my ability to perform a fair and unbiased survey.
4. I agree to adhere to the Code of Ethics set forth by my professional licensing body.
5. I agree to disclose any professional or financial interest in a facility that I am assigned to survey.
6. I agree to adhere to the responsibilities and requirements set forth in the QUAD A Surveyors Guidelines.
7. *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 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:

1. Ambulatory Surgical Center (ASC) surveyors must:
    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. Certified Registered Nurse Anesthetist
        iv. Physician Assistant
        v. Registered Nurse
2. Rural Health Center (RHC) surveyors must:
    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. Nurse Practitioner
        v. Nurse Midwife
        vi. Registered Nurse
        vii. Psychologist
        viii. State Licensed Mental Health Professional (Social Worker, Marriage & Family Therapist, Professional Counselor).
3. Occupational Physical Therapy (OPT) surveyors must:
    a. 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
4. Submit a current Curriculum Vitae that documents experience to qualify as a surveyor.
5. Sign and adhere to the initial QUAD A Surveyor Agreement, including Surveyor Attestation, Conflict of Interest, Code of Conduct, Surveyor Guidelines, and agreement to participate in an annual surveyor appraisal and review process conducted by the QUAD A Quality Assurance Committee and submit the same to QUAD A office.
6. 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.
7. Complete and pass all additional continuing education modules as assigned.

8. 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 Health and Safety 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. Two years' experience working in an office-based setting.
2. 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)
3. 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
4. Submit a current Curriculum Vitae that documents experience to qualify as a surveyor.
5. Sign and adhere to the initial QUAD A Surveyor Documents, including:
    a. Surveyor Attestation
    b. Conflict of interest
    c. Code of Conduct
    d. Agreement to participate in annual surveyor appraisal and review process conducted by QUAD A Quality Assurance Program.
6. 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.
7. Complete and pass all additional continuing education modules as assigned.

Life Safety Code Surveyors:

1. Must at minimum have/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 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.
2. Have experience with Hospitals or Ambulatory Surgery Centers.
3. Submit a current Curriculum Vitae or Resume that documents experience to qualify as a surveyor.
4. Sign and adhere to the practices as outlined in the current contract with QUAD A.
5. 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.
6. 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.

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 Qualification 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 the surveyors file with the current Surveyor Certificate.

QUAD A - Application Process

Cancellation or Refusal of Survey

Facilities may cancel a scheduled survey by written notice up to twenty-nine (29) days prior to the survey date and incur no additional charges.

A. Any facility that cancels a scheduled survey within thirty (30) days of the survey date will incur cancellation charges. The cancellation charges consist of:
   1. $550 administrative fee
   2. Any additional costs associated with the cancellation including, but not limited to, surveyor travel and lodging, and all other related expenses

B. If a facility cancels or refuses a survey after the surveyor has travelled to the survey location, the cancellation fee will include:
   1. $550 administrative fee
   2. The survey fee (in addition to the original survey fee paid to Quad A)
   3. Any additional cost already arranged for extraordinary costs such as expedited service or other special fees

If a facility cancels a Life and Safety survey, the facility will be responsible for all costs incurred by the life safety 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 scheduling, including expedited survey fees.

Any cancellations that occur within one (1) week of the scheduled survey should 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 OR 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.

Fee and Refund Policy:

The first-year accreditation annual fee plus the initial survey fee is due with each accreditation application. Additional fees will apply if special survey requests are made or for those facilities located outside the continental USA and internationally.

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.

In the event that 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 – is initiated to seek approval for facilities that have unanticipated methods of 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 physician qualification issues, such as those below:

- The requirement for hospital privileges, particularly since many specialties never practice in the hospital.
- 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.

The waiver process should not be an option for waiving compliance with a standard. QUAD A requires 100% compliance and facilities must adhere to all applicable standards. Waivers should only be deliberated when there is no other way a facility can comply with a requirement.

Types of Surveys for Scheduling

Start-up Facility Survey – Modified full surveys 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, NJ, TX. QUAD A also offers these surveys to facilities that have not performed any cases in the location requested to be surveyed. 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 anesthesia cases, the facility must submit the completed Anesthesia Validation form with the ten (10) cases with two being true-to-their 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. Seek guidance from the accreditation manager to determine appropriate time frames. When a facility is unable to perform ten (10) anesthesia cases prior to the expiration date or a facility is unable to complete a full survey, QUAD A will conduct no more than two 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 is actively providing all services 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, is eligible for an initial survey.

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

Resurvey (Triennial) - This is a full survey conducted for a facility that wishes to renew its accreditation with QUAD A. Resurveys 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 focused survey. These are conducted for facilities seeking reaccreditation where one or more Medicare Condition-Level deficiencies were cited during the triennial *re-accreditation survey,* an Initial with CCN survey, or when 20 or more deficiencies were cited for any non-Medicare survey. QUAD A requires a focused follow-up survey that will be conducted within forty-five (45) calendar days of

the previous full or investigative survey to verify correction of all condition-level deficiencies documented. (For Immediate Jeopardy situations, the follow-up survey must be conducted within twenty-three (23) days of the previous survey end date.) A second follow-up, if needed, must take place within forty-five (45) calendar days of the previous survey's end date. Facilities with condition level deficiencies will not be accredited or recommended for continued Medicare deemed status until a focus follow-up survey confirms full compliance. Quad A will conduct no more than two (2) follow up surveys (3 surveys total) concerning any single case 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 covers specific standards for specific reasons directing the focus of 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 any one sub-section, is marked as non-compliant. With the exception of standards 1.F.1 through 1.F.18 Patient Safety Data Reporting – a facility could be marked non-compliant with all standards due to failure to report. This may be considered one 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 20 or more deficiencies, a follow-up survey will normally be required. Be mindful that one finding across multiple standards may be considered as one deficiency (seek confirmation from management for such determination). Deficiencies that were corrected on site 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 ensure 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 or Investigation is a critical accreditation activity for ensuring that participating facilities continually meet all requirements. QUAD A conducts onsite investigative surveys for cases based on the Priority assignments or triage level.

Investigative Surveys are unannounced. The Survey Team 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 must conduct the survey and complete the appropriate sections of the Surveyor Handbook relevant to the allegations under investigation. The surveyor may expand the scope of a survey, based on findings, up to a full accreditation survey.

Upgrades, Addition of Services & Relocations – Surveys for these events occur when the facility is upgrading or downgrading its Program or Anesthesia Class to a higher level; adding specialties; have undergone construction; or relocated. This is a full re-survey that is conducted without a change in accreditation cycle dates.

Onsite Surveys

Each QUAD A facility is surveyed initially and at least every three 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 Class (A, B, C-M, or C).

Onsite QUAD A surveys of surgical facilities typically involve the attention of the facility's medical director (or designee), an anesthesia provider, and various facility staff working intensely with the QUAD A surveyor(s). Onsite QUAD A surveys of other facility types involve the attention of the facility's administrator (or designee), clinical staff, and various other facility staff working intensely with the QUAD A surveyor(s). The survey process must remain focused, and therefore, QUAD A has directed that equipment representatives may not be present during QUAD A announced or unannounced surveys. Accreditation consultants may be present during the surveys; however, QUAD A requires consultants to remain silent during the survey process until it is completed. All QUAD A surveyor(s) have the authority to request any participants to remove themselves from the survey process if interference becomes a problem. QUAD A greatly appreciates the cooperation of all parties concerned by complying with this directive.

Initial Surveys

Surgical, Procedural, CMS ASC, 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 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 RHC and CMS OPT: The initial survey is performed by a surveyor or team of surveyors after the facility has provided care for 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 and 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, 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.

- Surveyors must agree to abide by this requirement and attest to the same in signing the Surveyor Agreement upon becoming an active surveyor.
- 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 a 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 ASC only - Medicare requires an independent Fire Safety Specialist contracted by QUAD A to perform a Life Safety Code (LSC) survey in accordance with the NFPA 2012 Life Safety Codes and 2012 Health Care Facilities Codes, with a report submitted to QUAD A. A copy of the Statement of Deficiency Report will be provided to the ASC. The ASC must correct any deficiencies noted by the Fire Safety Specialist. The Fire Safety Specialist will review any plans of correction and make the final determination of acceptability. The ASC is responsible for all costs related to the LSC survey.

The Life Safety Code (LSC) *S*urveyor must consider all applicable National Fire Protection Association (NFPA), Life Safety Code (LSC), Health Care Facilities Code (HCFC), and reference document requirements when conducting the survey.

Extension Site Surveys

CMS OPT only - OPT facilities are permitted to have extension locations as approved by CMS. QUAD A renewal onsite surveys include all primary and 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 Statement of Deficiency Report that contains the primary and extension site survey results will be generated by QUAD A.

Per CMS policy, only an OPT with an established CMS provider agreement may apply to add extension locations. Those OPTs seeking new (initial) participation in the Medicare program are prohibited from enrolling extension locations at the time of their initial QUAD A application. For those OPTs that are currently participating in Medicare via State certification and are seeking continued participation via deemed status (An Initial Survey with a CCN) through QUAD A's CMS-approved OPT accreditation program, may apply to add extension locations with the initial accreditation application. In these cases, all extension locations will undergo an onsite survey, along with the primary site.

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 possess a valid AAAASF 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 must attest that the facility meets all local, state, and federal/national and regulatory requirements, since such governmental regulations may supersede Quad A standards. Please note, however, that the stricter requirement applies, whether it is the federal/national, local, 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 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

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.

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 requirement for clinical record review. Note 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 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 take into account that additional hours may be required to complete the onsite survey, if needed. 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.

The surveyor(s) should immediately hold an entrance conference with the medical director (or designee) and key staff, as identified by the facility, to:

1. Introduce surveyor(s) and their background.
2. Explain the reason for the survey (resurvey, follow-up, complaint, etc.)
3. Explain the survey process and approach.
    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 onsite.
    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, to the business office, lavatories, medication areas, exam and

consultation rooms, prep area, procedure room(s), recovery rooms, and discharge area.

ii. Request any QUAD A or CMS approved waivers, if applicable.
iii. Safety of Operating Room 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, hazardous waste protocols, IV fluids, and medication management and storage.
v. *CMS ASC only* – Observation of a surgical case: pre-op 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 notes, 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 survey, please enter the following statement: ***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.

4. Request an RN 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.
5. 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.
6. 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 if care will be observed as part of the survey process.

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

1. 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.
2. Perform a thorough and unbiased evaluation of the facility by observation, staff and patient interview, 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.

   a. Interview patients about their care, objectives of treatment, knowledge and understanding of treatment, post-treatment care and patient responsibilities, discharge planning, and rights.
   b. Interview the staff about their knowledge of patient care needs, their assigned patients and responsibilities, and their knowledge of facility policies and procedures.
   c. Use open-ended probing questions, not "Yes" or "No" inquiries.
3. 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 surgery center staff are aware of the findings as they are observed so that there are no surprises at the end of the survey.
4. 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 and key staff. Review all preliminary findings and observations. Clearly indicate 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 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 proof that deficiencies have been corrected within 60 calendar days of QUAD A issuing the Survey Report.
- Complete all surveyor documentation and return all survey documentation materials electronically within two calendar days of completing the survey. Any questions regarding the survey documentation requirements may be directed to the QUAD A accreditation department at 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 onsite 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 onsite 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 QUAD A Principles of Documentation to document every deficiency.

Upon receipt of the survey report, the QUAD A office may contact the surveyors 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 survey date. 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:

- The facility is required to produce a log or other record of closed cases for the previous six-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.*
- Sample size
  - CMS ASC, Surgical, Procedural, OMS, Pediatric Dentistry, International Surgical, and International Dental: The minimum number of records selected for review is twenty (20) for a facility with a monthly case volume exceeding fifty (50) and ten (10) for lower volume facilities.
    - 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.
    - The sample must include a representative sampling of procedures conducted, providers performing procedures, various anesthesia types (as appropriate), and adverse events including deaths, unanticipated transfers, and post-op infections.
    - *All CMS ASCs must have begun treating patients and are currently treating patients to enroll in the program.*
  - 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 review form.
    - 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: A minimum of 25 total clinical records must be reviewed for an established organization and a minimum of 10 total for a new start-up organization. The records must represent the organization's current roster of patients as well as records from discharged patients from the past six months.
    - *"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 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 (PT, OT, SLP) as offered at the site.*

- A sample of both open and closed cases must be reviewed.
  - *Surgical Facilities* - An open case is defined as a patient that is being treated the day of the survey.
  - *CMS ASC only* - The 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.
- The sample selected must represent a cross section of the cases performed at the facility.
  - 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:

- Choose “NO” from the drop-down if the required element is not present in the record (Deficient).

    - 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).
- Mark “N/A” if the required element does not apply to the record being reviewed.
    - Each “N/A” score requires an explanation in the comment section for that standard.
    - “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-op EKG/other testing.
    - “N/A” is not appropriate for instances in which the facility chooses not to collect a certain piece of information.

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) must ensure that a random sample of clinical personnel records are reviewed.

The minimum number of records selected for review is fifty percent (50%) of the total number of clinical personnel records. (See Glossary for QUAD A's definition of "Clinical Personnel".) *For ASCs **and** RHCs only:* Please note, all clinical personnel required to be licensed under State or 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.

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.

- **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 non-compliance.

The Personnel Record Review Worksheet is part of the electronic survey documentation in the survey application 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 review must be scored for each standard element on the worksheet.

- Choose “NO” from the drop-down if the required element is not present in the record (Deficient).
    - 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)).
- Mark “N/A” if the required element does not apply to the record being reviewed.
    - Each “N/A” score requires an explanation in the comment section for that standard.
    - “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.
    - “N/A” is not appropriate for instances in which the facility chooses not to collect a certain piece of information.

How to Conduct a Case Tracer

CMS ASC only - CMS requires surveyors to observe at least one 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.[2]

At the beginning of the survey, the lead surveyor must select one or more surgical cases for observation during the survey. Surgical patients remain in the facility up to a maximum of 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 operating or procedure rooms, or for multi-specialty facilities), surveyors should consider observing two 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, 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 90 minutes unless there are no shorter cases scheduled on the survey day.

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2 Verbiage to switch to for all surgery-based programs once we transition to case tracers on all appropriate surgical/procedural programs:
For Surgical, Procedural, Oral Maxillofacial, Pediatric Dentistry, International Surgical, International Dental, and CMS ASC surveys – QUAD A requires surveyors to observe at least one surgery during the QUAD A survey process referred to as the "case tracer." The following information is a guideline for QUAD A surveyors to use in completing the case tracer requirement as a part of a QUAD A survey.

- Surveyor(s) are required to follow at least one patient through admission, pre-op, surgery, post-op, and discharge.
    - If the surgery runs longer than 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-op.
    - 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 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 cleaning/prep may not be possible until after the observed patient is 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.

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 immediate jeopardy to the patient's safety.
- The surveyor should follow the patient starting with 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 labelling (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-, intra-, 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.

Submitting Survey Documentation

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

All survey documentation must be submitted in electronic form, no later than two business days after the survey ends.

Surveyors must be available for QUAD A staff support functions for 30 days after the survey date. (Available means you must be able to correspond with the QUAD A office). If you will not be available during the 30 days following the survey date, do not accept the survey assignment or if something unexpected comes up, please contact scheduling unit for reassignment.

The QUAD A staff may not revise surveyor documentation other than to make spelling or grammatical corrections.

Statements of Deficiency must be completed according to the 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 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.

All “Deficient” answers should be discussed with the medical director and/or appropriate staff, and the surveyor(s) should make recommendations as to how the deficiencies should be corrected (the recommendations should not need to be included in the SoD report).

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

1. An explicit statement that the requirement is “not met.”
2. 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 fails to comply with the requirements directly, not how it fails 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:

- An explicit statement that the requirement was NOT MET.
- The language from the standard which specifies the aspect(s) of the requirement with which the facility was non-compliant.
- The actual deficient practice statement, which includes:
    - The specific action(s), error(s), or lack of action (deficient practice),
    - Outcome(s) relative to the deficient practice or the number of deficient cases relative to the total number of such cases,
    - The identifier of the individuals or situations referenced in the extent of the deficient practice, and
    - The source(s) of the information through which the evidence was obtained.
- 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 of six 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 of these records were discharge records. When reviewing compliance with discharge orders, the total "universe" of applicable records would be "six." *Refer to the QUAD A/CMS Principles of Documentation for further detailed instruction.*

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 48 hours of completion of the survey (survey end date). Once received 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 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 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. *(Exception: Emergency Preparedness. If the facility does not have an EPP program, it is sufficient to cite only the Condition level deficiency and note all the Standard level deficiencies in the section.)*

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. *(Exception: Emergency Preparedness. If Emergency Preparedness is the only condition cited, the facility is not required to participate in an onsite follow-up survey, the follow-up survey will be virtual.)*

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 citation includes deficient practice statements and findings to support the determination of noncompliance with a Condition level requirement.

Example Statement of Deficiency (SoD)

Statement of Deficiency
Official Forms Only Please

Facility ID: 1234 **Surveyor:** I.M. Surveyor, RN **Date:** 12/12/2023
☐ **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 12/27/2023, but as of 01/27/2023, they had not yet been placed in the record.
- Patient #17 was received on 01/03/2023, but as of 01/27/2023, 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 12/27/2020, but as of 01/27/21, they had not yet been placed in the record. • Patient #17 were received on 01/03/2021, but as of 01/27/2021, they had not yet been placed in the record.

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 days of the last date of the survey and include all documented evidence of such suspected fraud, abuse and/or suspicious activity to info@Quad A.org, Attention: QUAD A Accreditation Manager.

If this is a Medicare-deemed facility, all reports submitted will be forwarded within two business days of receipt to the CMS Center for Program Integrity (CPI) and a copy to the appropriate CMS 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 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 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 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 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 on-site 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 components and provide a preliminary fact analysis in the right-hand column to support their determination. Use one 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 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 or more recipients.

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:
    - Basic surveyor expectations
    - Surveyor Code of Conduct
    - Unannounced survey policies
    - Conflicts of Interest
    - 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 the survey experience. This feedback is taken into consideration by the QA Committee when annually reviewing each surveyor or if a specific complaint is filed.

1. The QA Committee assesses surveyor performance to drive individual surveyor improvement and overall program enhancement.
    a. Surveyor performance is analyzed using performance metrics to identify opportunities for improvement relative to specific surveys, and
    b. Surveyor performance is analyzed using performance metrics to identify opportunities for improvement relative to trend analysis to capture more subtle, long-term performance concerns.
2. The Surveyor Performance Evaluation contains three sections:
    a. Section 1: The surveyor's depth of familiarity with standards are scored using a 1-5 scale.
    b. Section 2: The surveyor's performance of the essential functions of a survey are scored on a "Y/N" (Yes/No) basis.
    c. Section 3: The surveyor's time spent onsite, and narrative feedback provided by the facility are noted.
3. Scores may initiate a more detailed examination.
4. Surveyor violations can include:
    a. 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.
    b. If a survey violates more than one 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.

1. All complaints against a surveyor's performance or conduct must be made to QUAD A in writing to the surveyor relations manager's attention.
    a. Email is preferred.
2. All complaints will be reviewed by the surveyor relations manager. 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.
3. 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 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.
4. 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 Time) following the incident.

5. Any surveyor whose conduct was determined to warrant invalidation of survey results may not receive an honorarium.
6. Surveyors who are the subject of complaints based upon performance may be required to undergo retraining before being assigned to subsequent facility surveys.
7. 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 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

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. In order 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 (4:30pm CT) 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 in which QUAD A receives of a conflict of interest report, the QUAD A staff member responsible for surveyor and facilities records will enter the report in the surveyor and facility files. In the event that reassignment is necessary, the staff member will begin the process of reassigning the facility to a new surveyor immediately. If 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 files 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 as part of its Plan of Correction response must include a brief 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 may request that the surveyor(s) review the plan(s) of correction prior to approval to ensure the corrections are adequate, address every deficiency cited and appropriate.

Self-Surveys

Accredited facilities must perform a self-survey review of its compliance with all Quad A standards annually prior to the annual expiration date of its accreditation in each of the two years between Quad A onsite surveys. The self-survey documentation must be retained for a minimum of three years and include:

1. A completed Self-Survey checklist.
2. A Plan of Correction for any standard identified as non-compliant.
3. Evidence that each plan of correction has been carried out to establish compliance with standards.
4. 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, plans 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 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 deficiency corrections. Otherwise, the accreditation may be revoked.

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 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:

a) 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.
b) Has been found to be in violation of the Code of Ethics of any professional society or association for which they are a member.
c) Has had their right to practice limited, suspended, terminated or otherwise affected by any state, providence, or country or if they have been disciplined by any professional licensing authority.
d) 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 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.

Surveyor Resources

Various resources can be found on the QUAD A website under Surveyor Education.

Additional training/learning 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