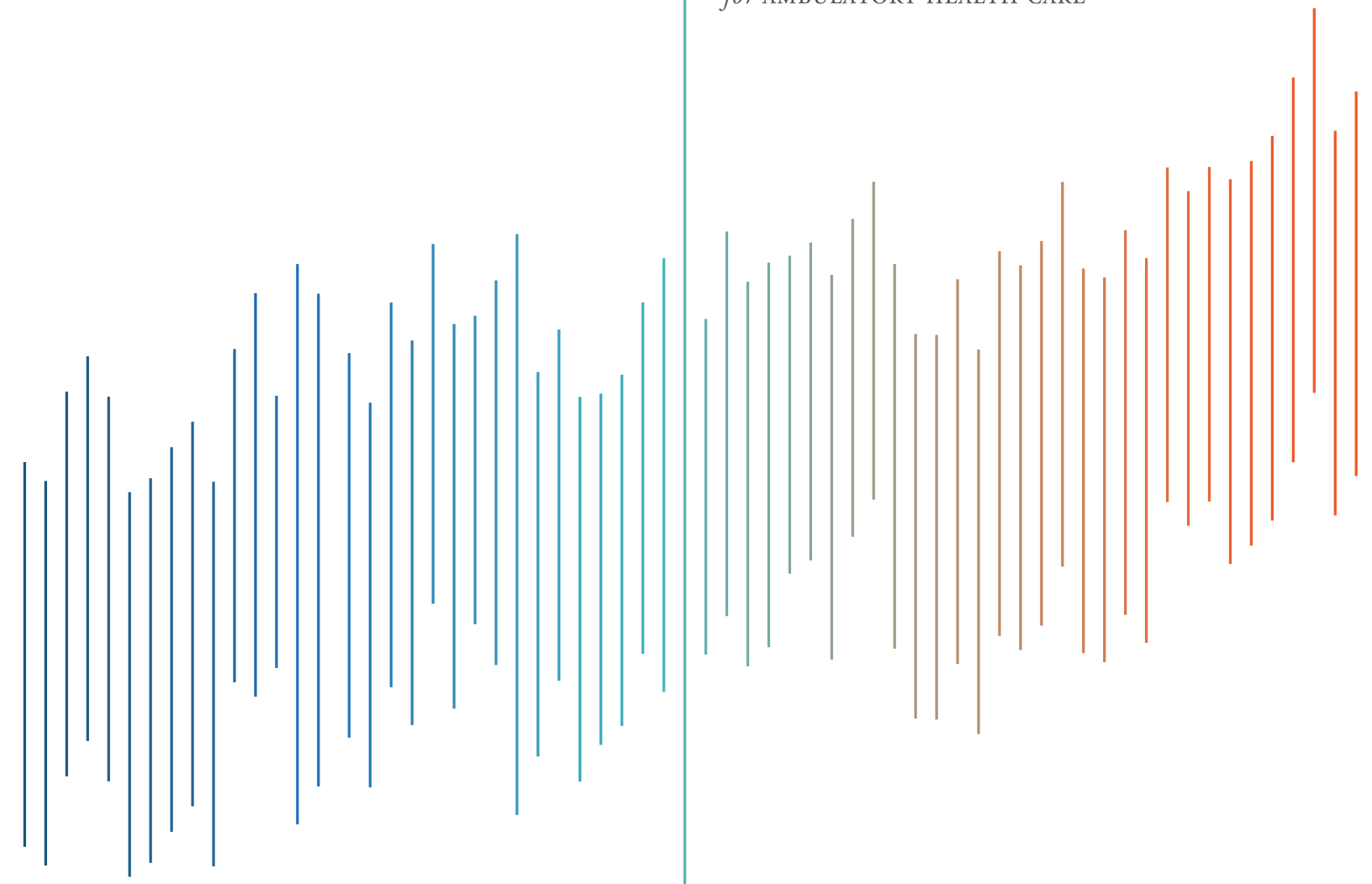
AAAHC

ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE



A report on accreditation survey results

2025 AAAHC Quality Roadmap

Institute for Quality Improvement

2025 *Quality Roadmap*

A report on accreditation survey results

Dear Colleagues,

The 2025 *AAAHC Quality Roadmap* has a new look and feel and now provides you with additional data and more insight to identify themes that deserve special attention in your organization as you pursue ongoing quality improvement throughout the accreditation cycle. In 2024, AAAHC rolled out *1095 Engage*, a uniquely designed accreditation and compliance management system, which empowers health care organizations to pursue excellence by providing single-source operations solutions. *1095 Engage* provides a full suite of automated guidance resources for our clients, such as self-service capabilities, site-specific and relevant Standards curation, and other efficiencies. For AAAHC, it provides robust data for business intelligence generation of improved analytics on survey findings leading to improved compliance guidance.

This year's *AAAHC Quality Roadmap* provides a thorough analysis of data from surveys conducted between May 1, 2024 – May 27, 2025, using Standards in the *Accreditation Handbook for Ambulatory Health Care*, v43 and v43.1 (AMB), *Patient Centered Medical Home,* v43 and v43.1 (PCMH), and the *Accreditation Handbook for Medicare Deemed Status*, v43 and v43.1 (MDS).

It is our pleasure to provide this information as a resource to our accredited organizations. Our goal is to increase your understanding of AAAHC Standards and provide useful benchmarks to help your organization improve the quality of care you provide to patients. While the report indicates that most facilities surveyed are in compliance with the majority of Standards, it also includes focus areas for improvement that warrant your attention.

We welcome your feedback on how we can assist you in better understanding the Standards and building compliance into the fabric of your quality improvement and assurance plans. Send feedback to quality@aaahc.org.

Please take the opportunity to look more closely at these survey findings and take advantage of the focused portfolio of educational programs and quality improvement resources that AAAHC offers to help you comply with our best practice Standards—*not just on the day of your survey but every day, throughout the 1,095 days of your accreditation term.*

Sincerely,

Noel M. Adachi, MBA
President and CEO

Julie Lynch, MS, BSN, RN
Director, Institute for Quality Improvement

www.aaahc.org

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We welcome your feedback on how we can improve this report and bring incremental value to your quality improvement efforts. Submit any suggestions or feedback to AAAHC at: quality@aaahc.org

I. *1095 Engage* Accreditation Management System

The *1095 Engage* accreditation and compliance-management system was created with the needs of the client at the forefront. This new accreditation and compliance-management portal provides a single-source operations solution for documentation, management of client profile information, communication, and workflow.

1095 Engage Application and Profile

An organization seeking accreditation enters organization information into the AAAHC *1095 Engage* electronic Application. The AAAHC uses Application information to verify eligibility, assess facility complexity, and scope and schedule a survey. The accuracy and veracity of information provided by an organization seeking or renewing accreditation is critical to the integrity of the accreditation program. Based on organization information provided in the Application or updated through the organization's *1095 Engage* Profile, AAAHC creates a set of Standards applicable to each organization that includes Selective and Universal Standards. Clients can access this curated Standards set electronically in the *1095 Engage* portal. This Standards set is also used by the Surveyor during the onsite survey process. Universal Standards apply to all organizations seeking to achieve or maintain accreditation. Selective Standards will apply based on the relevant services or specialty information pertaining to the organization as reflected in the organization's Application/Profile. For this reason, it is important to ensure the accuracy of the organization's initial Application and ongoing Profile by submitting any changes throughout the *1095 Strong* term. The same process applies to organizations seeking Patient-Centered Medical Home certification.

Programs

The *Quality Roadmap* integrates data from the Ambulatory (AMB), Medical Home (AMB/MHM), Dental Home (AMB/DHM), and Medicare Deemed Status (MDS) Accreditation programs, and the Patient-Centered Medical Home (PCMH) Certification program.

Standards Structure

AAAHC Standards are composed of multiple components: Categories, Statements of Requirement (SOR), Elements of Compliance (EOC), and Sub-Elements of Compliance (SEOC). Each SOR is also assigned a Level and classified as either Universal or Selective. When applicable, the Handbook also includes guidance and references to provide additional information to assist understanding and guide compliance. Each component is described below.

Categories

Standards are organized by Category which groups similar concepts to facilitate organization compliance and to streamline the onsite survey process. Each Category outlines applicability and expectations for compliance.

CATEGORY	CATEGORY DESCRIPTION
ADM	Administration
ASG	Anesthesia and Surgery
BEH	Behavioral Health
CMC	Care Management and Coordination
CPV	Credentialing and Privileging
CRD	Clinical Records
EMG	Emergency Management
FAC	Facilities and Equipment
GOV	Governance
IPC	Infection Prevention and Control

CATEGORY	CATEGORY DESCRIPTION
LRD	Laboratory and Radiology
MED	Medication Management
MHM*	Medical Home
DHM*	Dental Home
OCS	Other Clinical Services
QUA	Quality
PRR	Patient Rights, Responsibilities and Protections
SAF	Safety
VAL	Validation

* Applicable to *Accreditation Handbook for Ambulatory Health Care* only (AMB)

AAAHC has developed a survey tool to determine compliance with select Life Safety Code® (LSC) and Health Care Facilities Code® requirements. The Physical Environment Checklist for Ambulatory Surgical Centers provides for schematic review of the fire and life safety requirements for an ASC seeking certification by the Centers for Medicare and Medicaid Services (CMS). It is based on the CMS-approved requirements of the applicable National Fire Protection Association (NFPA) codes and standards, as referenced in the NFPA 101 Life Safety Code®, 2012 Edition and NFPA 99 Health Care Facilities Code®, 2012 Edition.

CATEGORY	CATEGORY DESCRIPTION	CATEGORY	CATEGORY DESCRIPTION
CON	LSC Construction	FAS	LSC Fire Alarm Systems
EGR	LSC Means of Egress	SFP	LSC Smoke and Fire Protection
LAB	LSC Laboratory Related Requirements	PFE	LSC Portable Fire Extinguishers
HAP	LSC Hazardous Area Protection	BLD	LSC Building Services
GAS	LSC Medical Gases	FEP	LSC Fire Emergency Plans
EES	LSC Electrical System	FRN	LSC Furnishings and Decorations

Statements of Requirement (SOR) and Universal and Selective Standards

Each Category is composed of multiple Standards or Statements of Requirement. The SOR states the overarching intent of the Standard. Within each Category, there are two types of SORs: Universal and Selective. Universal SORs apply to all organizations seeking or maintaining accreditation. Selective SORs apply based on program selection and the relevant services or specialty information as provided in the organization's Application or Profile. This report identifies top deficiencies in high volume services or specialties through selective indicators.

Elements of Compliance (EOC) and Sub-Elements of Compliance (SEOC)

The Standards are written in general terms followed by Elements and Sub-Elements of Compliance, which can be evaluated as Yes, No, or Not Applicable, and represent the minimum requirements to demonstrate compliance. An organization must demonstrate that all applicable SEOCs are compliant to meet EOC compliance. However, EOC and SEOC data are explicitly analyzed in this report.

Standards Levels

SORs are assigned a Standards Level that reflects the potential impact to patient and staff safety and care. The Standards Levels are one of several factors considered in determining accreditation decisions. There are three Standards Levels:

- Level 0: Standards in test mode, or during a grace period for implementation
- Level 1: Standards which specify, or apply to, activities or processes which DO NOT involve the provision or conduct of patient care, OR the assurance of patient or employee safety
- Level 2: Standards which specify, or apply to, activities or processes which involve the provision or conduct of patient care, OR the assurance of patient or employee safety

Validation

The Validation Category verifies information such as services, state requirements, and eligibility and allows for an evaluation of certain profile/application information to ensure accuracy and completeness. The Validation Category is excluded from this report.

Get the Most Value from this Report

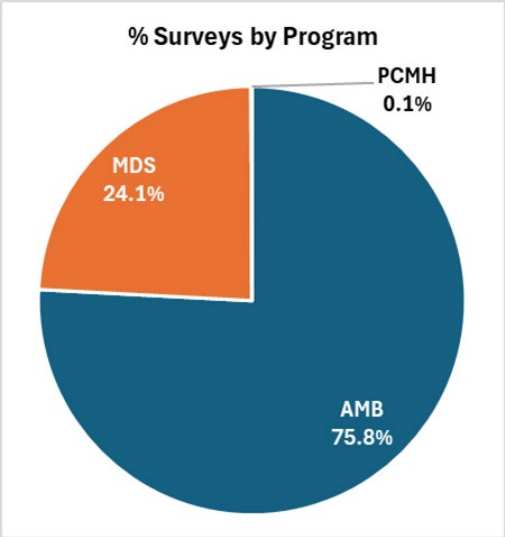
The 2025 *AAAHC Quality Roadmap* presents actionable data that you can use to improve the quality of care your organization provides. We encourage you to use this tool by taking the following steps:

1. Compare these findings to your last onsite survey report (Category Rating Summary) to see where you benchmark against organizations surveyed within the last year.
2. Compare these findings to your annual self-assessment, completed as part of the Annual Attestation. The Annual Attestation supports each organization's commitment to *1095 Strong*. An organization must submit an electronically signed attestation via *1095 Engage* no later than the organization's annual Anniversary Date. Through the Annual Attestation, the organization verifies the accuracy of its Profile in *1095 Engage*, acknowledges receipt of the latest version of AAAHC Standards, and attests to completion of a self-assessment of the applicable Standards.
3. Determine the most common deficiencies relevant to your program, facility type and specialty.
4. Annually and in preparation for your next AAAHC Survey, review your policies, procedures, and practices to ensure they reflect best practices and compliance to relevant AAAHC Standards.
5. Leverage AAAHC Toolkits and other resources available from AAAHC and other organizations to assure and improve quality.
6. Use this information as a resource to increase your understanding of AAAHC Standards and identify useful benchmarks to help your organization improve the quality of care you provide to patients.
7. Share and discuss the findings with others within your organization to drive understanding and effective decision making on Quality Improvement (QI) studies or other corrective actions that may be necessary.

Accreditation is a continuous improvement journey. While the report indicates that most facilities surveyed are in compliance with the majority of Standards, it also includes focus areas for improvement that warrant your attention. Focusing on these areas will help address and minimize previous deficiencies.

II. Data Description

This report is based on an analysis of Surveyor ratings of compliance with the *Accreditation Handbook*, v43 and v43.1 during onsite surveys conducted between May 1, 2024 – May 27, 2025, for organizations seeking initial or re-accreditation in the Ambulatory Accreditation (AMB) with or without Medical and/or Dental Home recognition, the Patient-Centered Medical Home Certification program (PCMH), and the Medicare Deemed Status (MDS) programs which includes frequent deficiencies related to the Centers for Medicare and Medicaid (CMS) Conditions for Coverage (CfC).



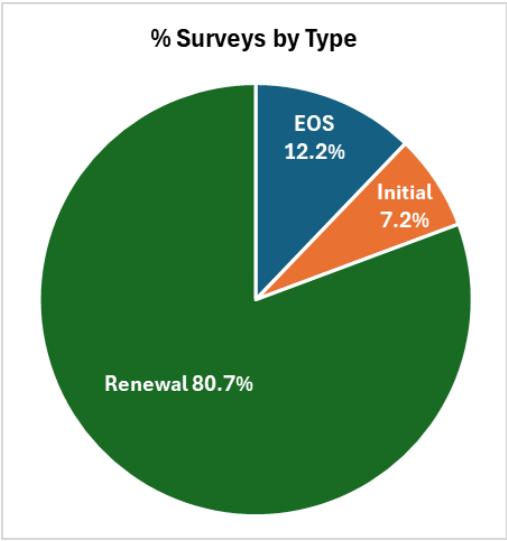
Survey results for organizations seeking accreditation through the AAAHC Health Plan or Federal Employee Health Benefits (FEHB) programs are not included. In addition, this report does not include state-specific Statement of Requirements (SORs) or intracycle surveys.

Under the *Accreditation Handbook*, v43/v43.1, Surveyors used a binary rating of "Yes" or "No" to assess whether each Element of Compliance (EOC) of a Statement of Requirement (SOR or Standard) was met. The compliance rating of Fully Compliant (FC), Substantially Compliant (SC), Partially Compliant (PC), Minimally Compliant (MC), and Non-Compliant (NC) was then automatically calculated based on the number of "Yes" ratings and the total number of applicable EOCs within a Standard. Depending on the Standard, SC, PC or MC may not apply (e.g., Standards without additional elements do not have rating options for SC, PC or MC; Standards that are CfC requirements are binary [FC or NC]).

Chart 1: Total surveys conducted by program

This report provides an analysis of compliance findings for those Standards that were applicable to at least 95 percent of the organizations surveyed. While this report looks in depth at those Standards with the highest incidence (5 percent or more) of any Standard with a less than FC rating, please note that most organizations that seek AAAHC Accreditation successfully achieve a three-year term.

Chart 2: Total surveys by type of survey



The data within this report is obtained from three types of AAAHC surveys: Early Option Survey (EOS), initial survey, and renewal survey.

An Early Option Survey is requested by a non-accredited organization that meets eligibility criteria and has been providing services for fewer than six months. These organizations are newly existing, operational, and require accreditation for third-party reimbursement, and a six-month wait for a survey would entail financial hardship; or require accreditation to meet laws or regulations before the facility can legally begin operations.

An initial survey is for an organization that is not currently accredited by the AAAHC and has been providing services for at least six months before the onsite survey.

A renewal survey is for a currently AAAHC-Accredited Organization seeking continuation of its AAAHC Accreditation.

The surveys completed can be segmented into two primary categories: surgical/procedural and primary care. See the charts below for further breakdown. Additional details of deficiencies for each of these two segments will be discussed in later sections of this report.

Surgical/Procedural

89.5%

Primary Care

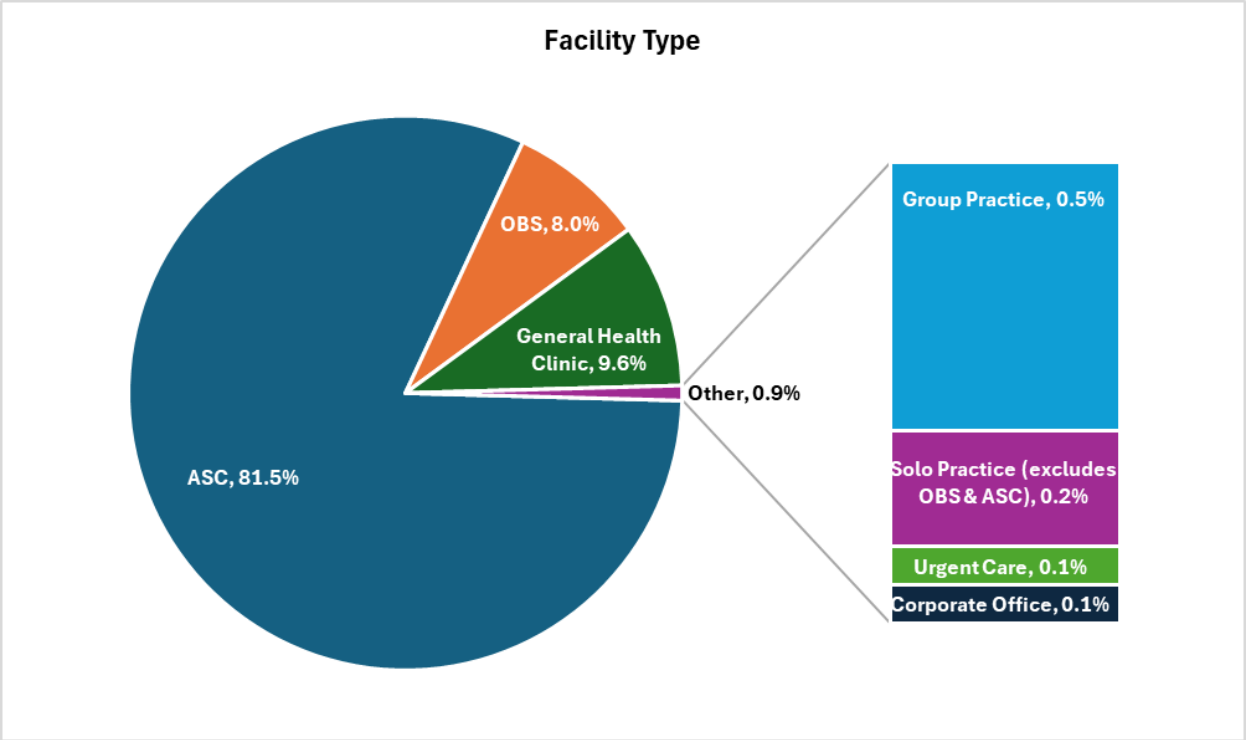
10.5%

Facility Type

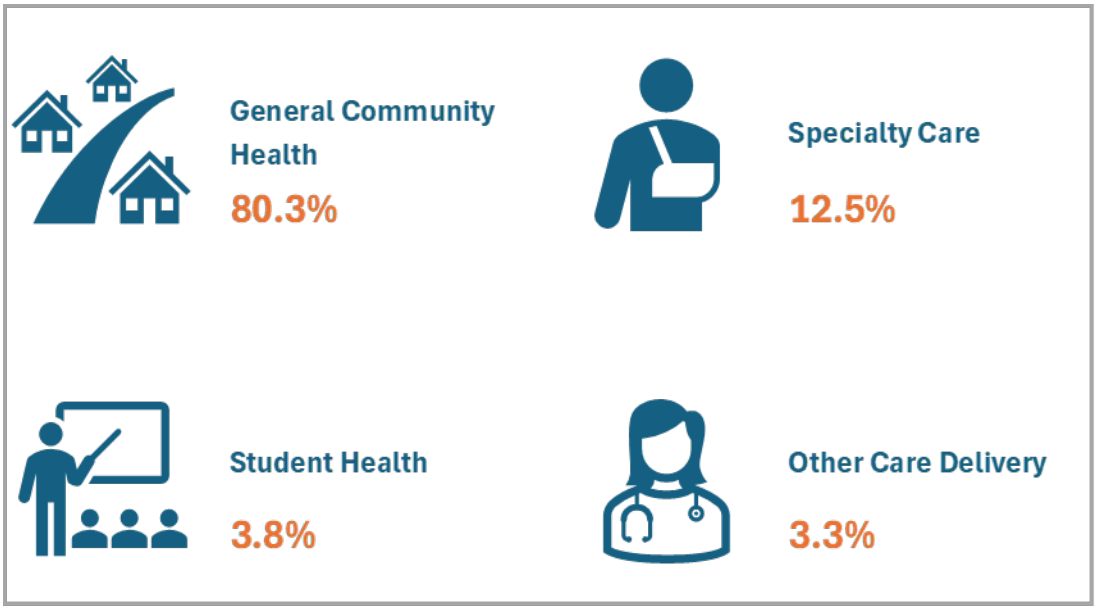
Surgical/Procedural includes facilities identified as Ambulatory Surgery Centers (ASC) or Office Based Surgery Centers (OBS) and represent 89.5 percent of surveys completed during this timeframe.

Primary care facilities include General Health Clinics representing specialty care, student health, worksite health, Indian health, tribal health, and military health, and represent 10.5 percent of surveys completed during this timeframe.

Chart 3: Total surveys by Facility Type



The percentages of the population served are noted in the infographic below.



The Other Care Delivery category noted in this graphic includes Indian health, tribal health, military health, and workplace health.

Specialties

The 2025 *Quality Roadmap* also analyzed the percentage of specialty services represented within the timeframe. Anesthesiology is excluded as it is incorporated in all systems.

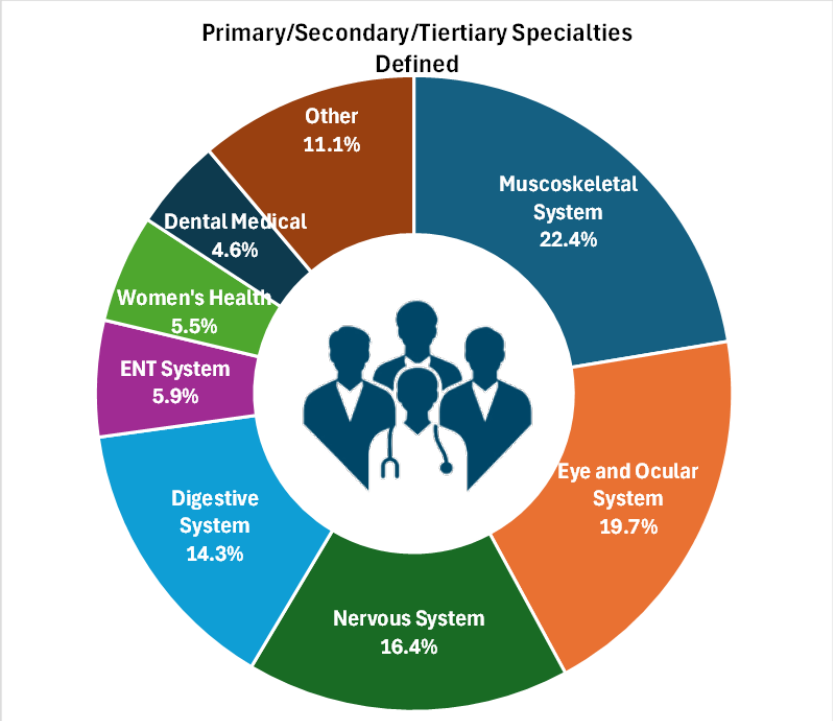


Chart 4: Specialty Services

"Other" Specialties constitute 11.1 percent and include:

- Cardiovascular System
- Behavioral Health
- Immune, Endocrine and Genetics
- Integumentary
- Oncology
- Pulmonary Medicine
- Urinary System

Ratings by Category

The following findings represent all surveys completed between May 1, 2024 and May 27, 2025 under the *Accreditation Handbook for Ambulatory Health Care*, v43/v43.1 health-related or clinical standards, excluding CMS Life Safety Code® requirements.

How to read this chart

The AAAHC Categories are listed on the horizontal axis of the graph. Category names can be referenced on page one of this report or in any *Accreditation Handbook for Ambulatory Health Care,* v43 or later version.

The vertical bar graphs represent all ratings for all surveys conducted. The color coding identifies the level of compliance achieved within each category, e.g., Fully Compliant (FC), Substantially Compliant (SC). See the full list of compliance descriptions on page 4.

The black data points indicate the percentage of deficiency for each category.

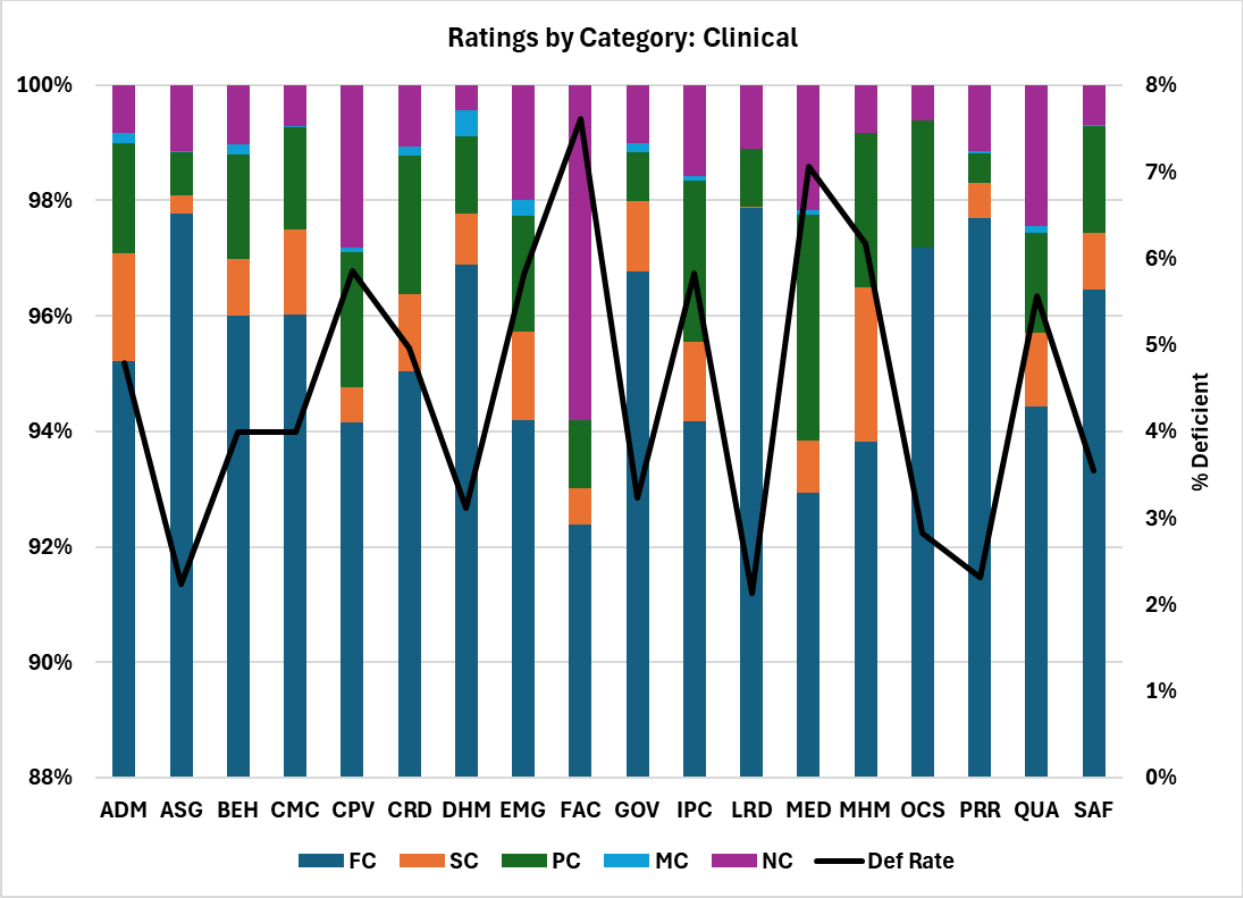


Chart 5: Ratings by Category, Surgical/Procedural Organizations: Clinical, all surveys

Therefore, the top deficiency areas for all organizations are Facilities and Equipment (FAC) followed by Medication Management (MED) and Credentialing and Privileging (CPV). See the next sections for further breakdown of deficiency data.

III. Surgical/Procedural Organizations

The data in this section represents all surgical/procedural organizations surveyed under the *Accreditation Handbook for Ambulatory Care* or *Medicare Deemed Status* for ASC and OBS facilities. Surgical/procedural organizations represent 89.5 percent of all organizations surveyed between May 1, 2024 and May 27, 2025.

A. Overall Performance

Chart 6 provides the overall performance per category for surgical/procedural organizations. Seven categories demonstrated deficiencies over the 5 percent threshold and will be discussed in further detail.

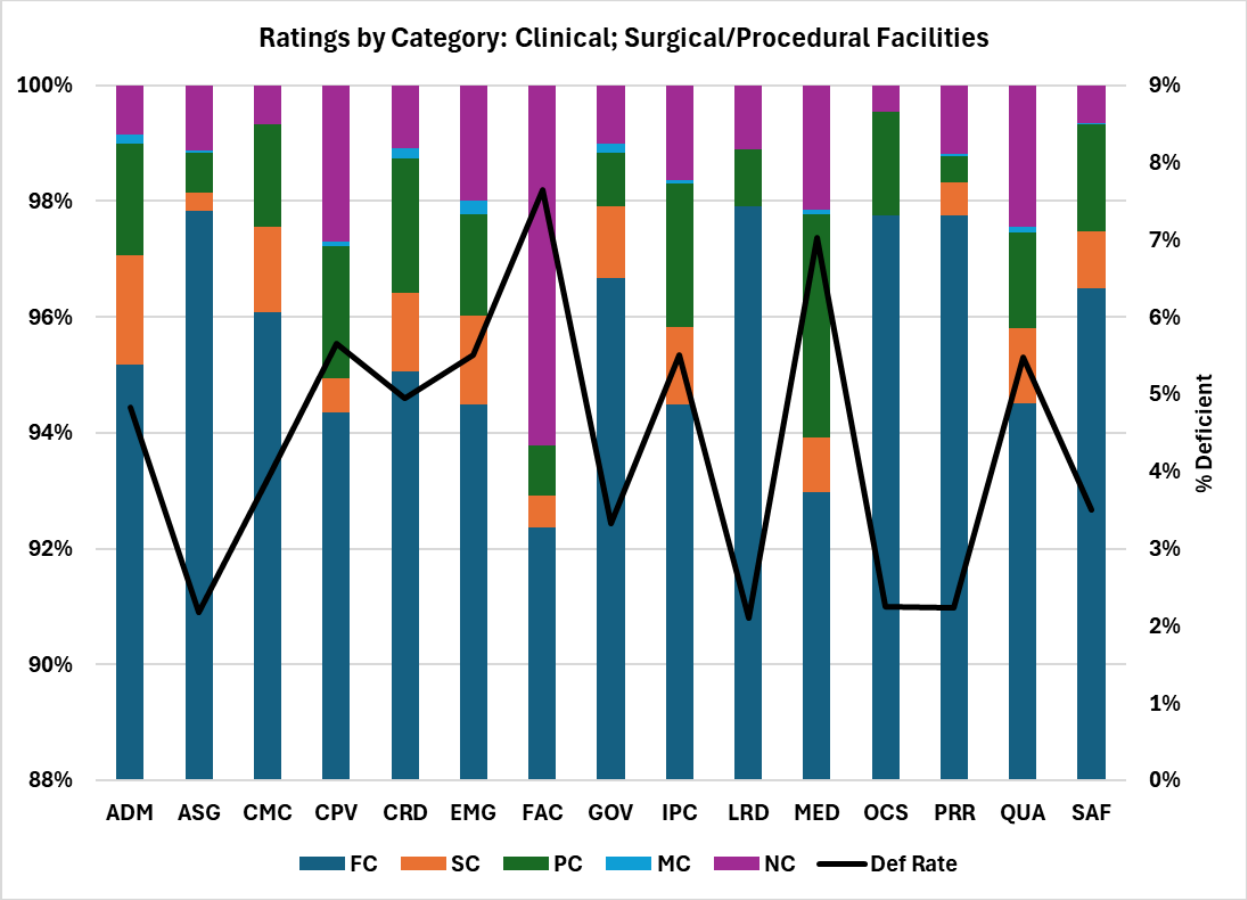


Chart 6: Clinical Category Rating for Surgical/Procedural Facilities

The top three deficiency categories for surgical/procedural organizations include:

FAC Facilities and Equipment

MED Medication Management

CPV Credentialing and Privileging

The highest deficiency categories are noted in Chart 7 below. Clinical categories will be discussed in detail. Life Safety Code® categories are excluded here and can be found in Section IV.

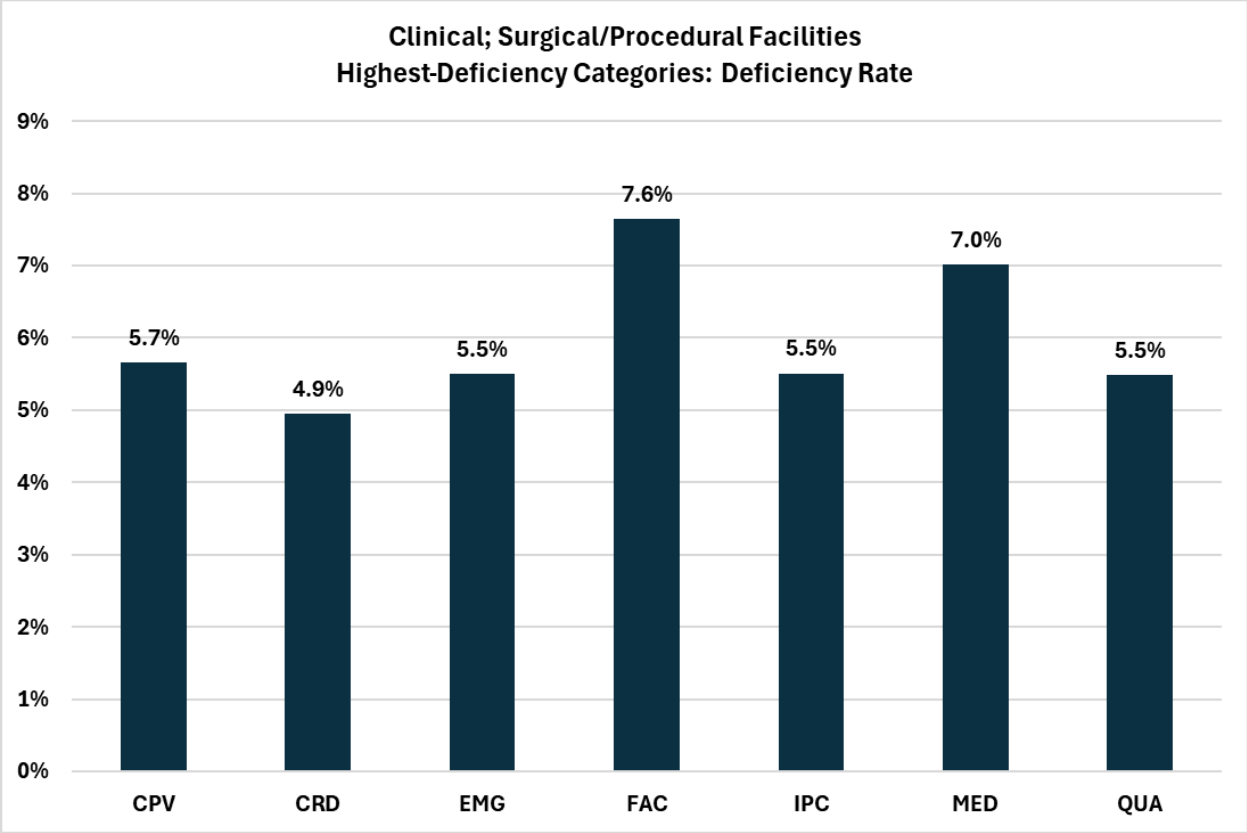


Chart 7: All surgical/procedural high-deficiency categories – clinical

B. High Deficiency Standards

The following charts are listed in order by highest deficiency rate category.

FAC Facilities and Equipment – 7.6 Percent

Elements of a "clean and properly maintained" facility include but are not limited to: Surfaces are free of dust and visible soil; wall finishes are smooth, uniform and easy to clean; lack of mold and rust in the facility; plumbing, window and door hardware, and HVAC systems are in working order; there is no visible damage or wear on electrical receptacles and light switches.

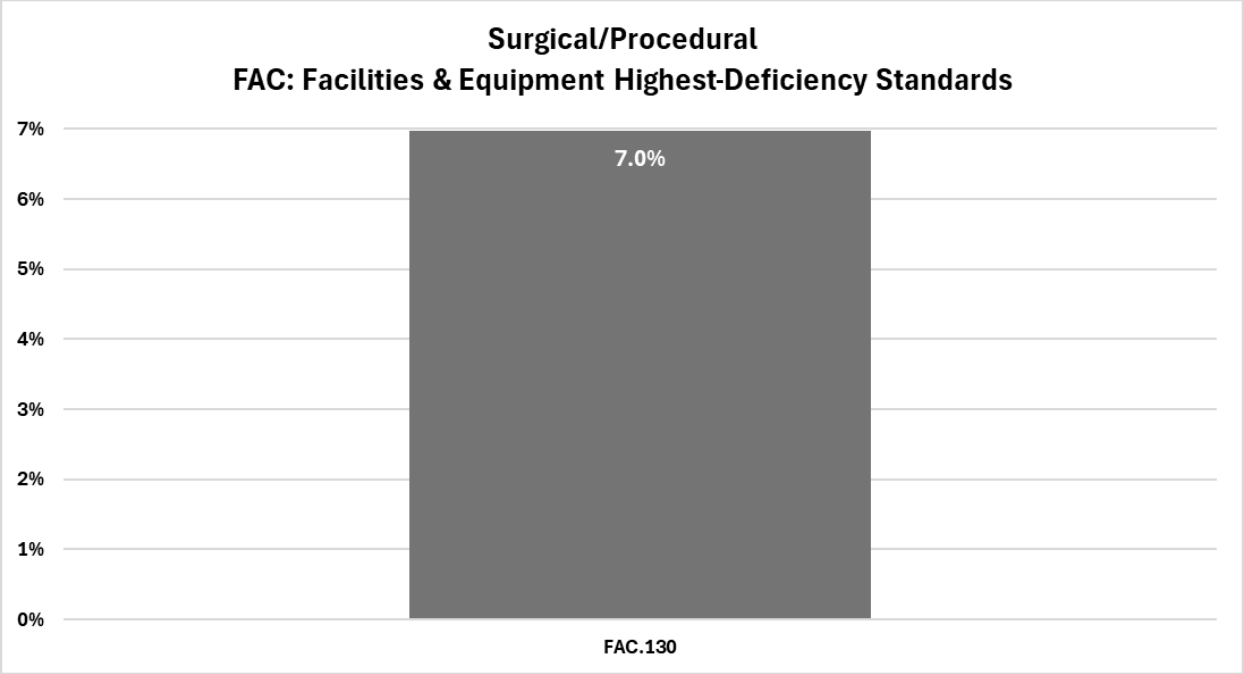


Chart 8: FAC high deficiency Standard

% DEF	SOR	SOR DESCRIPTION
FAC FACILITIES AND EQUIPMENT		
7.0%	FAC.130	Facilities are clean and properly maintained.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Dust and dirt found on floors, equipment, code cart, air vents, and on supplies • Equipment rust, wear • Walls scratched, chipped exposing drywall • Countertops chipped • Insects noted in light fixtures, under sinks • Floor cracks, missing tiles, floor seam gaps • Tears in furniture, exam tables, chairs • Roof leak, stained ceiling tiles	• Monitor housekeeping practices on a regular basis • Establish process and checklist to perform monthly rounds to monitor for additional maintenance and cleaning needs • Establish process for routine repairs and replacement needs • Monitor equipment warranties and end-of-life recommendations • Consider seamless floor systems • Decrease amount of supplies purchased to prevent storing excess supplies needing to be cleaned - base par levels on number of cases per year

This Standard does not address the cleaning of patient care or treatment areas or the cleaning and sterilization processes of patient instruments or supplies. Those Standards are assessed in the Infection Prevention and Control (IPC) category and did not trigger a deficiency of >5 percent.

MED Medication Management – 7 Percent

This category aims to prevent drug errors and patient harm related to drug names, labeling, or adverse reactions. It outlines the expectations for safe and effective medication oversight, prescription, dispensing, administration, storage, and disposal.

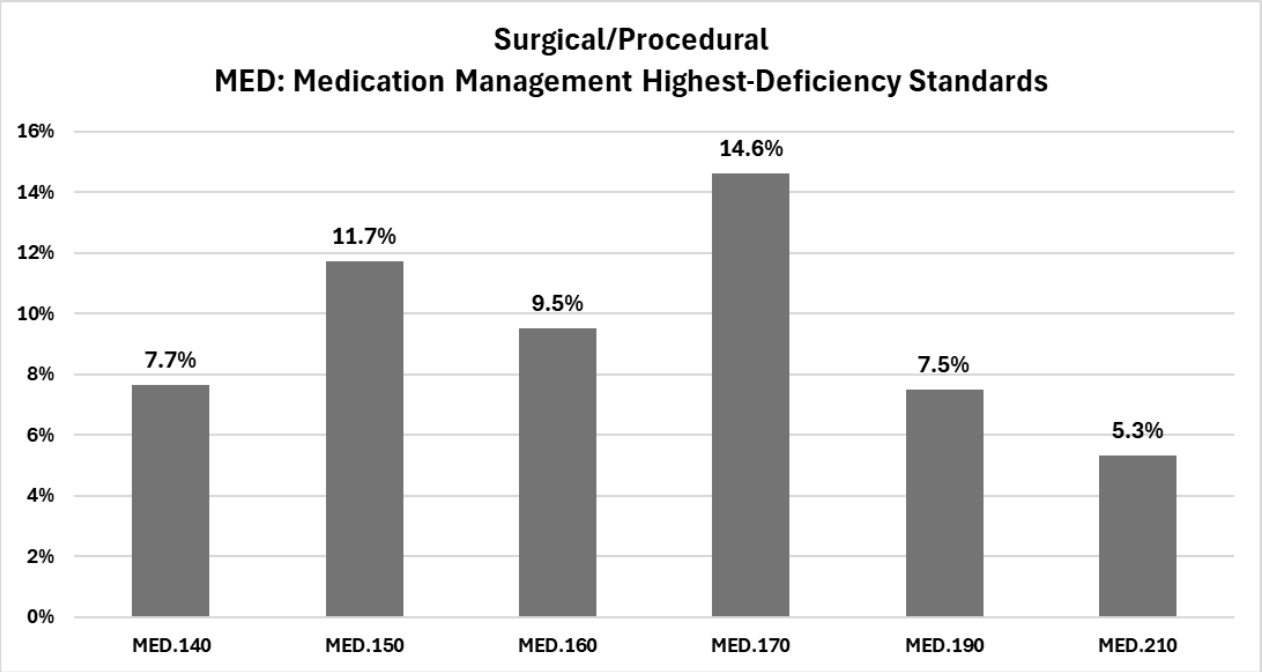


Chart 9: MED High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
MED MEDICATION MANAGEMENT		
7.7%	MED.140	The medication inventory is monitored to track the presence or absence of high-alert medications and medications with confused drug names.
11.7%	MED.150	Procedures are in place to prevent errors from high-alert medications.
9.5%	MED.160	Procedures are in place to prevent errors from medications with confused drug names.
14.6%	MED.170	Drug storage and security, including recordkeeping, are maintained to ensure the control and safe dispensing of drugs (including samples), to minimize medication errors, and to prevent diversion in compliance with prevailing laws and regulations.
7.5%	MED.190	If not administered immediately, all medications (injectable, oral, etc.) removed from the original container or packaging are labeled in a standard format in accordance with law, regulation, and standards of practice.
5.3%	MED.210	A written policy is present addressing the disposal or return of expired, damaged, and recalled medications in accordance with prevailing laws and regulations and accepted guidelines.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• No policy, training, or documentation that high-alert medications or medications with confused drug names are monitored • No list of high-alert medications or medications with confused drug names present	• Reference the Institute for Safe Medication Practices (ISMP) for protocols related to high-alert medications and medications with confused drug names

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• High-alert medications or medications with confused drug names are not labeled as such where they are stored • Confused drugs not identified as such and stored next to each other • Medications not segregated or labeled • Antidote/reversal agents not stocked near high-alert medications • No directions for use noted for reversal agents • Anesthesia cart with medications not secured to prevent diversion • Open vials on top of anesthesia cart utilized for more than one patient • Partial vials of Propofol discarded in sharps containers • Medications not stored at recommended temperatures • Medications drawn/not used within time limit for safe use, stored in provider pockets • Medications drawn into syringes not labeled or not labeled according to policy • Expired medications present	• Provide a list of high-alert and confused drug names of medications in all areas where medications are stored and prepared • Utilize drawer dividers to separate medications • Label high-alert medications or medications with confused drug names as such • Utilize "tall man lettering" to differentiate similar drug names • Place drugs with similar names apart from one another • Provide and document training on medication management policies and procedures • Store manufacturer's instructions for use of reversal agents with the medications for quick reference • Review national guidelines on Safe Injection Practices specific to multi-use vials and medication labeling • After checking state/local drug disposal guidelines, consider utilizing an activated charcoal-based drug disposal system for safe medication disposal • Refer to manufacturer's instructions for use for proper storage temperatures

The safety of all aspects of medication management in the ambulatory health care setting is essential to preventing harm to patients.

CPV Credentialing and Privileging – 5.7 Percent

The Credentialing and Privileging category outlines the expectations of an organized process designed and implemented to ensure health care professionals are qualified and competent to provide high quality patient care.

Credentialing, privileging, and peer review are separate but related processes. Credentialing is validating an individual's professional qualifications to provide health care services, while privileging is a formal process of obtaining governing body approval for a provider to deliver specific treatments, procedures, or to use specific equipment.

Peer review confirms a provider's competence by enlisting others of similar license and/or similar privileges to review clinical records and other aspects of care. Peer review is vital to the ongoing monitoring of clinical care; specific peer review Standards can be found in the Quality (QUA) category.

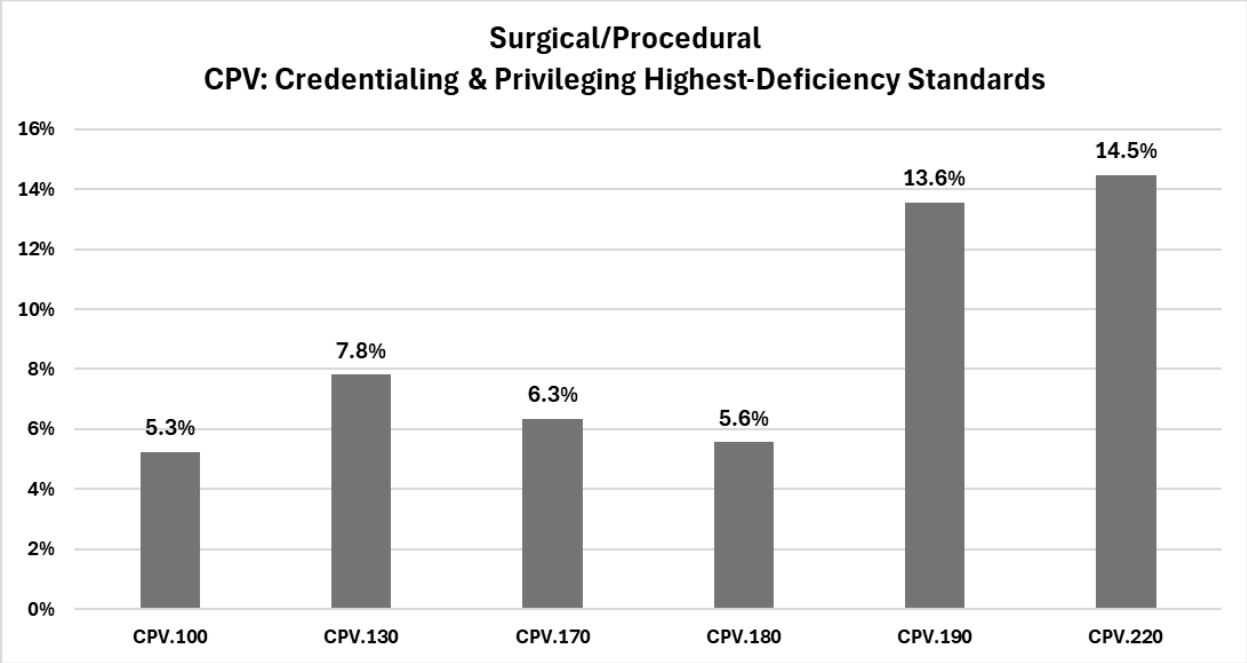


Chart 10: CPV High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
CPV CREDENTIALING AND PRIVILEGING		
5.3%	CPV.100	The medical and/or dental staff is accountable to the governing body through a credentialing, privileging, and reappointment process for which the governing body is responsible.
7.8%	CPV.130	On a formal application for initial staff privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested.
6.3%	CPV.170	Members of the medical and/or dental staff apply for reappointment every three years, or more frequently if prevailing laws and regulations, or organizational policies so stipulate.
5.6%	CPV.180	Upon receipt of the completed reappointment application, primary or secondary source verification is conducted.
13.6%	CPV.190	The governing body makes appointment and reappointment decisions following review of the applications or based on recommendations from an internal delegate.
14.5%	CPV.220	Privileges to carry out specified procedures are granted to legally and professionally qualified applicants.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Organization not following policy for timeframes, resulting in expired privileges • Missing/incomplete initial credentialing information, e.g., reappointment request, supporting documentation, signatures, NPDB • Primary source verifications partially obtained/ not obtained at initial or reappointment • Reappointment application missing or incomplete	• Create a credentialing and privileging calendar • Utilize a detailed checklist to document and date completion of each step of the credentialing and privileging process • Create a process to maintain currency of date-sensitive documents, e.g., licensure, DEA registrations, malpractice coverage

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Governing body review and approval of credentialing and privileging incomplete or not present • Allied health care professionals not credentialed or privileged • Peer Review or peer reference documentation incomplete or not present (also see QUA.160) • Written request for privileges not present • Approval of privileges not present • Privileges for supervision not present • Privileges approved for procedures not performed in the center • Privileges for level of anesthesia not present • Privileges not granted for a specific period	• Include contract and allied health care professionals in the credentialing and privileging process • Confirm governing body delegate review • Ensure privilege forms include only procedures that are performed at the organization • Ensure privilege forms include documentation of specific privileges, e.g., anesthesia, laser, supervision • Use a peer review summary form for each provider for recredentialing • Include a date-specific time period for which privileges are granted

Detailed information on how to implement an effective credentialing and privileging process at your organization and how to credential and privilege a provider can be found in the newly updated *Credentialing and Privileging Toolkit* available at: https://store.aaahc.org/toolkits

EMG Emergency Management – 5.5 Percent

The Emergency Management category outlines the expectations for ensuring preparedness for natural, man-made, or facilities emergencies that may include care related emergencies; equipment and power failures; interruptions in communications (e.g., cyberattacks); loss of a portion or all of a facility; interruptions in the normal supply of essentials, such as water and food; and emerging infectious disease threats.

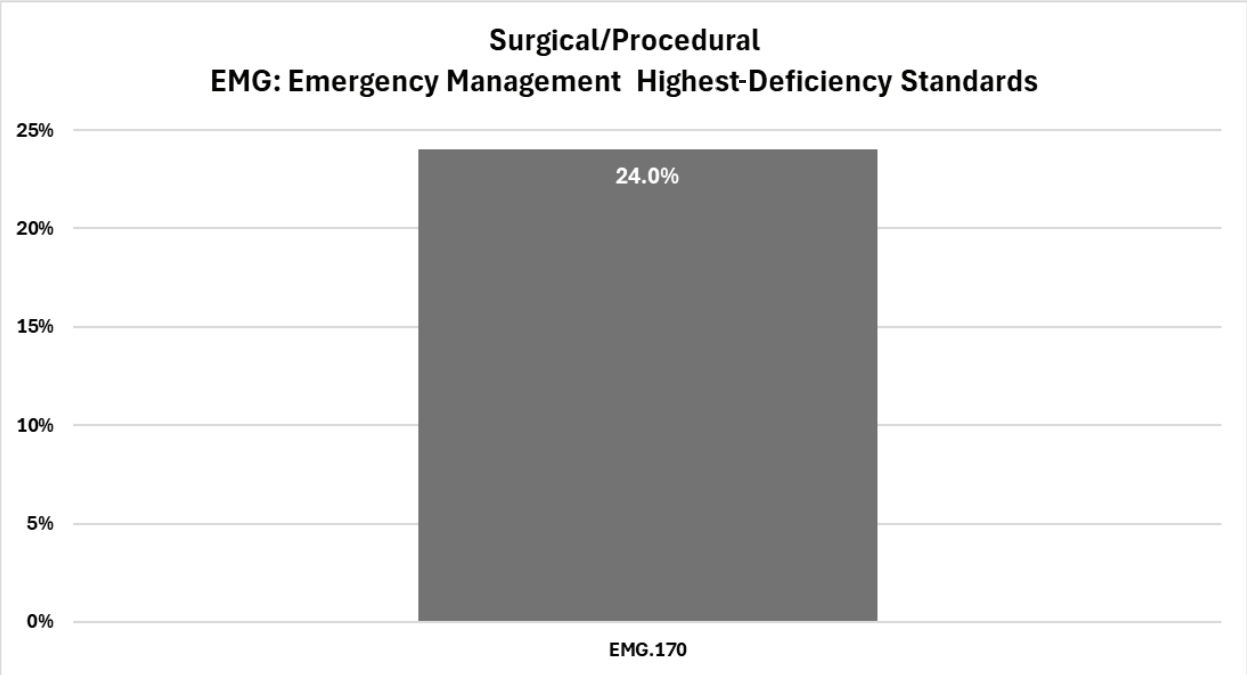


Chart 11: EMG High Deficiency Standard

% DEF	SOR	SOR DESCRIPTION
EMG EMERGENCY MANAGEMENT		
24.0%	EMG.170	Scenario-based drills of the internal and external emergency and disaster preparedness plan are conducted.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Drills are not scenario-based • Drills not completed each calendar quarter • CPR drill not conducted annually • Emergency disaster plan drill not conducted annually • Drill participants present not documented • Drill evaluation not documented • Needed corrections not documented	• Preschedule drills each quarter and assign a responsible party to complete • Create scenarios to make drill most applicable to a potential real-life situation • Act out the drill where each team member conducts their role (e.g., call for help, call 911, start CPR, retrieve oxygen/AED) • Create drill template/checklist that includes the participants, scenario, evaluation, and corrective actions • Invite an impartial party to view the drill and provide their evaluation

Issues related to performing scenario-based drills continue to be the highest Standard deficiency despite its criticality to patient and team member safety. Success with this Standard takes pre-planning of drill timing and a scenario appropriate to the facility's procedures, location, and risk assessment.

These drills allow health care providers to apply their skills in a realistic environment, without risking patient harm, to build confidence in the event of a real-life emergency situation. Drills also build teamwork, communication, and trust. They identify gaps in plans, policies, and procedures, and highlight training needs related to equipment, supplies, or processes. Drills also provide an environment where mistakes can be made, learning can occur, and staff can build the confidence needed when faced with real crisis situations.

AAAHC resources include an *Emergency Drills Toolkit,* which provides detailed steps for drill planning and documentation from start to finish, located at https://store.aaahc.org/toolkits. You can also participate in the AAAHC annual Emergency Preparedness Benchmarking Study when you purchase the annual benchmarking subscription. More details can be found at https://www.aaahc.org/quality-institute/benchmarking-studies/.

IPC Infection Prevention and Control – 5.5 Percent

The intent of the Infection Prevention and Control category is to ensure that organizations reduce the risk of infection and communicable diseases by developing a program based upon nationally-recognized infection control guidelines.

Non-compliance with Standards specific to infection prevention and control place patients at risk and are a potential liability for organizations.

How do you compare?

Are you among the majority of organizations that demonstrate full compliance to these requirements, or are these areas requiring improvement and action?

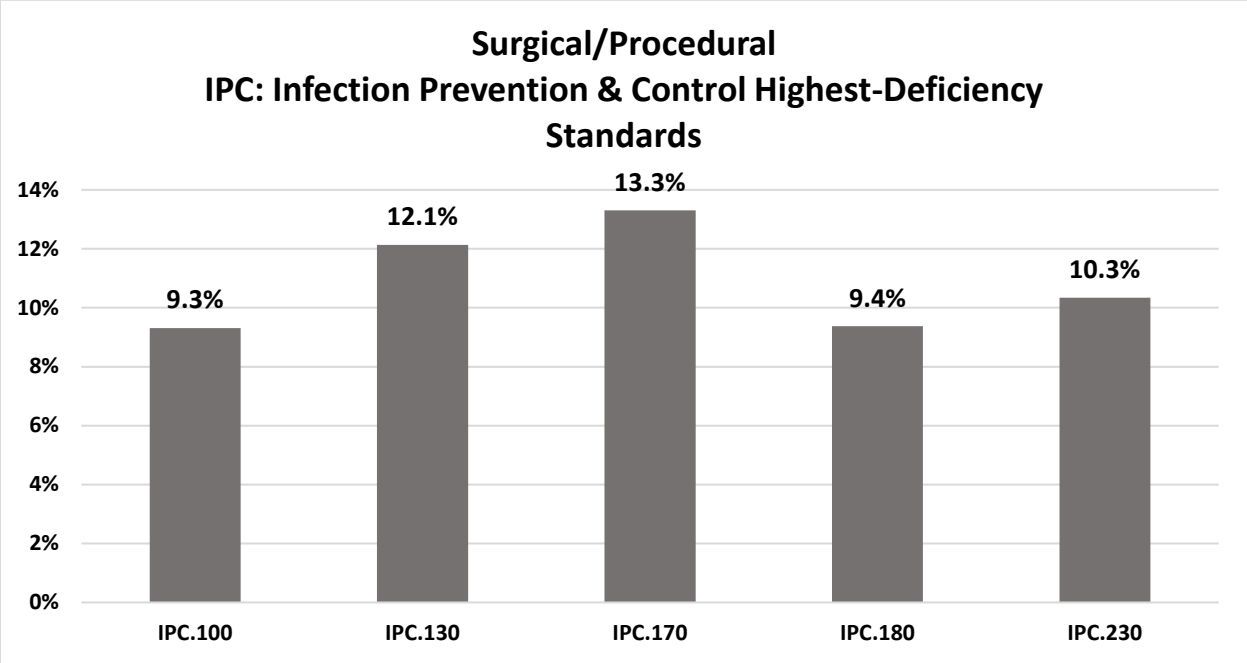


Chart 12: IPC High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
IPC INFECTION PREVENTION AND CONTROL		
9.3%	IPC.100	The organization has a written program for infection prevention and control.
12.1%	IPC.130	The written infection prevention and control program describes how infections and transmission of communicable diseases are prevented, identified, and managed.
13.3%	IPC.170	Safe processes are used for the cleaning, decontamination, high-level disinfection, and sterilization of instruments, equipment, supplies, and implants.
9.4%	IPC.180	A written sharps injury prevention program is present in the organization.
10.3%	IPC.230	The surgical environment contains safeguards to protect patients and others from cross-infection.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• IPC program not approved by the governing body • No formal, documented IPC risk assessment • No surveillance or monitoring activities performed • Hand hygiene not performed consistently per policy • Safe injection practices not followed, e.g., cleaning the rubber septum, opened multi-dose vials (MDV) not dated, MDV drawn up in treatment rooms and in the presence of patients • Biological monitoring not completed per national guidelines or manufacturer's instructions for use • No reference to national guidelines for sterilization processes	• Refer to resources such as CDC, CMS, APIC, AORN, and ADS for risk assessment and surveillance activities • Train staff upon hire, annually and as needed, on national IPC guidelines, sterilization guidelines, and safe injection practices • Ensure hand hygiene supplies are available in all areas hand hygiene should be completed • Provide visual cues such as posters for proper hand hygiene and safe injection practices • Use a clean, dedicated area to prepare and label medications • Maintain updated national guidelines, IPC policies, and manufacturers ' instructions for use in easily accessible location for staff reference

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE

• No policy on sterilization parameters or failures
• Improper transport of dirty instruments (OSHA); hinged instruments sterilized in closed position; single-use items used as multi-use; not following instructions for use of cleaning product concentrations, improper use of HLD
• Sharps containers not secured
• Per observation, written polices to prevent cross-infection not followed:
  ○ Personal attire/jackets in the OR
  ○ Looped masks
  ○ Reuse of disposable gowns
  ○ Scrubs laundered at home
  ○ Lack of hand hygiene
  ○ Improper surgical scrub
  ○ Lack of monitoring or out-of-range temperature and humidity controls without corrective action
	• Lock sharps holders
	• Secure storage room doors to prevent tampering of full sharps containers
	• Utilize the "AAAHC Documentation Requirements" worksheet in the Resources section of the *Accreditation Handbook for Ambulatory Health Care* or *Medicare Deemed Status* to ensure you have the written documentation required to comply with the AAAHC Standards
	• Review policy and procedures with staff
	• Train staff on actions to take when temperature or humidity controls are out of range

Effective infection prevention and control is a fundamental component of high-quality health care delivery. Ambulatory Surgery Centers (ASC) provide unique infection risks due to the brief nature of many services, resulting in higher patient turnover. Historically, ASCs lacked dedicated infrastructure, resources, and trained IPC personnel when compared to inpatient hospitals, however, the principles of IPC remain the same. Thanks to team-based approaches to care, robust education and training, strong policy and procedures, and the focus on a culture of safety, ASCs can and do maintain high standards for infection prevention and patient safety.

AAAHC resources include the *Safe Injection Practices Toolkit* (SIP), which provides a risk assessment tool to identify where your organization may be deficient in SIP, how to develop a training plan to address SIP deficiencies, and how to monitor safe injection practices. See https://store.aaahc.org/toolkits to purchase.

You can also participate in the AAAHC Safe Injection Practices Benchmarking Study and the Hand Hygiene Benchmarking Study when you purchase the annual benchmarking subscription. More details can be found at https://www.aaahc.org/quality-institute/benchmarking-studies/.

The AAAHC also recommends infection control resources from the Centers for Medicare and Medicaid Services (CMS), World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Association of perioperative Registered Nurses (AORN), Association for Dental Safety (ADS), and the Ambulatory Surgery Association Quality Collaboration (ASC QC).

QUA Quality – 5.5 Percent

The Quality category addresses the components of a quality management and improvement program that links peer review, quality improvement (QI) studies, infection prevention and control, safety, and risk management in an organized, systematic way.

The intent of the program is to continuously improve the effectiveness, efficiency, and safety of services and processes, leading to better clinical and organizational outcomes.

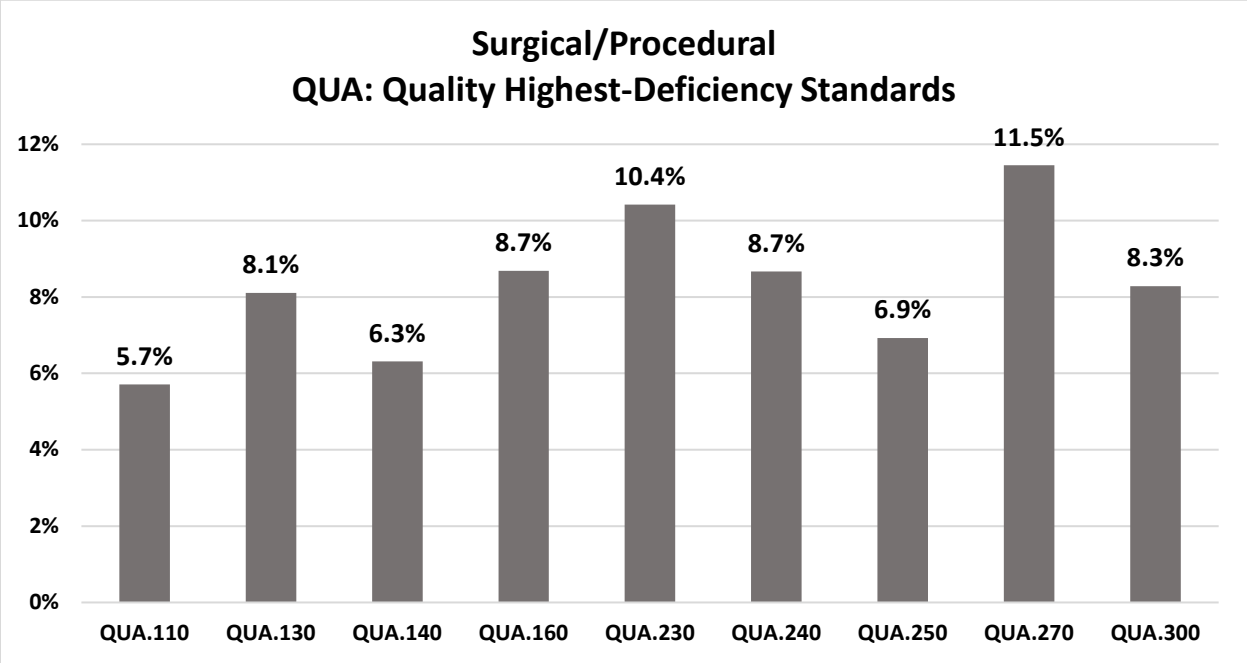


Chart 13: QUA High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
QUA QUALITY		
5.7%	QUA.110	Each physician, dentist or health care professional is reviewed by at least one similarly-privileged and/or similarly-licensed peer.
8.1%	QUA.130	Privileged health care professionals participate in the development and application of peer review criteria.
6.3%	QUA.140	Ongoing monitoring of important aspects of the care provided by physicians, dentists, and other health care professionals is conducted.
8.7%	QUA.160	The results of peer review are used as part of the process for granting continuation of clinical privileges.
10.4%	QUA.230	The organization has a written quality improvement program.
8.7%	QUA.240	The quality improvement program includes processes to ensure communication of the results of quality improvement activities.
6.9%	QUA.250	Ongoing data collection processes are in place to measure quality and to identify quality-related problems or concerns.
11.5%	QUA.270	The organization demonstrates that continuous improvement is occurring by conducting quality improvement studies when the data collection processes indicate that improvement is or may be warranted.
8.3%	QUA.300	The organization participates in external benchmarking activities that compare key performance measures with other similar organizations, with recognized best practices, and/or with national or professional targets or goals.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Peer review not being performed • Allied Health Professionals (AHPs) not included in the peer review process • Peer review data not used to establish internal benchmarks to identify improvement opportunities • No evidence that peer review is used to grant continuation of privileges (also see CPV.190) • Components of the written quality improvement program are missing, e.g., oversight, participants, annual evaluation • Communication of QI activities to the governing body not documented • Ongoing data collection of peer review, important processes or benchmarking not being performed • No QI studies performed • QI Studies do not contain the required elements • QI Studies do not contain measurable goals, e.g., improve a problem from X percent to Y percent • Quality *activities* being performed to determine if there is a problem, but no *studies* to correct a problem or improve the results • QI studies did not show improvement • QI studies did not show sustainment • QI studies were not communicated to staff or governing body • No external benchmarking occurring • External benchmarks reviewed but improvement not sought	• Encourage all providers to participate in the peer review process • Create a spreadsheet to monitor trending over time which can be used to identify improvement opportunities • Use a peer review summary form for each provider for recredentialing • Add the evaluation of the QI plan and ongoing activities to the governing body minutes template to ensure components and communications are completed and documented • Maintain a spreadsheet to monitor data for trends, which can also serve to benchmark internal performance over time • Review AAAHC Quality Resources at https://www.aaahc.org/quality-institute/quality-resources/ for tools to assist organizations with Quality Improvement • Perform a minimum of two quality improvement studies per accreditation cycle • Document baseline and goal as a number – increase from X to Y or decrease from X to Y • After goal is achieved, remeasure for an additional cycle or two to determine sustainability • Celebrate and share your improvement success with your facility and governing body • Utilize government agencies (CMS, CDC, HEDIS, UDS), professional organizations and societies (AHRQ, IHI, ASC QC), specialty organizations (ASGE, AAOS, AAO), peer reviewed journals, clinical guidelines, or AAAHC Benchmarking subscription as external benchmarking opportunities • Compare organization results with external benchmarks to determine if a quality improvement study should be performed

Peer review confirms a provider's competence by enlisting others of similar license and/or similar privileges to review clinical records and other aspects of care. Peer Review confirms a provider's competence and is, therefore, a vital component of providing high quality and safe patient care. Organizations can utilize the results of peer review to assist in identifying high and low performers and compare to an organization's goals for use in quality improvement activities.

Quality Improvement studies focus on making real-time, measurable improvements to existing systems or practices with a goal of improving efficiency, effectiveness, safety, and performance to address specific problems or opportunities for improvement to reduce waste, improve the patient experience, improve processes, and the elevation of patient outcomes.

AAAHC has several resources to assist organizations in complying with AAAHC quality Standards and enhancing the quality journey. See the AAAHC website under Quality Institute at https://www.aaahc.org/quality-institute/ for QI study topic ideas, how to use existing monitoring activities to generate a QI study, how to document a QI study using the AAAHC six-component criteria, and more. Learn directly from AAAHC quality experts at the AAAHC *Achieving Accreditation* conference or participate in the AAAHC Benchmarking Studies.

CRD Clinical Records – 4.9 Percent

The intent of the Clinical Records category is to ensure a complete, comprehensive, and accurate clinical record that facilitates the provision of safe, quality health care and supports continuity of care.

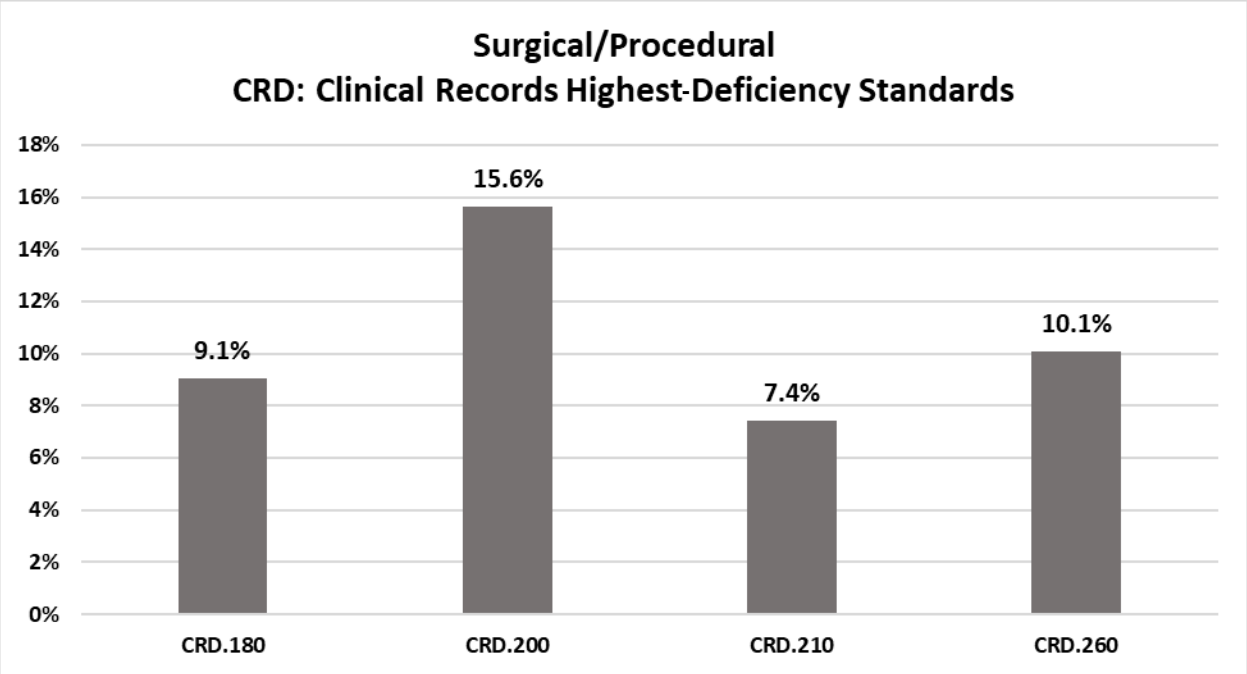


Chart 14: CRD High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
CRD CLINICAL RECORDS		
9.1%	CRD.180	Clinical record entries are consistent across records.
15.6%	CRD.200	The presence or absence of allergies, sensitivities and other reactions to drugs, materials, food, and environmental factors is recorded in a prominent and consistently defined location in all clinical records.
7.4%	CRD.210	Reports, histories and physicals, progress notes, and other patient information such as laboratory reports, x-ray readings, operative reports, and consultations, are reviewed and incorporated into the record, as required by the organization's policies.
10.1%	CRD.260	The findings and techniques of a procedure are accurately and completely documented immediately after the procedure.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Missing documentation of chief complaint, care rendered, medications given, post-op note, report authentication, reason for emergent transfer, medication reconciliation (also see CMC.100) • Allergy documentation not reviewed at each encounter • Incomplete allergy documentation – missing sensitivities, missing reactions • "NKDA" No known drug allergies utilized, not addressing allergies to food, materials, or environmental factors • Reports missing from clinical records – lab, history and physical, pathology • Reports from pathology, radiology, and lab not authenticated • Post procedure notes not available immediately for patient care • Pathology reports not signed	• Create documentation templates to improve documentation • Create mandatory fields in the electronic health record (EHR) • Determine a consistent method for allergy documentation and incorporate into policies and procedures • Train staff on allergy documentation requirements • Make documentation of allergies, sensitivities, and reactions required fields in the EHR; use a consistent allergy documentation form that includes all elements (paper documentation) • Avoid the use of NKDA for documenting allergies • Create a policy and procedure outlining the process to ensure appropriate documents are placed in the medical record • Use a stamp or flags to indicate documents that need to be authenticated by the provider • Implement an immediate post-procedure note process • Implement a specimen log process to ensure the loop is closed and pathology reports are reviewed, communicated, signed, and incorporated into clinical records • Conduct a QI study to address issues noted in clinical record documentation

Accuracy and comprehensive clinical record documentation in health care is imperative to safe, quality care. Common documentation challenges stem from time constraints, lack of standardization, lack of understanding, and technological usability issues – interoperability between systems, confusing interfaces, or lack of EHR.

Successful strategies in improving clinical record documentation include:

- Standardized and structured templates, forms, mandatory clicks/worksheets, and the reduction in free text entry where appropriate to drive consistency.
- Clear policies and procedures outlining compliance requirements and safety goals
- Comprehensive training in documentation best practices at hire, and ongoing
- Regularly conducted chart audits with constructive feedback to encourage accountability and a culture of safety, compliance, and best practice
- Enhancing technology by advocating for intuitive systems with streamlined navigation and fewer clicks, mandatory fields, and interoperability

AAAHC resources include *Allergy Documentation Toolkit,* which provides tips on improving documentation including an allergy action plan reference that can be used when asking patients about their allergies and sensitivities and documentation of their reactions. Also available is a *Medication Reconciliation Toolkit* outlining best practices, interventions, and six keys to providing quality medication reconciliation in the ambulatory setting. Both of these toolkits are available for purchase at https://store.aaahc.org/toolkits.

Organizations can also participate in the AAAHC Allergy Documentation and Medication Reconciliation Benchmarking Study when you purchase the annual benchmarking subscription. More details can be found at https://www.aaahc.org/quality-institute/benchmarking-studies/.

Improvement in clinical record documentation benefits patients and providers across the health care system.

IV. Medicare Deemed Status Organizations

The data in this section represents all ASCs surveyed under the *Accreditation Handbook for Medicare Deemed Status* facilities. Condition level findings result from the risk associated with a single deficiency and/or compounded risk from multiple deficiencies.

A condition-level finding (or condition level deficiency) is a serious type of regulatory non-compliance identified during an onsite survey. While the following findings pertain to organizations in the Medicare Deemed Status program, they offer actionable insights to all ASCs with a CMS Certification Number (CCN).

Unlike standard-level deficiencies, which may involve isolated or less severe issues, condition-level findings reflect egregious or systemic problems that could significantly impact patient care or safety. For example, a condition-level deficiency might involve widespread failures in infection control, credentialing and privileging, or quality improvement processes.

A. Overall Performance: Condition for Coverage, Condition Level

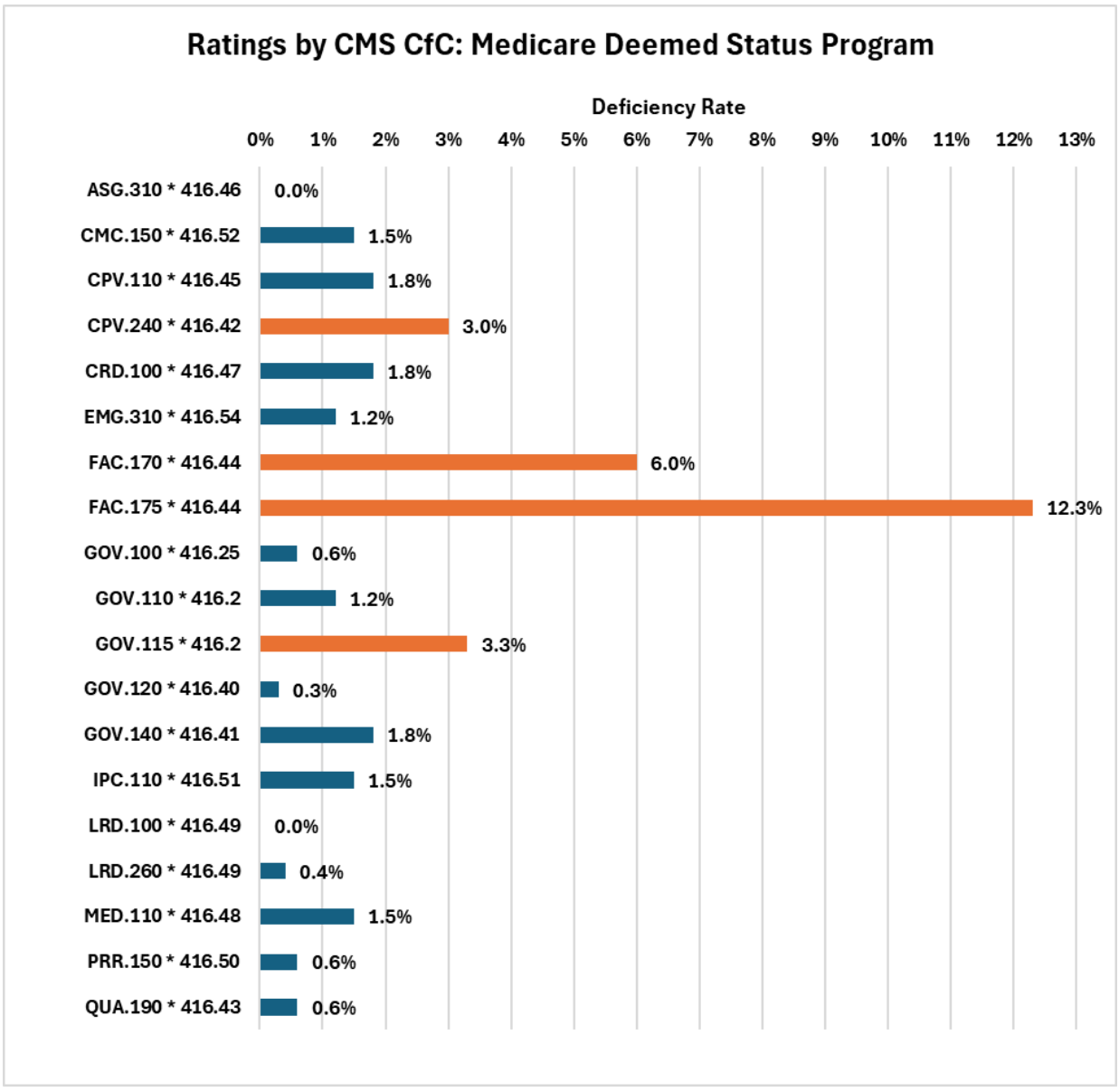


Chart 15: Ratings by Condition for Coverage

- The following is listed in order of the highest deficiency CMS Condition for Coverage (CfC). Note the results for this section are binary, with answers either Fully Compliant (FC) or Non-Compliant (NC).
- Condition level findings can result from either risk associated with a single deficiency and/or compounded risk from multiple deficiencies within a category, or across multiple categories. Condition level deficiencies that result from compounded risk of multiple deficiencies, sometimes from different categories, can be cited for pervasive or systemic non-compliance.
    - A missing component from the credentialing or personnel file may be a deficiency. However, when failure to ensure that the credentialing and privileging process is uniformly applied results in no primary source verification, missing privileges, peer references, and DEA registration, and missing governing body approval, the accumulation of deficiencies rises to the level of a condition
    - Missing consecutive quarterly fire drills is a standard level deficiency in itself. However, when combined with deficiencies such as blocked egress paths, improper exit signage, or noncompliant emergency lighting, the risk presented by this combination rises to the condition level

§ 416.44 Physical Environment

The Condition for Coverage (CfC) for Physical Environment consists of two distinct components: Health and Life Safety. These are addressed separately under two different AAAHC Standards (v43.1 FAC.170 and FAC.175, respectively) to ensure comprehensive oversight of both patient care and facility infrastructure.

§ 416.44 (FAC.175) Physical Environment, Life Safety – 12.3 Percent

This condition for coverage addresses physical environment deficiencies that are more egregious or systemic in nature as compared to Standard level deficiencies. For example, failure to have a self-contained battery-operated task lights in an operating room that administers general anesthesia is egregious. Failure to perform generator testing for consecutive months is a standard level deficiency on its own but may rise to the condition level when related deficiencies demonstrate systemic failure, such as a lack of or incomplete required inspection, testing, maintenance, and repair related to other critical building systems.

% DEF	SOR	SOR DESCRIPTION
FAC FACILITIES		
12.3%	FAC.175	**§ 416.44 Condition for Coverage—Environment**. *The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.*

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• A storage rack containing combustible materials decreased corridor width and blocked access to a fire extinguisher in the exit corridor • Monthly and annual inspection, testing, and maintenance of the fire alarm, sprinkler, essential electrical, and piped gas systems have not been completed since June of 2023 • EES Type was less than required to support risk related to the ASC scope of practice • Operating rooms were not protected from electrocution hazards as wet locations by LIM or GFCI • No manual fire alarm pull stations were located inside the ASC at exits to either common areas and/or the outside	• Storage of combustible materials that exceed what would be typically found in any other room of an ASC requires code compliant protection that is based on the type and quantity of materials stored and whether the building has a sprinkler system • Fire extinguishers must be conspicuously located and readily accessible for use • The clear width of any corridor or passageway required for exit access must not be less than 44 inches • Conduct a gap analysis of all maintenance programs for critical building systems to ensure full compliance with code requirements

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• No EES annunciator was installed at a continuously monitored location inside the ASC • No self-contained battery-operated task lights in areas that exceeded moderate sedation • Waiting room lacked a 1-hour fire separation from the neighboring clinic • Large amount of combustible materials with an associated heavy fire load were stored in an unprotected area	• Engage stakeholders on all levels of the organization (architects, engineers, providers, maintenance, facility management, ownership, support staff) during the design phase of an ASC • Perform a wet location risk assessment to either rule out a hazard or determine the need for protection • Manual fire alarm pull stations must be installed within 5 feet of all exits on the ASC side of the wall adjacent to an exit door • An EES remote annunciator must be installed inside the ASC at a staffed position that is constantly monitored, such as a nurses station • Areas that exceed moderate sedation are required to have self-contained battery-operated task lights installed • ASCs are required to have a one-hour rated fire separation that extends floor to deck between the ASC and any other business entity • Storage of combustible materials that exceeds what would be typically found in any other room of an ASC requires code compliant protection, based on the type and quantity of materials are stored and whether the building has a sprinkler system

§ 416.44 (FAC.170) Physical Environment, Clinical – 6 Percent

% DEF	SOR	SOR DESCRIPTION
FAC FACILITIES		
6.0%	FAC.170	**§ 416.44 Condition for Coverage—Environment**. *The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.*

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Inadequate separation of spaces in the OR suite leading to noncompliant air exchanges, consistently out-of-range temperature and humidity in the OR without corrective actions • Lack of maintenance of a sanitary environment, damaged infrastructure and furniture, visible mold, rust and stain, exposed raw wood, missing laminate, use of gaffer tape, holes in the wall, floors, and ceilings and inadequate terminal cleaning practices • Worn medical equipment such as stretchers, OR pads, blood pressure cuffs, carts, AEDs, monitors • Visible signs of vermin	• The Association of PeriOperative Registered Nurses (AORN) recommends that ***operating rooms*** maintain at least 15 air changes per hour (ACH) with 3 from outdoor air, and ***procedure rooms*** maintain at least 6 ACH with 2 from outdoor air, while both should adhere to specific temperature and humidity ranges to ensure a safe and sterile surgical environment

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Storage and organization issues with inadequate storage solutions, mix of clean and dirty, compromised sterile supplies, and open corrugated boxes stored in egress pathways and patient care areas • Compromised sterility of sterile supplies due to improper biologics, packaging and storage • No appropriate chemical spill kit for soaking and stabilizing a spill • Crash cart and MHAUS deficiencies are documented in this Condition, refer to the section on Immediate Jeopardy for guidance	• Address infrastructure issues, facilities should conduct a comprehensive assessment to identify damage and contamination, remediate mold, repair or replace compromised structures and surfaces, eliminate temporary fixes like gaffer tape, and implement a routine maintenance schedule for ongoing upkeep • Inventory and assess all devices for wear, replace or refurbish worn items, implement a documented preventive maintenance program, and maintain oversight by biomedical engineering for all critical equipment • Review and redesign storage areas to separate clean and dirty supplies, eliminate open corrugated boxes from patient care and egress areas, install proper shelving to keep items off floors and windowsills, and clearly label and organize supplies to prevent cross-contamination and ensure accessibility • Audit sterile supplies for packaging, expiration, and storage compliance, promptly discard compromised or expired products, ensure biologics are stored according to manufacturer guidelines, train staff in proper handling and storage practices, and implement environmental monitoring with temperature and humidity logs in sterile storage areas • Identify spill risks and purchase an appropriate spill kit, place it in accessible areas, train staff on its use, and implement a documented spill response protocol

The Association of Perioperative Registered Nurses (AORN) recommends the following:

- ***Operating rooms*** maintain a minimum of 15 air changes per hour (ACH), with at least 3 ACH consisting of fresh outdoor air. Additionally, AORN advises maintaining relative humidity between 30 percent and 60 percent, and temperature within the range of 68°F to 75°F (20°C to 24°C) to support a safe and sterile surgical environment.
- ***Procedure rooms*** maintain a minimum of 6 air changes per hour (ACH), with at least 2 ACH consisting of fresh outdoor air. Additionally, AORN advises maintaining relative humidity between 20 percent and 60 percent, and temperature within the range of 68°F to 73°F (20°C to 23°C) to support a safe and sterile surgical environment.

§ 416.2 (GOV.115) Distinct Entity, LSC – 3.3 Percent

% DEF	SOR	SOR DESCRIPTION
GOV GOVERNANCE		
3.3%	GOV.115	**§ 416.2 Condition for Coverage—Definitions.** *Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC and must meet the conditions outlined in subparts B and C of this part.*

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Lack of 1-hour fire separation of the ASC from the rest of the building. After reviewing the blueprints, inspecting the doors and above the ceiling, the waiting room is compromised. Since the ASC waiting room is outside the ASC firewall, the waiting room is required by NFPA to be surrounded by a 1-hour firewall • Employee breakroom and locker rooms are within the ASC and are accessed and shared by the adjoining medical practice at the same time • The ASC shares a reception area space with a receptionist from another entity • The ASC shares a waiting area for patients and families with another entity • The north wall of the clean utility room was not a rated wall as required for walls that separate the ASC from non-ASC space	• An ASC is considered "distinct" when it is wholly separate and clearly distinguishable from any other health care facility or office-based physician practice. This required separation must be both administrative and physical, with an ASC boundary that consists of a one-hour rated firewall if not temporally separate. • To be considered temporally separate, an ASC cannot occupy the same space as another entity at the same time. This includes break rooms, waiting rooms, and reception desk areas

§ 416.42 (CPV.240) Medical Staff – 3 Percent

% DEF	SOR	SOR DESCRIPTION
CPV CREDENTIALING AND PRIVILEGES		
3.0%	CPV.240	**§ 416.45 Condition for Coverage—Medical staff.** *The medical staff of the ASC must be accountable to the governing body.*

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• The ASC did not implement independent credentialing files and utilized the hospital's credentialing and privileging files as its own • No surgery center-specific delineation of privileges that the governing body had approved • ASC failed to maintain current credentialing and privileging files for providers. Two surgeons continued to perform procedures during this time • The governing body did not approve reappointment privileges for providers	Ensure that when starting a new ASC or when a change of ownership occurs, that: • All providers undergo an initial appointment specific to the new entity, and the GB of the new entity individually reviews and appoints each provider • The scope of privileges for each provider is consistent with the new entity's scope of services Tips for setting up a credentialing process:

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• There were no medical staff bylaws, and credentialing policies lacked clarity on required documentation, timeframes for credentialing and the process for credentialing providers and allied health professionals • The ASC did not follow its policies for recredentialing, as there was no evidence that providers completed the reappointment application, attestation, release of liability, or delineation of privileges • The provider's privileges included additional procedures not listed as part of the scope of the ASC	• The ASC's governing body must establish and approve the minimum qualifications to provide care and services • Create initial credentialing and recredentialing application(s) as well as privilege request forms • Create a credentialing and privileging workflow (process) and document that workflow in a policy and procedure(s) that are approved by your governing body • Train credentialing staff on the process • Use the workflow process to flag dates and reminders for specific activities, such as renewals • Conduct random audits on credentialing files

Deficiencies in this condition revealed systemic issues with credentialing and privileging processes, as well as a lack of compliance with policies and procedures, and inadequate oversight by the governing body for appointments and reappointments.

Significant non-compliance with credentialing and privileging standards often arises when organizations rely on outdated or missing policies, apply inconsistent practices, and maintain poor documentation. When provider files lack essential components—such as completed applications, primary source verifications, and peer reviews—or when staff delay or skip credentialing steps, organizations may grant privileges without proper verification. Decentralized credentialing processes, conflicting policy timelines, and insufficient oversight further compound the problem, leading to errors like incorrect appointment dates and missed reappointment cycles.

To resolve these issues, organizations must take a structured, high-level approach. They should centralize and standardize all credentialing activities under a single, accountable authority. Leadership must revise policies to clearly define timelines, documentation requirements, and verification procedures, ensuring full alignment with AAAHC Standards and applicable state and federal regulations. Conducting an immediate audit of all current provider files will help identify and correct deficiencies. By implementing a credentialing management system, organizations can automate tracking, reminders, and documentation processes. Training staff and leadership on the updated procedures and establishing a compliance monitoring program will ensure consistent adherence and continuous improvement. These actions will help organizations restore compliance, reduce risk, and build a sustainable, reliable credentialing infrastructure.

Condition-Level Findings

Condition level findings are important because they can trigger serious consequences. If an ASC is found to have condition-level deficiencies, CMS may impose enforcement actions, such as civil monetary penalties, suspension of Medicare payments, or even termination from the Medicare program, if the issues are not corrected promptly. The goal is to ensure that providers maintain a high standard of care and protect patient well-being.

AAAHC uses these findings to hold facilities accountable and to prompt corrective actions that address not just individual incidents, but the underlying systems that allowed those issues to occur. This helps maintain the integrity of the health care system and ensures that patients receive safe, effective, and high-quality care.

An ASC with a CCN that receives a deficiency at the condition for coverage is also required to undergo an unannounced follow up survey to clear the condition. An ASC without a CCN cannot be recommended to CMS for certification and will need to reapply for another EOS/Initial survey, causing a delay to business operations.

Condition level findings must be addressed swiftly, and action must be taken to ensure that any changes are effective and sustainable.

B. Overall Performance: Life Safety Code

A compliant physical environment is crucial for enhancing patient safety, reducing risk, and improving the overall quality of care. AAAHC classifies Life Safety Code (LSC) deficiencies by risk into three categories: standard level, condition level, and immediate jeopardy. Of all deficiencies, standard level carries the lowest risk and indicates that CMS Conditions for Coverage (CfC) are not severely impacted. Of all MDS surveys in 2024, the top three LSC deficiencies included:

FEP Fire Emergency Plans

SFP Smoke and Fire Protection

EES Essential Electrical Systems

Chart 16 below describes the rating results of the Physical Environment Checklist. Note the results for this section are binary, with answers either Fully Compliant (FC) or Non-Compliant (NC).

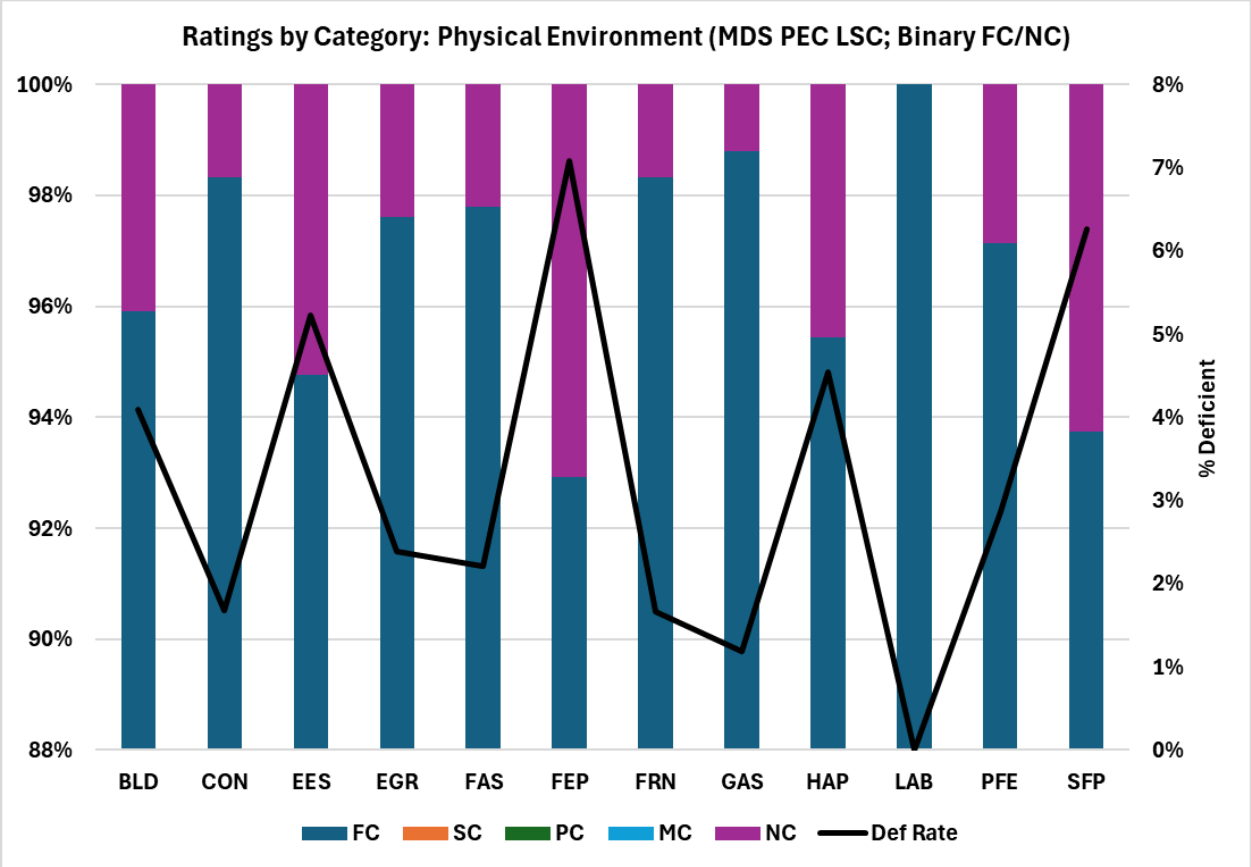


Chart 16: Physical Environment Checklist ratings by category

C. High Deficiency Standards: Life Safety Code

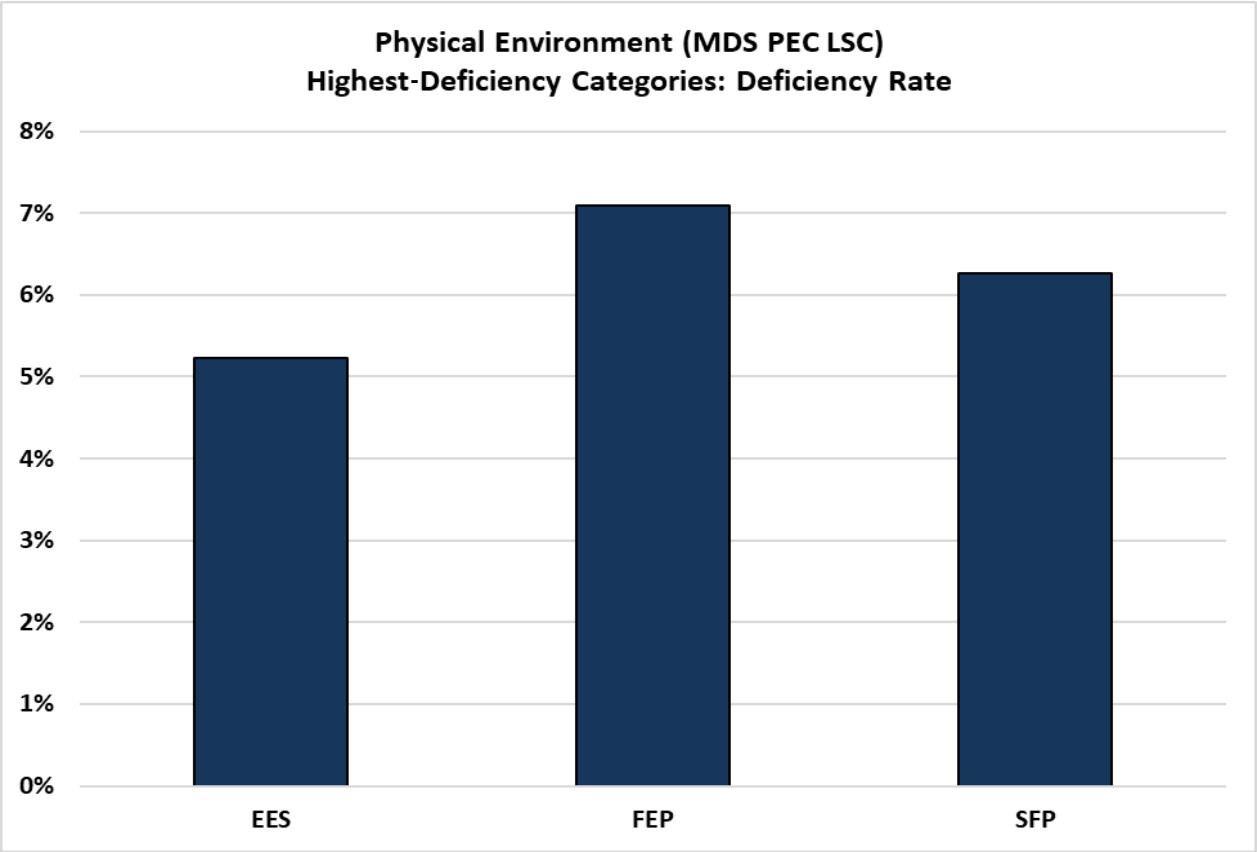


Chart 17: MDS Physical Environment Checklist high deficiency Standards

FEP Fire Emergency Plans – 7.1 Percent

The Fire Emergency Plans category requires that plans provide a clear path to preparation and response to fire emergencies, ensuring the safe evacuation of patients and staff. Deficiencies in the FEP category were most common, accounting for 7.1 percent of all LSC observations, most often related to fire drills not being completed quarterly and/or not containing an actual transmission of an alarm, as required. Also, the absence of "No Smoking" signs at building entrances was prevalent. Often, this category of deficiency alone carries low risk, but it is important to understand that inadequate preparedness and training can compound the risk of deficiencies in other categories, resulting in condition-level findings from pervasive non-compliance and systemic risk.

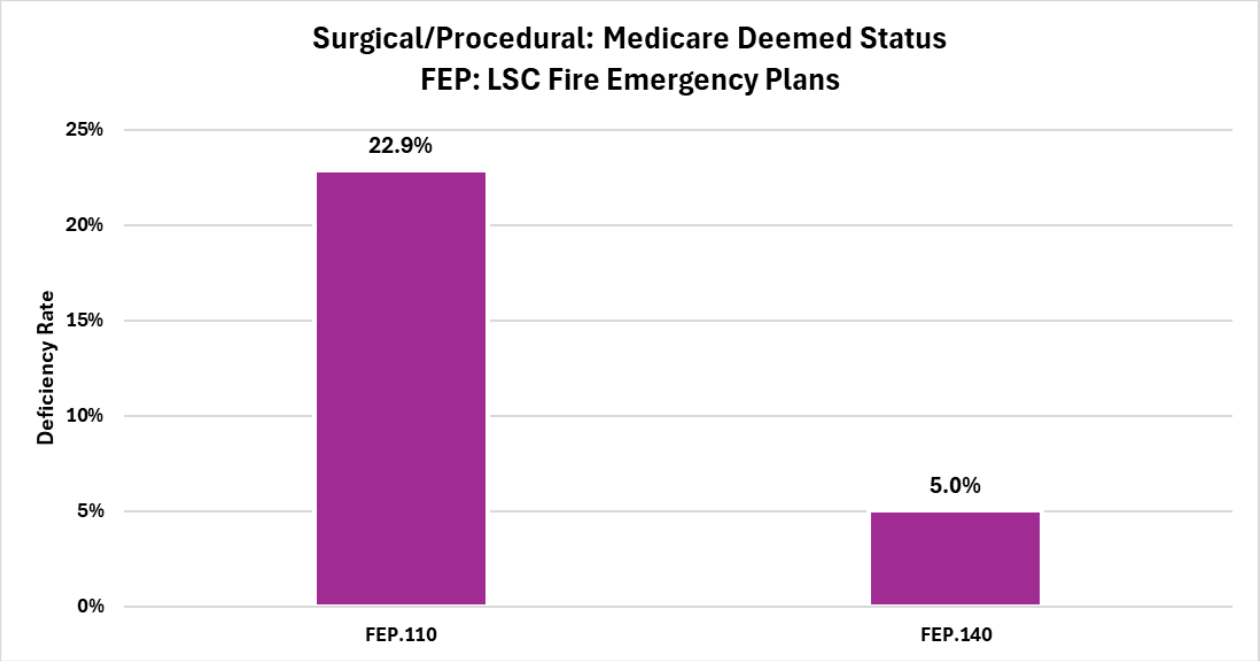


Chart 18: FEP High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
FEP FIRE EMERGENCY PLANS		
22.9%	FEP.110	The ASC must develop a written plan for the protection of all persons in the event of a fire and for their evacuation to areas of refuge and from the building. ~NFPA 101: 20.7.1, NFPA 101: 21.7.1
5.0%	FEP.140	Smoking regulations are adopted. ~NFPA 101: 20.7.4, NFPA 101: 21.7.4

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Drills are not scenario-based • Same scenario used for all drills • Drills not completed quarterly • Drills do not include transmission of alarm signal • No evidence of "No Smoking" signs posted at main entrance	• Preschedule drills each quarter and assign a responsible party to complete • Create multiple scenarios to make drill most applicable to a potential real-life situation • Create drill template/checklist to better evaluate staff response and activation of alarm signal • Invite an impartial party to view the drill and provide their evaluation • Activate the fire alarm signal for each drill and document • Add signage at major entrances

SFP Smoke and Fire Protection – 6.3 percent

The Smoke and Fire Protection category outlines the expectations for certain aspects of building design that slow or prevent fires to protect individuals from the hazards of fire and smoke. This category addresses separation of the ASC from other occupancies; smoke and firewall integrity; the protection of openings in fire or smoke barriers; fire related doors, assemblies, windows; and smoke control systems.

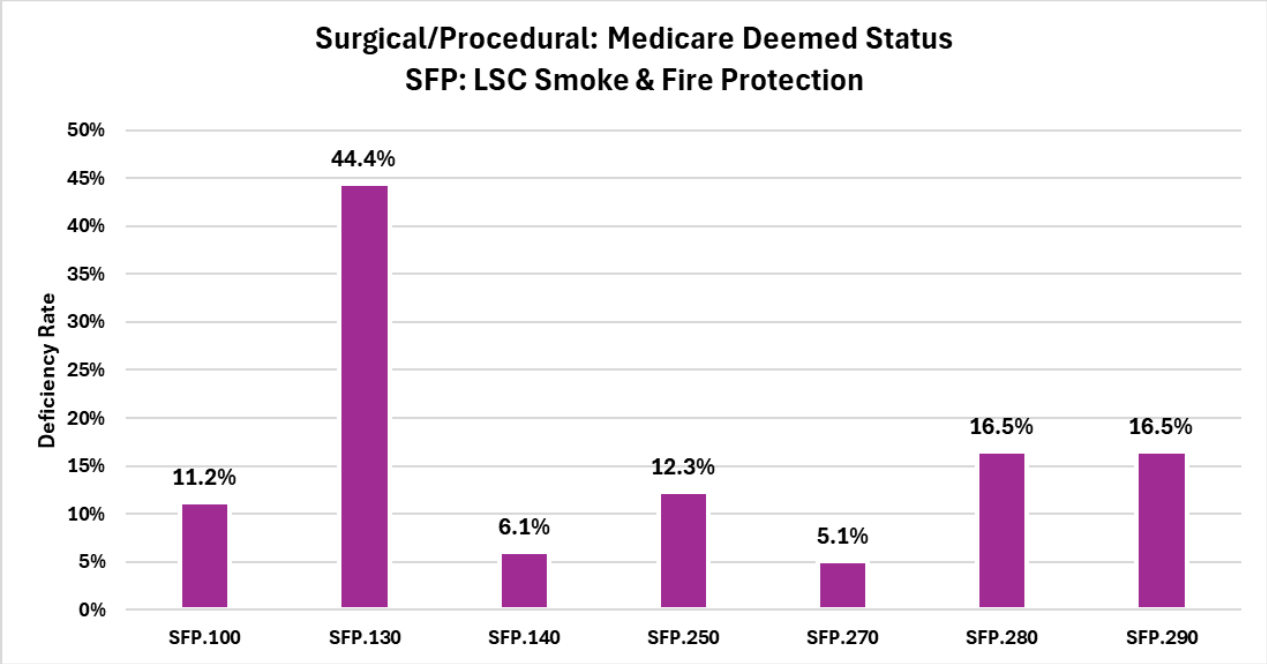


Chart 19: SFP High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
SFP SMOKE AND FIRE PROTECTION		
11.2%	SFP.100	The ASC is separated from adjacent occupancies/facilities by walls of 1-hour fire-resistive construction.
44.4%	SFP.130	Pipes, conduits, bus ducts, cables, wires, air ducts, HVAC ducts, and similar building service equipment that passes through fire-rated barriers or smoke partitions are protected as required by NFPA 101.
6.1%	SFP.140	Pipes, conduits, bus ducts, cables, wires, air ducts, HVAC ducts, and similar building service equipment that passes through fire-rated barriers or smoke partitions are protected.
12.3%	SFP.250	Doors in rated assemblies are self-closing and close with a positive latch when released from any position.
5.1%	SFP.270	Fire-rated door assemblies consist of labeled (with fire rating) frames and labeled doors, with or without labeled vision panels.
16.5%	SFP.280	All fire-rated door assemblies are visually inspected by individuals with demonstrated knowledge and understanding of the requirements and functional components of the rated assemblies being evaluated at least annually for signs of wear, damage, or other condition that could impair their performance and/or reliability.
16.5%	SFP.290	Annual fire rated door assembly inspection includes the following components.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• A fire separation wall between the Pre-Op/Pacu and an adjacent tenant did not continue to the roof/floor above • Above the ceiling, an unprotected opening around an electrical conduit was observed on both sides of a wall, along with a 1/4 x one-inch opening around the fire sprinkler pipe • Doors from PACU and pre-op were held open by kickstands, did not close and seal, had excessive gaps >1/8 inch, and had labels that were not legible • An ASC has no documentation of their annual fire door inspection and testing, per NFPA 80, having been conducted by a qualified individual	• Implementation of an "above the ceiling" policy that requires any contractor working above the ceiling to "permit" that activity with staff once a rated assembly is found to be compliant helps ensure that no new penetrations are made • Labels on fire-rated doors should remain legible throughout the service life of the door and be protected from coverage by paint or stain. • Individuals lacking sufficient knowledge who are tasked with performing annual door tests are a contributing cause of deficient fire doors • Certify staff on performing fire door inspections that comply with NFPA 80 through available training classes

The Smoke and Fire Protection category has the second most common deficiencies, occurring in 6.3 percent of all LSC surveys. The SFP category measures compliance of rated assemblies that make up required separations, such as walls, doors, windows, and other protective features that limit the spread of smoke and fire. SFP.130 was scored non-compliant in 44 percent of all SFP deficiencies, with full and membrane (partial thickness) penetrations of a firewall being the most common finding. Consultative comments for these Standards indicated that some organizations had done an exceptional job of preventing these deficiencies by implementing an "above the ceiling" permitting policy. That is, once a rated assembly was found to be compliant, any contractor working in that general area is required to "apply for a permit" with the facility manager, who will inspect and "approve" the work to ensure no penetrations exist.

SFP.280 and SFP.290 were each scored non-compliant in 16.5 percent of SFP deficiencies, with annual fire door testing being the subject of these deficiencies. SFP.280 deficiencies often noted that untrained personnel were tasked with conducting door inspections, and Surveyor comments at SFP.290 often mentioned excessive gaps and non-functioning door hardware. While these two standards are separate, it is worth noting that individuals lacking sufficient knowledge who perform annual door tests may be a cause of the deficient doors noted by AAAHC Surveyors at SFP.290. Other significant findings that accounted for between 5 to 15 percent of SFP deficiencies were at SFP.100, SFP.140, SFP.250, and SFP.270.

While representing 11.2 percent of SFP deficiencies, SFP.100 comments indicated that this deficiency related most to fire-rated walls and doors in required separations that were either absent or deficient to varying degrees. In severe cases that posed an increased risk, deficiencies at SFP.100 often rose to the condition level. SFP.140 accounted for 6.1 percent of all SFP deficiencies, where missing escutcheon plates were most common. SFP.250 comments indicated that fire doors absent a positive latch represented 12.3 percent of all SFP deficiencies, while SFP.270 made up 5.1 percent from fire-rated door frames that had obscured or missing labels. As previously noted, deficiencies at SFP.280 may also have contributed to SFP.250 and SFP.270, as these deficiencies would also likely have been noticed during a properly performed annual door inspection.

EES Essential Electrical System – 5.2 Percent

The Electrical System Category outlines the expectations for safeguarding people and property from electrical hazards and ensuring sufficient alternate power when there are disruptions to the normal power system. Requirements for new Essential Electrical Systems (EES) and/or additions/modifications to existing EES are determined through an Electrical System Risk Assessment performed by the organization. The Category addresses power strips; essential electrical system design and construction; transfer switches; panel distribution; receptacles; annunciators; and inspection, testing and maintenance.

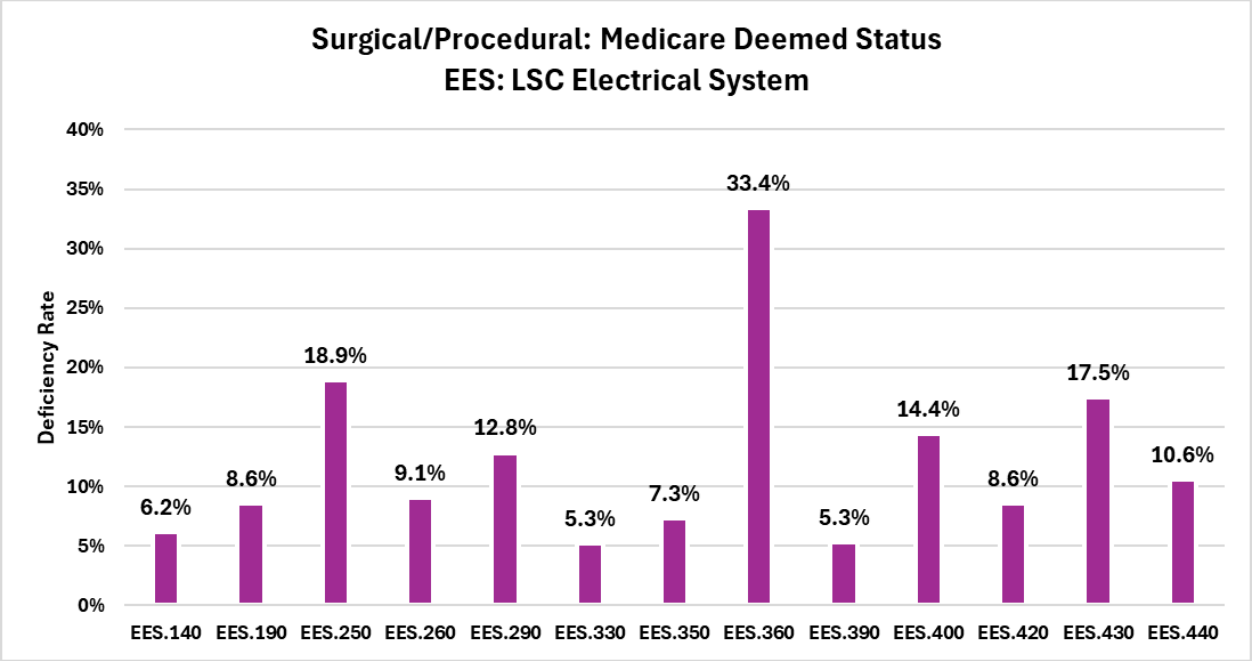


Chart 20: EES High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
EES ESSENTIAL ELECTRICAL SYSTEM		
6.2%	EES.140	All tests related to the electrical system are documented and include the required components.
8.6%	EES.190	Electrical receptacles comply with NFPA 99 and NFPA 70.
18.9%	EES.250	Self-contained rechargeable-battery-powered lights comply with NFPA 99.
9.1%	EES.260	Non-egress fixture self-contained battery-powered lights are provided at the required locations.
12.8%	EES.290	Receptacles in Category 1 patient care spaces and areas where deep sedation or general anesthesia is administered are tested in accordance with the following requirements.
5.3%	EES.330	Emergency and Standby Power System (EPS) equipment (generator set) is selected, located, installed, and maintained in full compliance with the 2010 edition NFPA 110.
7.3%	EES.350	A storage battery-powered remote annunciator is provided for generator sets and NEW battery source systems.
33.4%	EES.360	Generator sets are maintained per NFPA 110, Chapter 8.
5.3%	EES.390	The cover plates for the electrical receptacles (or the electrical receptacles themselves) arranged to be supplied with alternate power are readily identifiable, as evidenced by distinctive color or permanent marking.
14.4%	EES.400	Documentation confirms that circuitry is tested and maintained in accordance with the requirements of NFPA 99.
8.6%	EES.420	The life safety branch and critical branch are kept entirely separate from all other wiring and equipment and do not enter the same raceways, boxes, or cabinets with each other or with other wiring.
17.5%	EES.430	The essential electrical system (EES) type is appropriate to the areas served.
10.6%	EES.440	The critical branch supplies power for task illumination, fixed equipment, selected receptacles, and selected power circuits serving required areas and functions related to patient care as required by NFPA 99.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Battery-operated lights in the operating rooms were not wired to the branch serving general lighting in the room • Lacking records to substantiate that hospital-grade receptacles in patient care spaces have been inspected and tested as required • There was no evidence that the generator is being exercised for 30 minutes each month, with no annual documentation to show, e.g., the loads, status, water temperature, voltage, oil pressure • No record of circuit testing and maintenance was available	• Programs for inspection, testing, and maintenance (ITM) of electrical systems should be compliant with all applicable codes (NFPA 70, Chapter 6 of NFPA 99, NFPA 110 for generators, NFPA 111 for SEPSS) and must be accompanied by documentation that demonstrates compliance with all required ITM items and frequencies

The Essential Electrical System category contains the third most common deficiencies, occurring in 5.2 percent of all LSC surveys. The EES category ensures sufficient alternate power exists during a loss of normal power and measures compliance for system components such as panels, circuits, outlets, and power strips. EES.360 was scored non-compliant in 33.4 percent of all EES deficiencies, with the most common findings related to inadequate monthly loading of the generator and its battery inspection, not having copies of the generator instruction manual at required locations and failing to perform triannual load testing for emergency generators. EES.250 was rated non-compliant in 18.9 percent of EES deficiencies, with insufficient monthly and/or annual testing of emergency lighting fixtures being the focus of these findings. EES.430 deficiencies were found in 17.5 percent of LSC surveys, which most often noted electrical loads not appropriate to the Life Safety branch installed in that panel and/or inaccurate or unclear labeling of the panel directory. Most often, EES.430 deficiencies were related to circuits that serve egress lighting and signage and/or emergency components required for reliable generator operation.

EES.140 represented 6.2 percent of EES deficiencies, with the most frequently cited observations being inadequate documentation for required testing of electrical outlets that failed to demonstrate dates, identify the areas or devices tested, or describe the performance requirements of the test. EES.190 accounted for 8.6 percent of all EES deficiencies, specific to locations that serve pediatric populations, where tamper-resistant outlets were not present. EES.260 was 9.1 percent of all EES deficiencies, with comments most often indicating that rooms exceeding moderate sedation did not have required self-contained battery-powered fixtures. Many findings related to absent or malfunctioning fixtures noted at EES.260 reached the condition level, with some classified as Immediate Jeopardy (IJ), determined by the level of risk and need for immediate action. EES.290 specifically addresses hospital-grade receptacles, citing inadequate documentation for the required testing of hospital-grade electrical outlets, which accounted for 12.8 percent of all EES deficiencies.

Representing 5.3 percent of EES deficiencies, EES.330 comments most often found generator deficiencies related to the absence or improper placement of the emergency stop button or a lack of a means to maintain suitable water jacket and/or battery temperatures in cold weather environments. EES.350 accounted for 7.3 percent of all EES deficiencies, citing a remote annunciator for the EPS (generator or Stored Emergency Power Supply System) was not installed, was found nonfunctioning, or was not installed at an appropriate location. The majority of findings related to remote annunciators noted at EES.350 rose to the condition level.

EES.390 represented 5.3 percent of all EES deficiencies, with comments most often indicating that noncompliant outlet cover plates for receptacles that supply emergency power are either improperly labeled, have an inconsistent color scheme, or are damaged in some way. Deficiencies at EES.400 accounted for 14.4 percent and commonly involved a complete lack of testing of main and/or feeder circuits as required, or an inability to provide documents demonstrating that these required tests were performed annually. Deficiencies at EES.420 and EES.440 occurred at 8.6 percent and 10.6 percent, respectively, and most often cited mixed loads between the Life Safety and Critical Branch panels, inappropriate circuits located in the Critical Branch, or inaccurate and unclear panel directories in either branch panel.

EES.420, EES.430, and EES.440 are three Standards specific to Type 1 EES systems that, when cited together, often indicate an increased risk and rise to the condition level. Consultative comments for these Standards showed that some organizations had done an exceptional job of preventing these deficiencies by having their electrical contractor validate all panel directories during the required annual exercise and testing of circuits.

How do you compare?

LSC deficiencies are among the most frequently cited challenges for organizations new to accreditation—for both new and existing construction.

V. Primary Care Organizations

The data in this section represents all primary care organizations surveyed under the *Accreditation Handbook for Ambulatory Care,* v43/v43.1. Facilities and populations include general health clinics, group practices, solo practices, Indian health, tribal health, military health, student health, and workplace health, and incorporate the specialties of dental health, behavioral health, family medicine, internal medicine, preventative medicine, and pediatrics. Primary care facilities represent 10.5 percent of all surveys completed between May 1, 2024 and May 27, 2025.

A. Overall Performance

Chart 21 provides the overall performance per category for primary care organizations. Five categories demonstrated deficiencies over the 5 percent threshold and will be discussed in further detail.

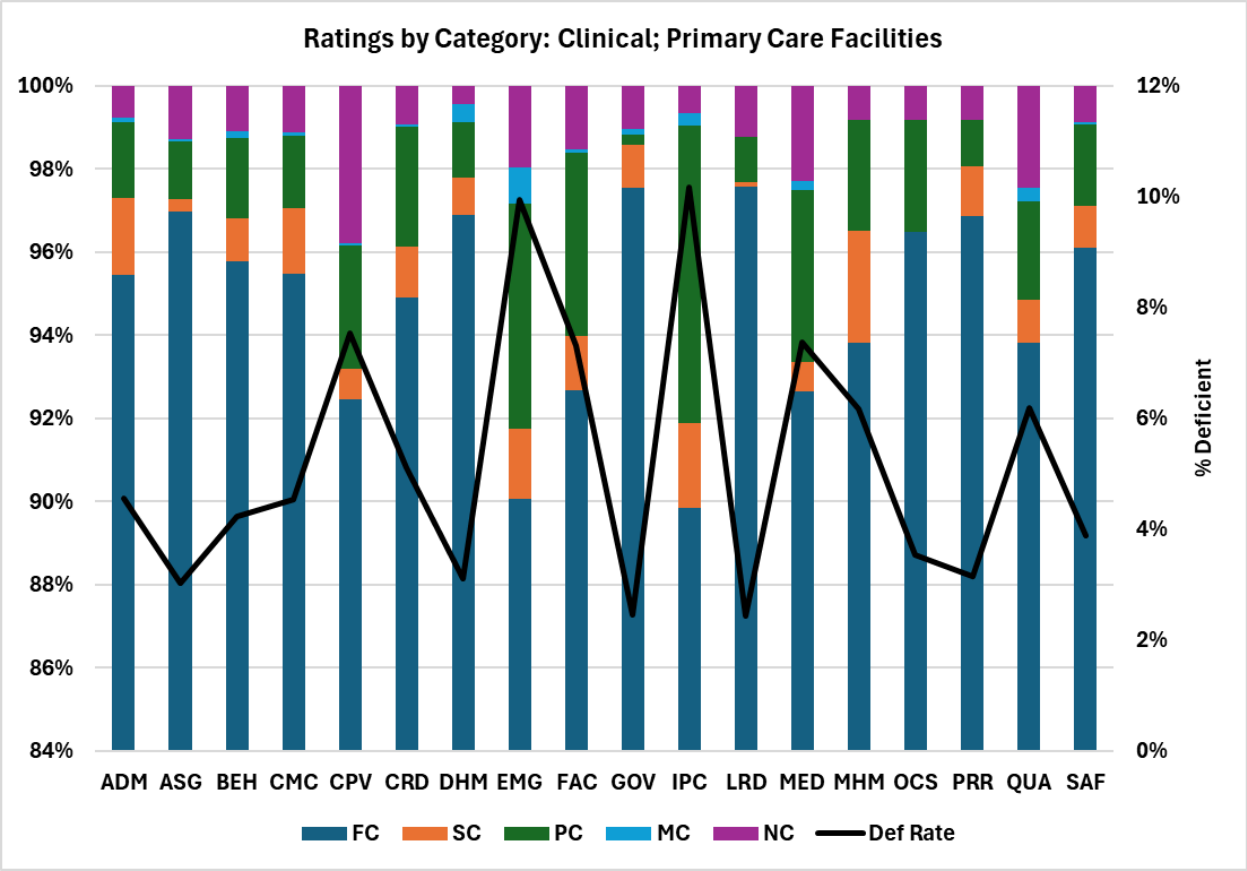


Chart 21: Ratings by Category, Primary Care Organizations: Clinical, all surveys

The top three deficiency categories for primary care organizations include:

IPC Infection Prevention and Control

EMG Emergency Management

CPV Credentialing and Privileging

The highest deficiency categories are noted in Chart 22 below.

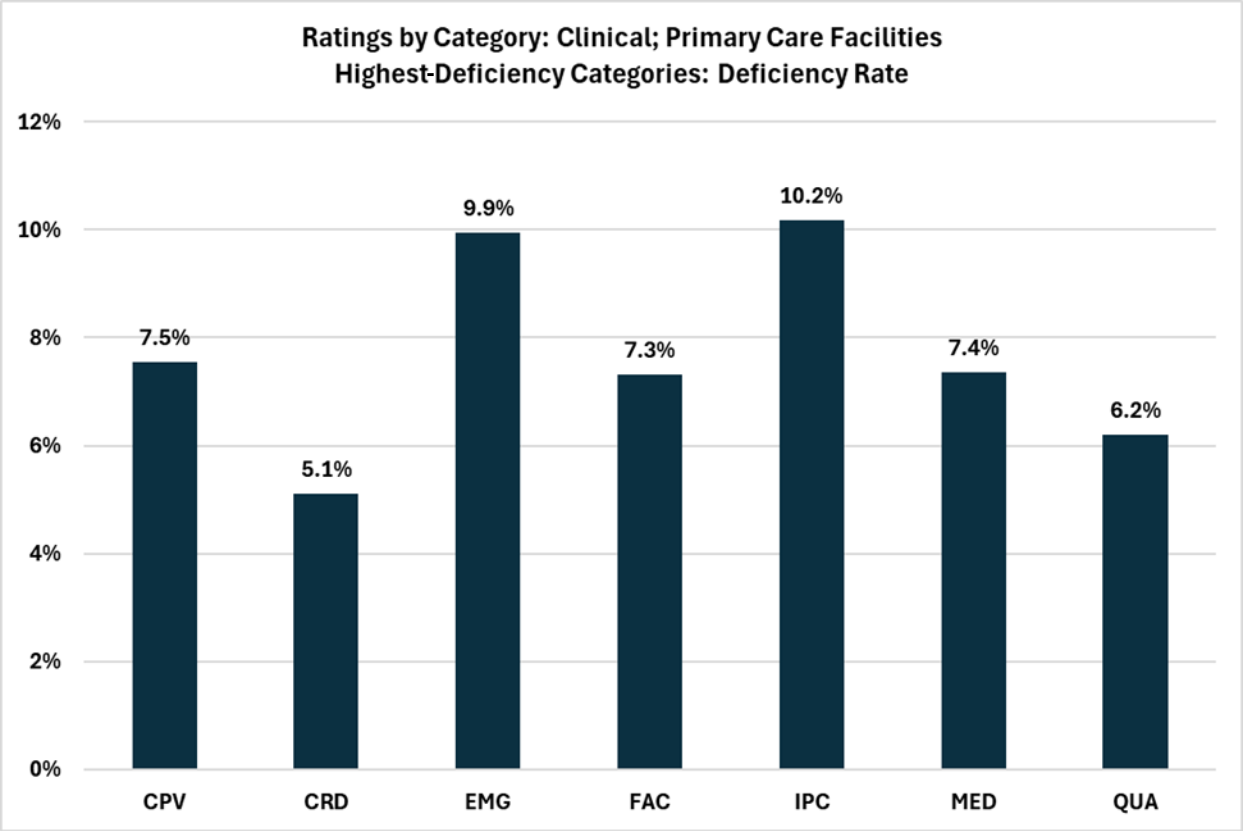


Chart 22: All primary care high-deficiency categories – clinical

Chart 22 provides the overall performance per category for primary care organizations. Seven categories demonstrated deficiencies over the 5 percent threshold and will be discussed in further detail.

B. High Deficiency Standards

The following charts are listed with the highest deficiency rate category first.

IPC Infection Prevention and Control – 10.2 Percent

The intent of the Infection Prevention and Control Standards is to ensure that organizations reduce the risk of infection and communicable diseases by developing a program based upon nationally-recognized infection control guidelines.

Non-compliance with Standards specific to infection prevention and control place patients at risk and are a potential liability for organizations.

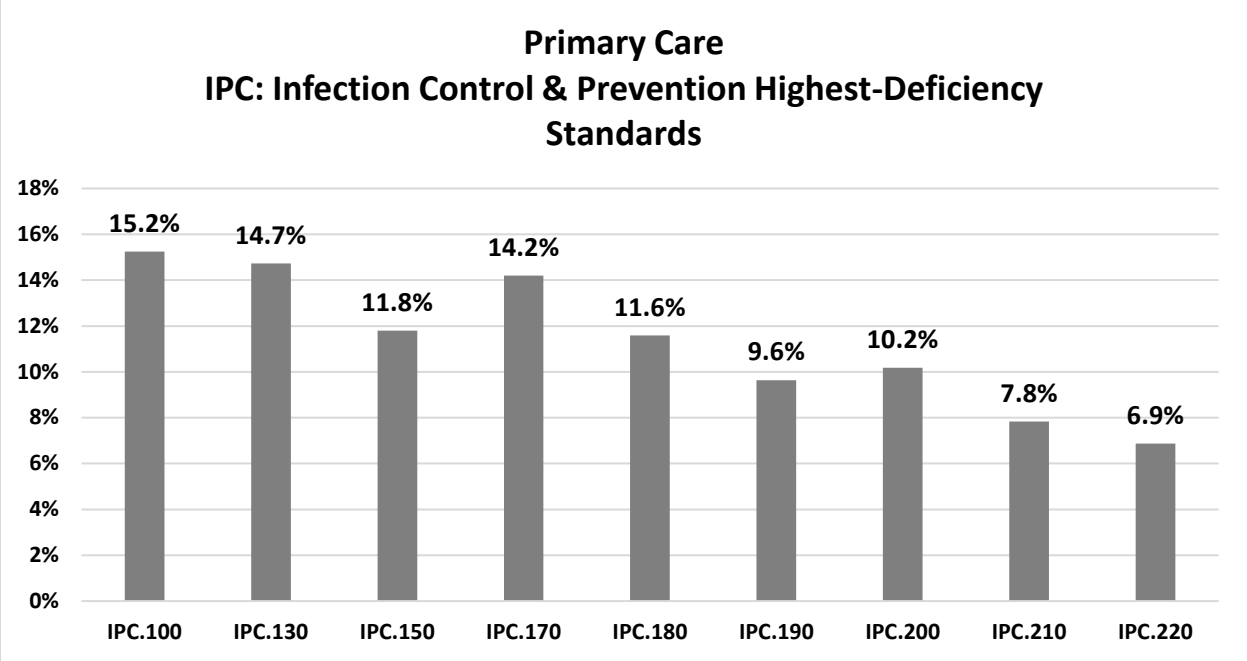


Chart 23: IPC High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
IPC INFECTION PREVENTION AND CONTROL		
15.2%	IPC.100	The organization has a written program for infection prevention and control.
14.7%	IPC.130	The written infection prevention and control program describes how infections and transmission of communicable diseases are prevented, identified, and managed.
11.8%	IPC.150	The infection control program is under the direction of a designated and qualified.
14.2%	IPC.170	Safe processes are used for the cleaning, decontamination, high-level disinfection, and sterilization of instruments, equipment, supplies, and implants.
11.6%	IPC.180	A written sharps injury prevention program is present in the organization.
9.6%	IPC.190	Safeguards are in place to protect patients and others from cross-infection.
10.2%	IPC.200	Resources are sufficient to protect patients and others from cross-infection.
7.8%	IPC.210	Written policies address the cleaning of patient treatment and care areas.
6.9%	IPC.220	Medical devices for use with multiple patients are processed between patients according to the manufacturer's instructions or nationally recognized guidelines, whichever are more stringent.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• No evidence or documentation of infection prevention and control program being reviewed regularly and approved by the governing body • No documented infection prevention risk assessment • No written surveillance program documentation • Lack of surveillance activities to support infection control practices • Infection preventionist did not have necessary training or qualifications • Not following manufacturer's instructions for use • No policy for sterilization practices or policy does not account for failure to meet sterilization standards • Autoclave logs lacking maintenance • Failure to follow safe injection and sharps practices • Sharps containers not secured and susceptible to tampering • Lack of policy and procedure for referral or transfer of patient with communicable disease • Inadequate hand hygiene performed • Unsterile instruments and equipment in clean areas • Critical staffing levels • Failure to clean between patients • Lack of cleaning policy for multi-use devices	• Refer to resources such as CDC, CMS, APIC, AORN, and ADS for risk assessment and surveillance activities • Utilize the "AAAHC Documentation Requirements" worksheet in the Resources section of the *Accreditation Handbook for Ambulatory Health Care* or *Medicare Deemed Status* to ensure you have the written documentation required to comply with the AAAHC Standards • Provide IPC leaders with additional training via organizations such as APIC or ADS (dental) • Train staff upon hire, annually and as needed, on national IPC guidelines, sterilization guidelines, and safe injection practices • Maintain updated national guidelines, IPC policies, and manufacturer's infections for use in easily accessible location for staff reference • Utilize the CDC "One & Only" Campaign or AAAHC toolkit for Safe Injection Practices guidance • Provide visual cues such as posters for proper hand hygiene and safe injection practices • Use used-by-date or beyond-use-date stickers for improved compliance with multi-dose vials • Lock sharps holders • Secure storage room doors to prevent tampering of full sharps containers • Ensure hand hygiene supplies are available in all areas hand hygiene should be completed • Consider disposable instruments or workflow for sterile processing if autoclave infrequently used • Add audit to monitor safety of sharps • Amend cleaning contract to include daily cleaning of all facility spaces • Review timing and staffing requirements to promote efficiency • Secure equipment in other areas to avoid cross-contamination • Add cleaning frequency tip sheets in convenient locations for quick reference • Revise logs to include steps for equipment cleaning, disinfection, and monitoring

While fundamental principles of infection prevention and control remain the same as hospitals and ambulatory surgery centers, the primary care setting offers some unique challenges which can lead to less emphasis on rigorous infection control practices. These challenges include lean staffing, lack of infection prevention trained professionals, limited surveillance data, variable patient acuity, lack of reinforcement, and a lower perceived risk of health care associated infections. Robust education and training, strong policy and procedures, and the focus on a culture of safety, will assist primary care settings in maintaining high standards for infection prevention and patient safety.

AAAHC resources include the *Safe Injection Practices Toolkit* (SIP), which provides a risk assessment tool to identify where an organization may be deficient in SIP, how to develop a training plan to address SIP deficiencies, and how to monitor safe injection practices. See https://store.aaahc.org/toolkits to purchase.

Your organization can also participate in the AAAHC Safe Injection Practices Benchmarking Study and the Hand Hygiene Benchmarking Study when you purchase the annual benchmarking subscription. More details can be found at https://www.aaahc.org/quality-institute/benchmarking-studies/.

The AAAHC also recommends infection control resources from the Centers for Medicare and Medicaid Services (CMS), World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), and the Association for Dental Safety (ADS).

EMG Emergency Management – 9.9 Percent

The Emergency Management category outlines the expectations for ensuring preparedness for natural, man-made, or facility emergencies that may include care related emergencies; equipment and power failures; interruptions in communications (e.g., cyberattacks); loss of a portion or all of a facility; interruptions in the normal supply of essentials, such as water and food; and emerging infectious disease threats.

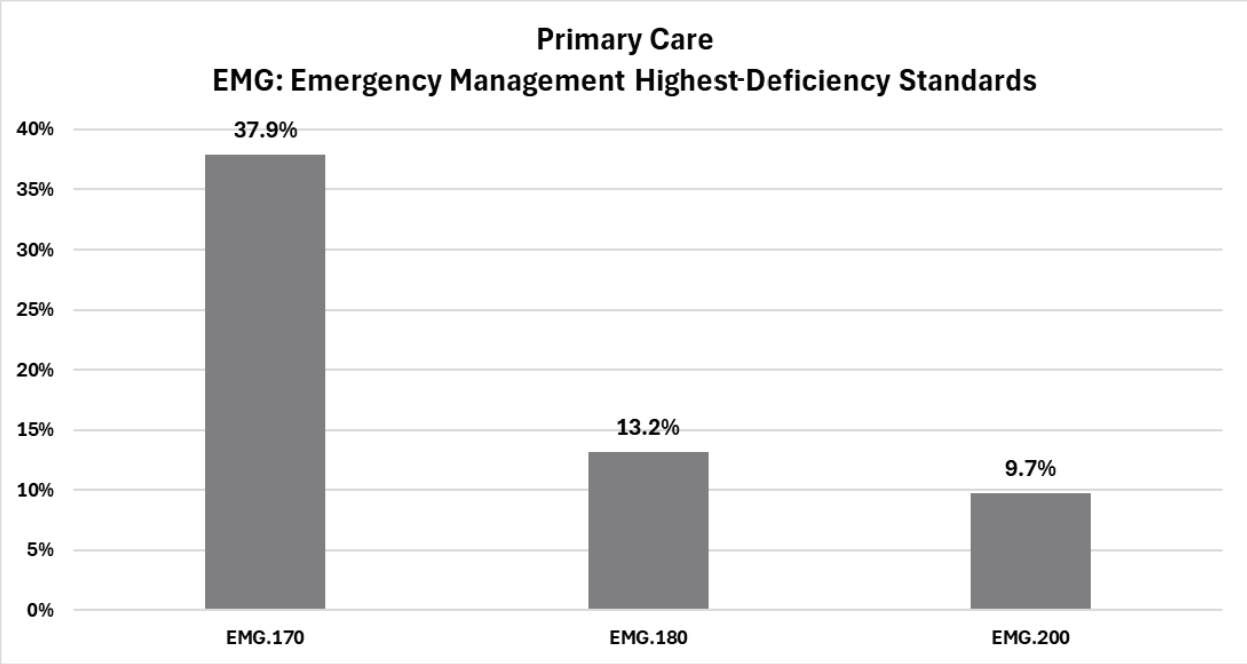


Chart 24: EMG High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
EMG EMERGENCY MANAGEMENT		
37.9%	EMG.170	Scenario-based drills of the internal and external emergency and disaster preparedness plan are conducted.
13.2%	EMG.180	Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of each patient care service site.
9.7%	EMG.200	Resuscitation equipment is available.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Drills are not scenario based • Drills not completed each calendar quarter • CPR drill not conducted annually • Emergency disaster plan drill not conducted annually • Drill participants present, not documented • Drill evaluation not documented • Needed corrections not documented • Lack of written policy regarding emergency equipment and supplies • Lack of emergency equipment and supplies • No adult or pediatric Ambu bag present • Expired medications in emergency box • AED not available or AED pads are expired • No oxygen tank available	• Preschedule drills each quarter and assign responsible party to complete • Create scenarios to make drill most applicable to a potential real-life situation • Act out the drill where each team member conducts their role (e.g., call for help, call 911, start CPR, retrieve oxygen/AED) • Create drill template/checklist that includes the participants, scenario, evaluation, and corrective actions • Invite an impartial party to view the drill and provide their evaluation • Mark Ambu bags and AED pads with expiration dates • Ensure clinical staff can demonstrate adequate resuscitation equipment use

Issues related to performing scenario-based drills continue to be the highest deficiency Standard despite its criticality to patient and team member safety. Success with this Standard takes pre-planning of the drill timing and a scenario appropriate to the facility's procedures, location, and risk assessment.

The importance of performing these drills allows health care providers to apply their skills in a realistic environment, without risking patient harm, to build confidence in the event of a real-life emergency situation. Drills also build teamwork, communication, and trust. They identify gaps in plans, policies, and procedures, and highlight training needs related to equipment, supplies or processes. Drills also provide an environment where mistakes can be made and learning can occur, and staff can build the confidence needed when faced with real crisis situations.

AAAHC resources include an *Emergency Drills Toolkit* which provides detailed steps on drill planning and documentation from start to finish, located at https://store.aaahc.org/toolkits. You can also participate in the AAAHC annual Emergency Preparedness Benchmarking Study when you purchase the annual benchmarking subscription. More details can be located at https://www.aaahc.org/quality-institute/benchmarking-studies/.

CPV Credentialing and Privileging – 7.5 percent

The Credentialing and Privileging category outlines the expectations of an organized process designed and implemented to ensure health care professionals are qualified and competent to provide high quality patient care.

Credentialing, privileging, and peer review are separate but related processes. Credentialing is validating an individual's professional qualifications to provide health care services, while privileging is a formal process of obtaining governing body approval for a provider to deliver specific treatments, procedures, or to use specific equipment.

Peer review is confirming a provider's competence by enlisting others of similar license and/or similar privileges to review clinical record and other aspects of care. Peer review is vital to the ongoing monitoring of clinical care; specific peer review Standards can be found in the Quality category.

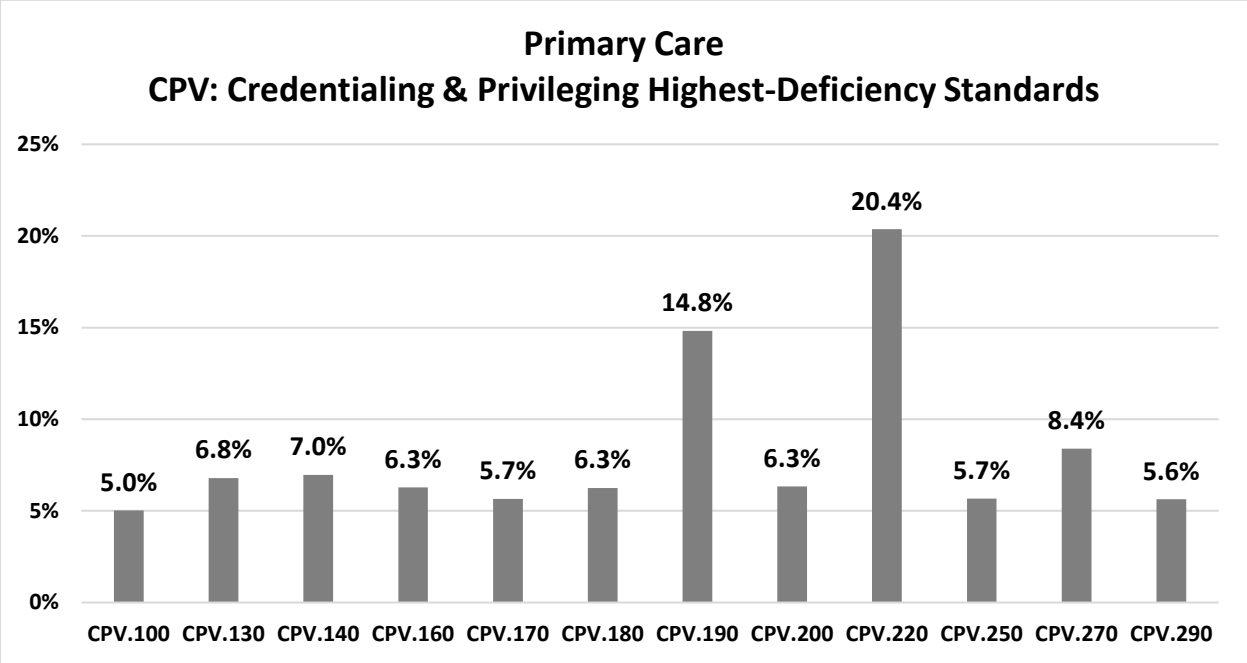


Chart 25: CPV High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
CPV CREDENTIALING AND PRIVILEGING		
5.0%	CPV.100	The medical and/or dental staff is accountable to the governing body through a credentialing, privileging, and reappointment process for which the governing body is responsible.
6.8%	CPV.130	On a formal application for initial staff privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested.
7.0%	CPV.140	The application for initial staff privileges includes written attestation from the applicant addressing other information pertinent to the appointment and privileging processes.
6.3%	CPV.160	Upon receipt of a completed and signed initial application, primary or secondary source verification of credentials is conducted in accordance with the organization's written procedures for credentialing.
5.7%	CPV.170	Members of the medical and/or dental staff apply for reappointment every three years, or more frequently if prevailing laws and regulations, or organizational policies, so stipulate.
6.3%	CPV.180	Upon receipt of the completed reappointment application, primary or secondary source verification is conducted.
14.8%	CPV.190	The governing body makes appointment and reappointment decisions following review of the applications or based on recommendations from an internal delegate.
6.3%	CPV.200	The currency of date-sensitive credentialing and privileging information is monitored and documented on an ongoing basis (at minimum, at expiration, appointment, and re-appointment).

% DEF	SOR	SOR DESCRIPTION
20.4%	CPV.220	Privileges to carry out specified procedures are granted to legally and professionally qualified applicants.
5.7%	CPV.250	The governing body provides a process for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for allied health care professionals.
8.4%	CPV.270	Anesthesia is only administered by health care professionals approved by the governing body to administer anesthesia in accordance with AAAHC Standards for credentialing and privileging.
5.6%	CPV.290	Other qualified health care professionals administering anesthesia are directly supervised by a physician or dentist who has been granted privileges for supervision.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Organization not following credentialing policies • Missing credentialing files • Missing peer references • Lack of current licensure for providers or verification of licensure • Application does not inquire about licensure denial, suspension, limitation, termination, or nonrenewal of professional privileges • Missing applications • Lack of training and education verification • No reappointment application completed • Primary and secondary source verification not reviewed • No appointment approval from governing body • Ongoing monitoring of licensure not completed • No ongoing monitoring of DEA • Missing privileges or requests for privileges • Lack of provider privileges for supervision, administering anesthesia	• Add another month to processes to account for application processing time • Adopt a continuous query model of NPDB • Use a peer review summary form for each provider for recredentialing • Investigate training and education for verification services • Review AAAHC *Credentialing and Privileging Toolkit* for additional resources • Standardize credentialing process • Increase the number of peer reviews and include all credentialed staff in process • Add annual evaluation results to peer review documentation • Incorporate peer review information into re-credentialing process • Add a standard agenda item for governing body to document approval of privileging applications • Include a date-specific time period for which privileges are granted • Add ability to deliver local/topical anesthesia to general privileging request form • Add oversight of anesthesia program to appropriate provider's privileges

Detailed information on how to implement an effective credentialing and privileging process at your organization and how to credential and privilege a provider can be found in the newly updated *Credentialing and Privileging Toolkit* available at: https://store.aaahc.org/toolkits

How do you compare?

On your most recent survey or annual self-assessment, make sure to pay specific attention to these deficiencies cited among peer organizations in AAAHC Accreditation programs.

MED Medication Management – 7.4 Percent

This category aims to prevent drug errors and patient harm related to drug names, labeling, or adverse reactions, and outlines the expectations for safe and effective medication oversight, prescription, dispensing, administration, storage, and disposal.

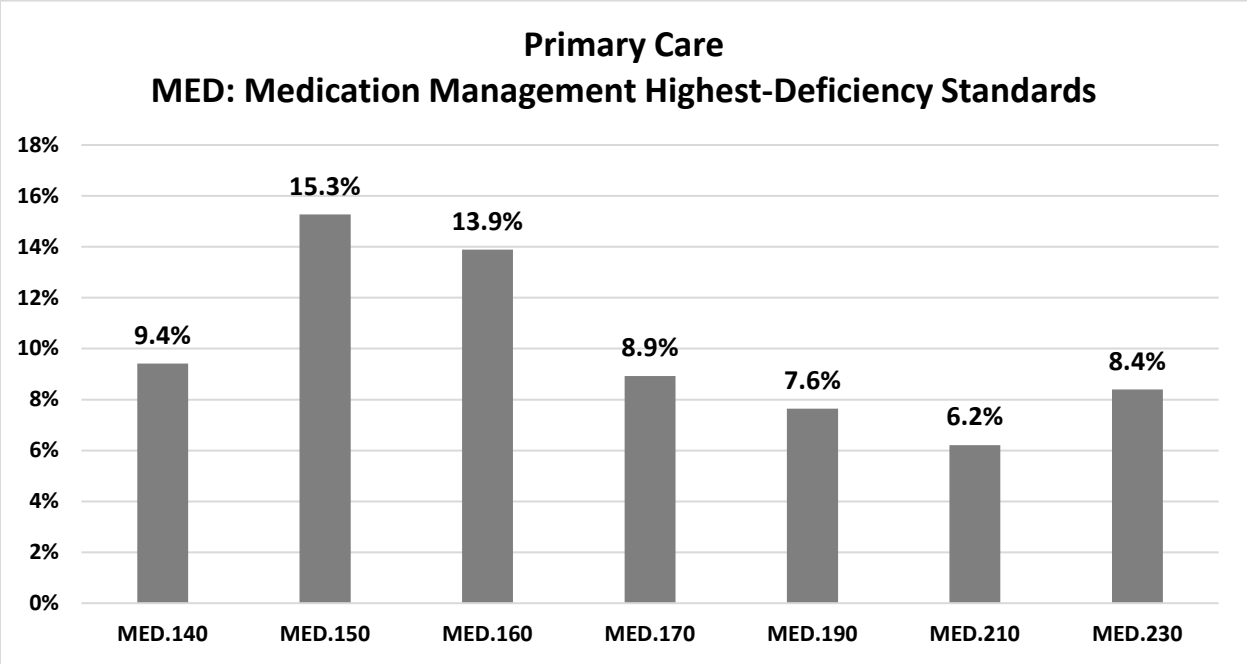


Chart 26: MED High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
MED MEDICATION MANAGEMENT		
9.4%	MED.140	The medication inventory is monitored to track the presence or absence of high-alert medications and medications with confused drug names.
15.3%	MED.150	Procedures are in place to prevent errors from high-alert medications.
13.9%	MED.160	Procedures are in place to prevent errors from medications with confused drug names.
8.9%	MED.170	Drug storage and security, including recordkeeping, are maintained to ensure the control and safe dispensing of drugs (including samples), to minimize medication errors, and to prevent diversion in compliance with prevailing laws and regulations.
7.6%	MED.190	If not administered immediately, all medications (injectable, oral, etc.) removed from the original container or packaging are labeled in a standard format in accordance with law, regulation, and standards of practice.
6.2%	MED.210	A written policy is present addressing the disposal or return of expired, damaged, and recalled medications in accordance with prevailing laws and regulations and accepted guidelines.
8.4%	MED.230	Nationally recognized guidelines for vaccine storage and handling are followed.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• No policy for monitoring and tracking high-alert medications • Lack of training or continuous monitoring on medication stock • No high-alert list or labeling of identified medications • No policy on identification of medications with confused drug names • Medications not stored in secure locations • No process for segregation of high-alert of confused drug name medications • No written policy on proper medication labeling • No written policy on expired medications • Expired medications present in general storage and among emergency supplies • No written policy regarding routine storage and handling of vaccines • No policy for staff training regarding vaccines	• Reference the Institute for Safe Medication Practices (ISMP) for protocols related to high-alert medications and medications with confused drug names • Provide a list of high-alert and confused drug names of medications in all areas where medications are stored and prepared • Implement competency assessments to ensure relevant staff are trained on high-alert and confused drug name medications • Segregate high-alert and confused drug medications for easier identification • Label high-alert medications or medications with confused drug names as such • Utilize “tall man lettering” to differentiate similar drug names • Provide and document training on medication management policies and procedures • Use expired medications as training tool to familiarize staff with packaging, reconstitution, and administration • Create a log for medication expiration tracking • Provide comprehensive training on vaccine handling and storage

The safety of all aspects of medication management in the ambulatory health care setting is essential to preventing harm to patients.

FAC Facilities and Equipment – 7.3 percent

Elements of a "clean and properly maintained" facility include but are not limited to: surfaces are free of dust and visible soil; wall finishes are smooth, uniform and easy to clean; lack of mold and rust in the facility; plumbing, window and door hardware, and HVAC systems are in working order; there is no visible damage or wear on electrical receptacles and light switches. It is also critical that the environment is safe and secure for personal safety, and there is a means of egress in the event of facility emergencies.

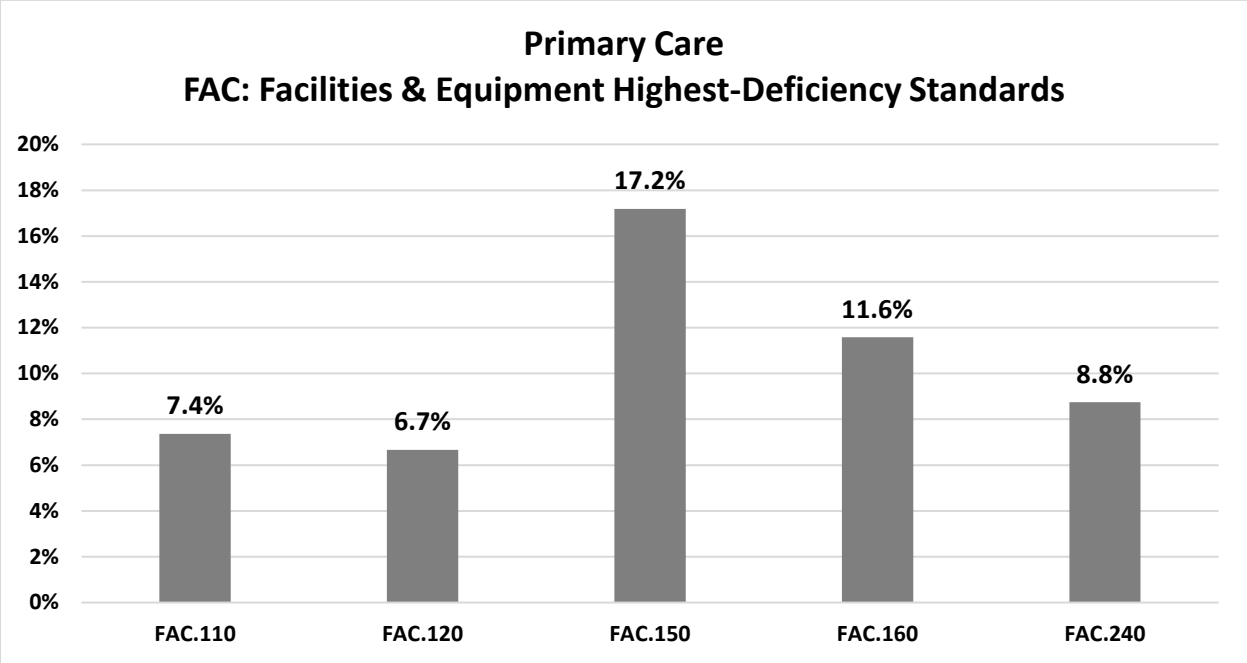


Chart 27: FAC high-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
FAC FACILITIES AND EQUIPMENT		
7.4%	FAC.110	The facility is operated in a safe and secure manner.
6.7%	FAC.120	The physical environment supports patient comfort and privacy.
17.2%	FAC.150	The facility is equipped to protect occupants from fire.
11.6%	FAC.160	The facility is designed to provide safe exiting in an emergency.
8.8%	FAC.240	Medical equipment is appropriately maintained.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Doors leading to patient areas unsecured • Staff entrances unsecured and easily accessible by bystander • Panic buttons not present • Facility not ADA accessible • No recent fire extinguisher inspection or replacement • Missing exit sign or exit sign not illuminated	• Install a lock on the door leading to patient care area • Install emergency pull cords in bathrooms • Implement personal panic buttons for all staff • Add privacy curtains in all examination rooms where table faces the door • Request full detailed report of annual fire inspection to train staff • Expand placement of evacuation maps

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Lack of documentation for monthly fire extinguisher monitoring • Missing documentation of fire rated doors • Missing documentation of preventative maintenance for medical equipment	• Add additional illuminated exit signs as necessary • Add a note of completion on the preventative maintenance reports

Creating a clean, safe, and secure environment for patients and visitors is essential in promoting trust, positive health outcomes, and meeting regulatory requirements.

QUA Quality – 6.2 Percent

The Quality category addresses the components of a quality management and improvement program that links peer review, quality improvement (QI) studies, infection prevention and control, safety, and risk management in an organized, systematic way.

The intent of the program is to continuously improve the effectiveness, efficiency, and safety of services and processes, leading to better clinical and organizational outcomes.

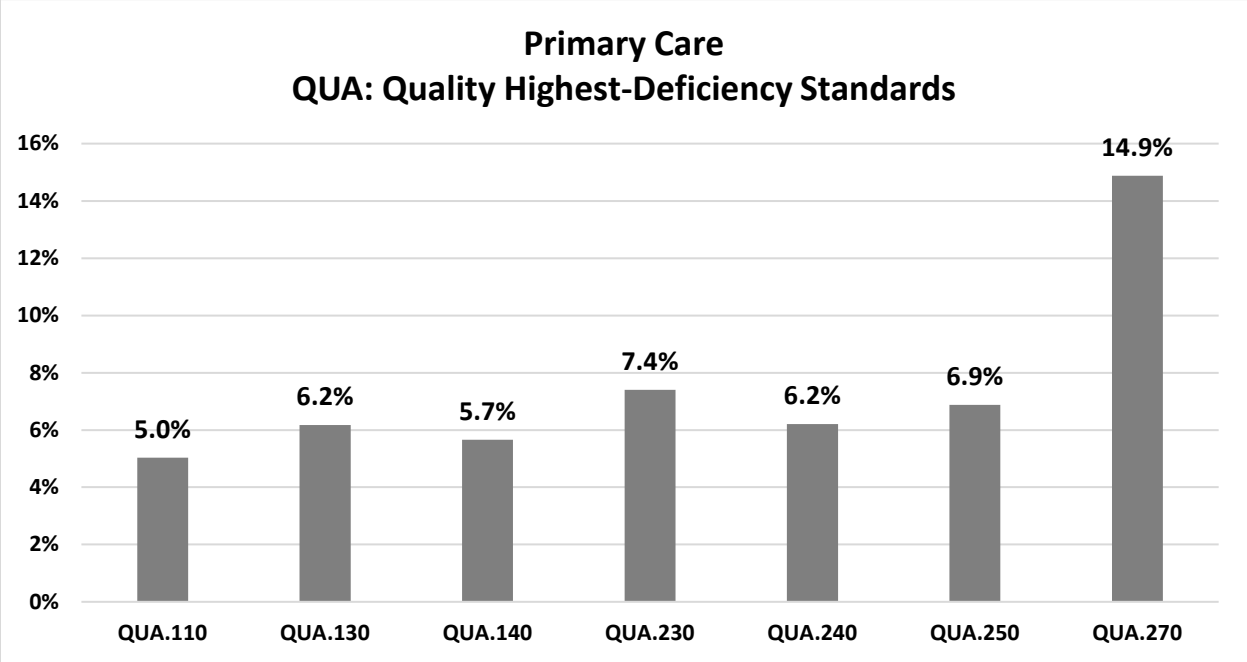


Chart 28: QUA High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
QUA QUALITY		
5.0%	QUA.110	Each physician, dentist or health care professional is reviewed by at least one similarly-privileged and/or similarly-licensed peer.
6.2%	QUA.130	Privileged health care professionals participate in the development and application of peer review criteria.
5.7%	QUA.140	Ongoing monitoring of important aspects of the care provided by physicians, dentists, and other health care professionals is conducted.
7.4%	QUA.230	The organization has a written quality improvement program.
6.2%	QUA.240	The quality improvement program includes processes to ensure communication of the results of quality improvement activities.

% DEF	SOR	SOR DESCRIPTION
6.9%	QUA.250	Ongoing data collection processes are in place to measure quality and to identify quality-related problems or concerns.
14.9%	QUA.270	The organization demonstrates that continuous improvement is occurring by conducting quality improvement studies when the data collection processes indicate that improvement is or may be warranted.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Peer review not being performed • Not all providers included in the peer review process • No documentation for ongoing review • Peer review data not used to establish internal benchmarks to identify improvement opportunities • Ongoing data collection of peer review, important processes or benchmarking not being performed • No description of ongoing data collection activities to support QI program • QI program effectiveness not evaluated on an annual basis • Components of the written quality improvement program are missing • Communication of QI activities to the governing body not documented • No QI studies performed • QI studies do not contain the required elements • QI studies do not contain measurable goals, e.g., improve a problem from X percent to Y percent • Quality *activities* being performed to determine if there is a problem, but no *studies* to correct a problem or improve the results • QI studies did not show improvement • QI studies did not show sustainment • QI studies were not communicated to staff or governing body	• Encourage all providers to participate in the peer review process • Create a spreadsheet to monitor trending over time which can be used to identify improvement opportunities • Use a peer review summary form for each provider for recredentialing • Add the evaluation of the QI plan and ongoing activities to the governing body minutes template to ensure components and communications are completed and documented • Maintain a spreadsheet to monitor data for trends, which can also serve to benchmark internal performance over time • Review AAAHC Quality Resources at https://www.aaahc.org/quality-institute/quality-resources/ for tools to assist organizations with Quality Improvement • Perform a minimum of two quality improvement studies per accreditation cycle • Document baseline and goal as a number – increase from X to Y or decrease from X to Y • After goal is achieved, remeasure for an additional cycle or two to determine sustainability • Celebrate and share your improvement success with your facility and governing body

Peer review confirms a provider's competence by enlisting others of similar license and/or similar privileges to review clinical records and other aspects of care. Peer Review confirms a provider's competence and is, therefore, a vital component of providing high quality and safe patient care. Organizations can utilize the results of peer review to assist in identifying high and low performers and compare to an organization's goals for use in quality improvement activities.

Quality Improvement studies focus on making real-time, measurable improvements to existing systems or practices with a goal of improving efficiency, effectiveness, safety, performance to address specific problems or opportunities for improvement to reduce waste, improve the patient experience, improve processes, and the elevation of patient outcomes.

AAAHC has several resources to assist organizations in complying with AAAHC Quality Standards and enhancing the quality journey. See the AAAHC website under Quality Institute at https://www.aaahc.org/quality-institute/ for QI study topic ideas, how to use existing monitoring activities to generate a QI study, how to document a QI study using the AAAHC six-component criteria, and more. Learn directly from AAAHC quality experts at our *Achieving Accreditation* conference or participate in the AAAHC Benchmarking Studies.

CRD Clinical Records – 5.1 Percent

The intent of the Clinical Records category is to ensure a complete, comprehensive, and accurate clinical record that facilitates the provision of safe, quality health care and supports continuity of care.

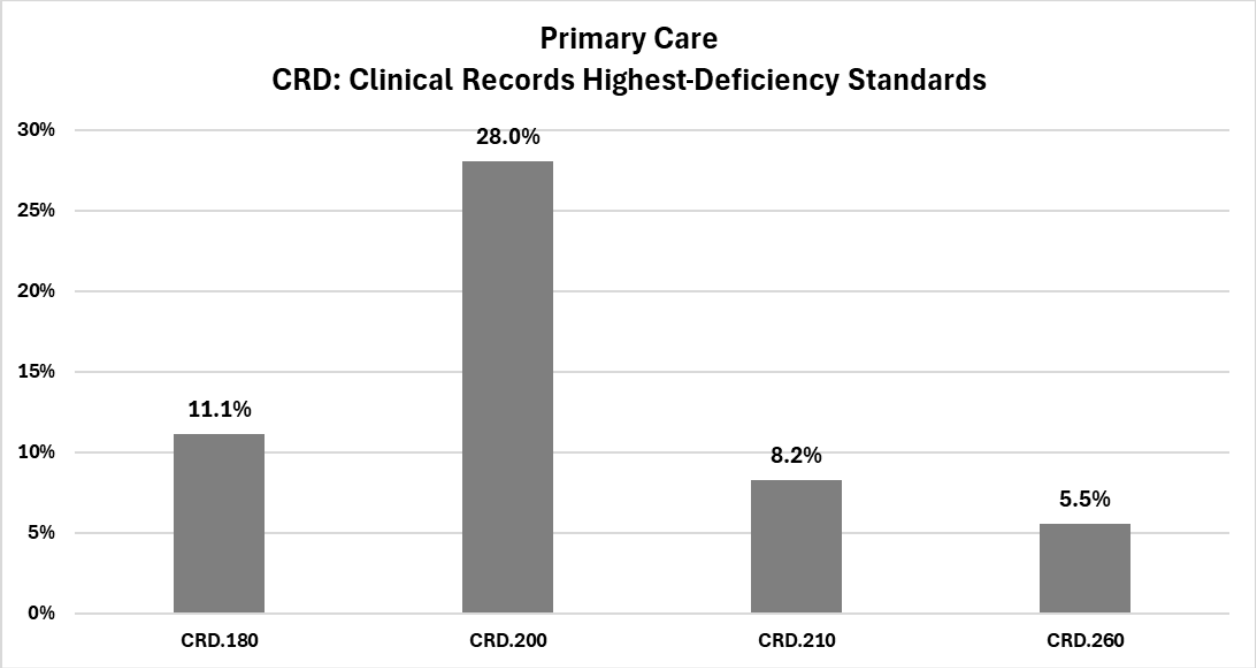


Chart 29: CRD High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
CRD CLINICAL RECORDS		
11.1%	CRD.180	Clinical record entries are consistent across records.
28.0%	CRD.200	The presence or absence of allergies, sensitivities and other reactions to drugs, materials, food, and environmental factors is recorded in a prominent and consistently defined location in all clinical records.
8.2%	CRD.210	Reports, histories and physicals, progress notes, and other patient information such as laboratory reports, x-ray readings, operative reports, and consultations, are reviewed and incorporated into the record, as required by the organization's policies.
5.5%	CRD.260	The findings and techniques of a procedure are accurately and completely documented immediately after the procedure.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Missing documentation of pertinent aspects of a patient visit • Missing medication reconciliation (also CMC.100) • Medication profile not updated during visit • Allergy documentation not updated • Incomplete allergy documentation – missing sensitivities, missing reactions • Conflicting allergies and sensitivities documented • Medical tests documented as reviewed prior to clinical provider actual review of results • Absent imaging or laboratory test reports • Patient transfers or hospitalizations not recorded in medical record • Incomplete documentation of procedures • Lack of documentation of amount of anesthetic used	• Create policy outlining what is expected in each clinic visit note • Create documentation templates to improve documentation • Create a quality metric to track compliance with medication reconciliation and allergy/drug sensitivity • Determine a consistent method for allergy documentation and incorporate into policies and procedures • Train staff on allergy documentation requirements • Implement a quality activity regarding improving consistency of allergy documentation • Develop notifications that require acknowledgments of reports from referral offices • Obtain referral and transfer notes from other facilities for timely incorporation into medical record

Accuracy and comprehensive clinical record documentation in health care is imperative to safe, quality care. Common documentation challenges stem from time constraints, lack of standardization, lack of understanding, and technological usability issues – interoperability between systems, confusing interfaces, or lack of EHR.

Successful strategies in improving clinical record documentation include:

- Standardized and structured templates, forms, mandatory clicks/worksheets, and the reduction in free text entry where appropriate to drive consistency.
- Clear policies and procedures outlining compliance requirements and safety goals
- Comprehensive training in documentation best practices at hire, and ongoing
- Regularly conducted chart audits with constructive feedback to encourage accountability and a culture of safety, compliance, and best practice
- Enhancing technology by advocating for intuitive systems with streamlined navigation and fewer clicks, mandatory fields, and interoperability

AAAHC resources include the *Allergy Documentation Toolkit,* which provides tips on improving documentation including an allergy action plan reference that can be used when asking patients about their allergies and sensitivities and documentation of their reactions. Also available is a *Medication Reconciliation Toolkit* outlining best practices, interventions, and six keys to providing quality medication reconciliation in the ambulatory setting. Both of these toolkits are available for purchase at https://store.aaahc.org/toolkits.

You can also participate in the AAAHC Allergy Documentation and Medication Reconciliation Benchmarking Study when you purchase the annual benchmarking subscription. More details can be found at https://www.aaahc.org/quality-institute/benchmarking-studies/.

Improvement in clinical record documentation benefits patients and providers across the health care system.

How do you compare?
Comprehensive documentation can facilitate new hire training, ongoing compliance, and competency assessment.

VI. Medical/Dental Home Accreditation/Certification Organizations

The data in this section represents organizations surveyed under the *Accreditation Handbook for Ambulatory Care,* v43/v43.1 or the *Certification Handbook for Patient-Centered Medical Home,* v43/v43.1.

Chart 30 below outlines the overall performance deficiencies for organizations seeking ambulatory accreditation plus medical and/or dental home, or organizations seeking Patient-Centered Medical Home (PCMH) Certification. While most organizations seeking medical/dental home accreditation or certification successfully achieve it, there are six categories demonstrating deficiencies over the 5 percent threshold that are discussed in further detail below.

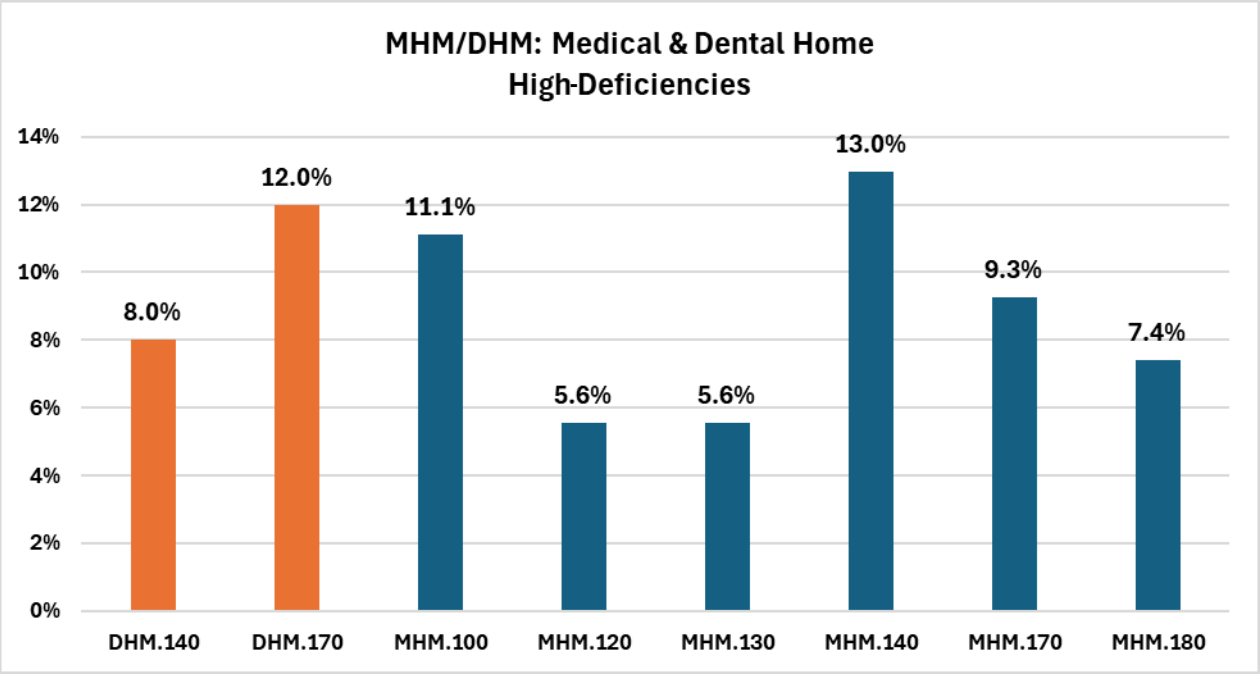


Chart 30: MHM/DHM High-Deficiency Standards

% DEF	SOR	SOR DESCRIPTION
MHM/DHM MEDICAL AND DENTAL HOME		
11.1%	MHM.100	The Medical Home establishes relationships with its patients.
5.6%	MHM.120	Providers and patients discuss the patient's health problems and concerns.
5.6%	MHM.130	Written policies supporting patient access are present.
13.0% 8.0%	MHM.140 DHM.140	Patients are provided with information regarding how to obtain medical care at any time, 24 hours per day, every day of the year. Patients are provided with information regarding how to obtain dental care at any time, 24 hours per day, every day of the year.
9.3% 12.0%	MHM.170 DHM.170	The Medical Home ensures continuity of care for its patients. The Dental Home ensures continuity of care for its patients.
7.4%	MHM.180	The Medical Home provides high-quality patient care.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• No formal process to provide patients with medical home approach to care • Lack of documentation that patient's concerns were addressed • No policy supporting all aspects of patient access • No process for driving awareness to community of MHM/DHM • Patients not assessed regarding access to care outside of patient satisfaction surveys • Lack of on-call coverage available • Lack of continuity of care data collection • No referral tracking • Lack of referral follow up • Missing medication reconciliation documentation	• Expand website to educate patients and the community regarding medical home concepts • Educate staff on how to be more intentional with patients regarding medical home principles • Add brochures to further educate patients on the differences within a medical home • Update policies to address patient access and medical/dental home documentation requirements • Create documentation templates that include all topics for providers to use at each visit • Work with patient satisfaction vendor to incorporate patient perceptions on access • Create overall referral program • Routinely conduct chart audits with constructive feedback to staff

The purpose of the MHM/DHM/PCMH Standards is to ensure that services provided are patient-centered, physician/dentist, nurse practitioner, physician associate/assistant directed (as permitted by state law/regulation), comprehensive, accessible, continuous, and organized to meet the needs of the individual patients served. The foundation of the Medical/Dental Home is the relationship between the patient, their family (as appropriate) and the Medical/Dental Home. Within the Patient-Centered Medical Home, patients are empowered to be responsible for their own health care. As described in these Standards, a Medical Home is the primary point of health care for the patient.

VII. Immediate Jeopardy

Patient Safety Concerns Identified by the Surveyor

Immediate Jeopardy (IJ) occurs when non-compliance with Standards has resulted in or made serious injury, serious harm, serious impairment, or death likely. When a Surveyor identifies an Immediate Jeopardy, AAAHC requests a Removal Plan. In the Removal Plan, the organization documents the immediate action it will take to prevent serious harm from occurring or recurring. If identified during an onsite survey, organizations must complete the Removal Plan before the Surveyor leaves the facility and follow internal escalation requirements. If identified during AAAHC staff survey report review, organizations have 24 hours to complete the Removal Plan once requested by AAAHC. The Surveyor and the AAAHC clinical team review all Removal Plans. After completing the Removal Plan, organizations will receive a request for a Plan of Correction to address other deficiencies identified during the survey.

NOTE: AAAHC will report the Immediate Jeopardy to the State or CMS as required by applicable law or agreement with a state agency, or when AAAHC determines reporting is necessary to prevent serious injury, serious harm, serious impairment, or death.

If an Immediate Jeopardy is *not* verified as abated during the onsite survey, the Plan of Correction completion requirement for other survey deficiencies is reduced from 10 to five calendar days from the date of the AAAHC POC request. The POC window is reduced because for Medicare Deemed Status surveys, CMS requires a return survey after an Immediate Jeopardy within a shorter window than a Medicare Follow-Up survey.

Ensuring patient safety and delivering high-quality care remain top priorities in health care settings. However, certain practices can compromise these objectives and result in Immediate Jeopardy. This section outlines examples of IJ to illustrate situations that pose serious threats to patient health, safety, or well-being. These examples serve as a reference to help identify and eliminate high-risk practices, reinforce compliance with AAAHC Standards, and promote a culture of safety and accountability. The section also examines the most frequently cited IJs and outlines strategies organizations can implement to address them effectively. Chart 31 provides a breakdown of all IJs reported over the past year.

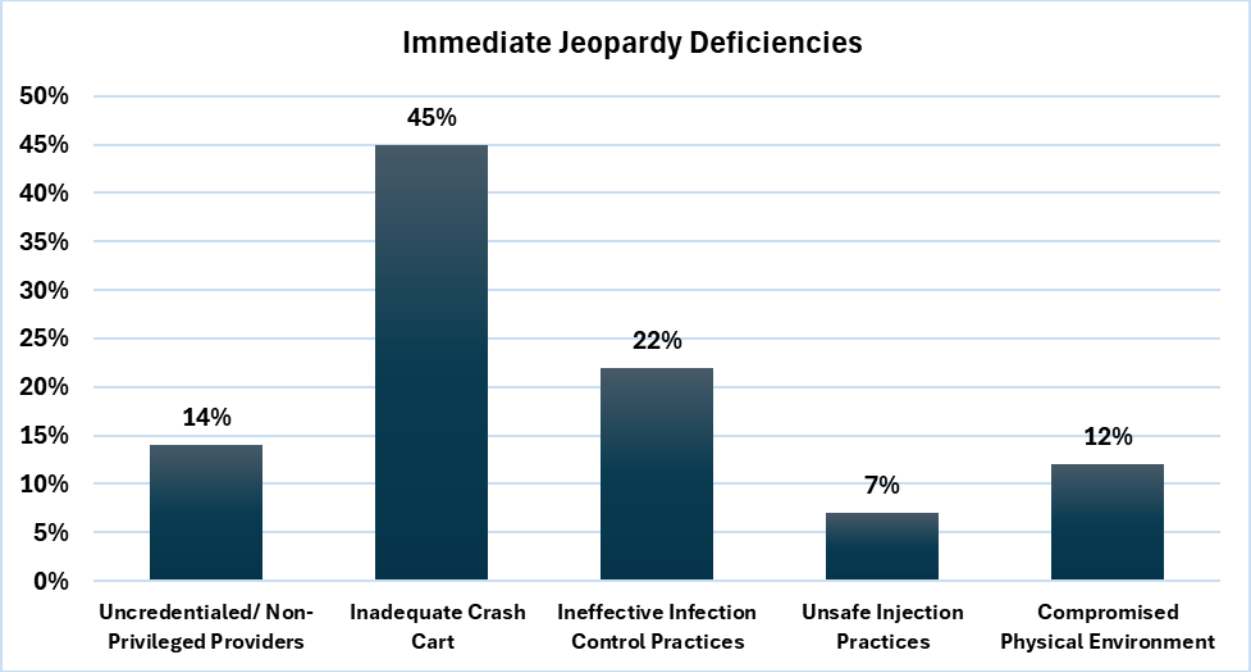


Chart 31: Number and reason of Immediate Jeopardy cited

Inadequate Crash Cart with Faulty or Missing Equipment

A crash cart is a vital component in emergencies, equipped with life-saving medications and equipment. An inadequate crash cart with faulty or missing equipment can delay critical interventions, potentially resulting in patient harm or death. This is the leading cause of an IJ, accounting for 45 percent of all IJs. Deficiencies were all egregious, with missing or malfunctioning resuscitative equipment and expired medication, cited at FAC.170, EMG.200, and EMG.220. However, some deficiencies revealed more systemic issues, including ineffective policies, missing procedures, and a lack of training (ADM.160) and drills (EMG.170, EMG.220).

% DEF	SOR	SOR DESCRIPTION
EMG EMERGENCY		
45.0%	FAC.170	The organization meets the following CMS Condition for Coverage: The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.
	EMG.200	Resuscitation equipment is available.
	EMG.220	If anesthetic and resuscitative agents known to trigger malignant hyperthermia are available in the facility, staff are prepared to respond to an episode of malignant hyperthermia.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• *Emergency Equipment Policy:* The emergency equipment policy did not define the required emergency equipment; staff were unable to produce a list of required items for the cart; there was no emergency policy; and MHAUS (MH) protocols/postings were not available • *Laryngoscope Issues:* The laryngoscope or handle is missing. The laryngoscope handles were not functioning due to flat batteries. One organization retrieved a second laryngoscope, which was dimly lit. The laryngoscope blades were observed in the crash cart located in the PACU; however, the handles were in the OR, 50 feet away • *Defibrillator Issues:* The defibrillator had a missing or expired defibrillation patch; there were no batteries in the defibrillator unit; and in one case, the defibrillator connection cable was missing. The defibrillator had not been inspected or tested by the Biomed contractor for three years • *Expired Medications:* Expired medications included labetalol, metoprolol, esmolol epinephrine, phenylephrine, ephedrine, nitroglycerin spray, fluids, and lidocaine • *MHAUS*: Organizations that were cited had anesthetic agents known to trigger MH onsite, but did not have adequate supplies of Ryanodex/dantrolene or diluent fluids • *Training and Drills*: No formal training or drills were conducted or documented, including CPR and MHAUS	To mitigate failures with crash carts, an ASC can implement several strategies to ensure that crash carts are always ready for emergencies. • It is essential to assign a designated person responsible for overseeing and maintaining the crash cart. This individual should conduct regular checks to verify the contents, expiration dates, and functionality of the equipment. • Labeling drawers and organizing items for easy access, while clearly distinguishing between pediatric and adult supplies, can help staff quickly locate necessary items during an emergency. • Training staff in the proper use of crash cart supplies and equipment should begin with orientation and continue annually, incorporating in-situ simulations and augmented reality apps to enhance learning. • Regular drills, planned on different days and times, can reinforce order and readiness, allowing staff to practice their roles and identify any issues with processes or equipment. • Random quality checks and spot checks can help prevent false documentation and ensure compliance. By maintaining a well-organized and regularly checked crash cart, an ASC can minimize the risk of failures and ensure adequate emergency response.

Ineffective Infection Control Practices

Infection control is crucial in preventing the spread of health care-associated infections (HAIs). Ineffective infection control practices can lead to outbreaks, putting patients and staff at risk. Infection control accounted for 22 percent of all IJ incidents, primarily due to a pattern of pervasive non-compliance and the organization's inadequate ability to safeguard patients and staff from infection. This included poor cleaning, decontamination, and sterilization processes (IPC.110, IPC.170), poor workflow, and a lack of staff training in infection control practices (ADM.150).

% DEF	SOR	SOR DESCRIPTION
IPC INFECTION PREVENTION AND CONTROL		
21.0%	IPC.110	The organization meets the following CMS Condition for Coverage: The ASC must maintain a written infection prevention and control program that seeks to minimize infections and communicable diseases.
	IPC.170	Safe processes are used for the cleaning, decontamination, high-level disinfection, and sterilization of instruments, equipment, supplies, and implants.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• *MIFUs:* Staff were unaware of and did not follow AAMI guidelines or the Manufacturer's Instructions for Use (MIFUs). Staff responsible for the high-level disinfection of the GI scopes did not follow the MIFUs for MetriCide or test strips. This step is integral to the cleaning process for reprocessing endoscopes and has significant implications for patient safety if done incorrectly. Staff used Sani wipes to clean surgical instruments, which is inappropriate for proper sterilization • *Cross Contamination:* The organization reused surgical equipment and supplies that were opened in the operating room (OR) but not used during a prior case. A Surgical Tech was observed wearing the same disposable gown during multiple procedures. This individual processed a dirty scope, placed the washed scope in the Automated Endoscope Reprocessor (AER), and then returned to the procedure room to assist the surgeon with another patient. Endoscopes are cleaned and rehung in the same room where procedures are performed, rather than in a cabinet • *Workflow:* The decontamination area was non-functional, resulting in cross-contamination due to poor workflow	Organizations can mitigate infection control issues through several key strategies. • Adhering to evidence-based guidelines and protocols is essential. This includes regular training sessions on hand hygiene, sterilization techniques, and the proper use of personal protective equipment (PPE) • Conducting routine audits and feedback sessions can help identify and rectify lapses in infection control practices • Implementing strict protocols for cleaning and disinfecting surfaces, equipment, and patient areas can significantly reduce the risk of health care-associated infections (HAIs) • Ensuring that all staff are well-trained and consistently follow these protocols is crucial. Furthermore, health care organizations should establish a robust system for monitoring and reporting infections, enabling timely interventions and continuous improvement By fostering a culture of safety and vigilance, ASCs can effectively mitigate infection control issues and enhance patient safety.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• *Training:* There was a lack of documentation in employee files indicating that training, specifically in the facility, had occurred. This was also evident in employees' inability to answer questions about cleaning methods, the incorrect cleaning of instruments, and the general uncleanliness of the area	

Uncredentialed and nonprivileged Providers

Uncredentialed and nonprivileged providers pose a significant risk to patient safety. They may lack the necessary qualifications, training, or experience to perform medical procedures, which can lead to errors and substandard care. 14 percent of organizations that received an IJ had providers continuing to operate with missing or expired privileges.

% DEF	SOR	SOR DESCRIPTION
CPV CREDENTIALING AND PRIVILEGING		
14.0%	CPV.100	The medical and/or dental staff is accountable to the governing body through a credentialing, privileging, and reappointment process for which the governing body is responsible.
	CPV.110	The organization meets the following CMS Condition for Coverage: The medical staff of the ASC must be accountable to the governing body.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Overdue or Missed Reappointments • Systemic credentialing process failures with missing and incomplete applications • Failure to ensure up-to-date privileging for the medical staff • Uncredentialed providers • CRNA is not credentialed but was scheduled to provide anesthesia for a case next day • Solo provider with no outside approval or peer review	• To address this issue, health care organizations should establish stringent credentialing processes. This includes ensuring that all providers undergo the recredentialing and privileging process well in advance of their application expiration. Additionally, a provider renewal schedule and regular audits can further ensure that all providers remain current • Solo providers are required to ensure an outside physician (for a medical practice) or dentist (for a dental practice) reviews the credentials file and requests for privileges prior to governing body approval

Compromised Physical Environment

Ambulatory surgical settings must be equipped to handle emergencies, including power outages. Of all condition level findings reported to AAAHC in 2024 that rose to Immediate Jeopardy, 14 percent related to the physical environment and Life Safety Code Standards. Of these, three main types of deficiency were reported: 60 percent related to EES.260, 60 percent to EES.140, and 20 percent associated with the Egress (EGR) category.

% DEF	SOR	SOR DESCRIPTION
EES ESSENTIAL ELECTRICAL SYSTEMS		
12.0%	EES.260	Non-egress fixture self-contained battery-powered lights are provided at the required locations.
	EES.140	All tests related to the electrical system are documented and include the required components.
	EGR.370	Exits, exit pathways, and paths of egress comply with the appropriate guidelines.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• Required rooms lacked self-contained battery-operated emergency lighting fixtures, and providers did not have immediate access to mitigating factors such as headlamps or flashlights • Equipment such as ventilators, defibrillators, EKGs, and SPO2 monitors were found to have non-functioning and/or expired batteries. • Defibrillator that the FDA recalled was in use on a crash cart • Facilities had noncompliant egress paths that did not accommodate the safe removal of patients and staff from the building during an emergency. Additionally, faulty and/or improper door hardware rendered exit doors inaccessible	• Operating suites and procedure rooms that exceed moderate sedation require self-contained battery-operated emergency lighting fixtures to ensure safety and continuity of care during power outages. Fixtures in these areas serve as a primary source of backup lighting or bridge the gap until a generator or other alternative power source is available to provide lighting. These fixtures mitigate risk associated with power loss by providing uninterrupted lighting that allows providers to complete procedures safely during a power outage • Line-operated patient care equipment that requires continuous operation during power outages must provide a seamless transition of power to an alternate source to prevent shutdowns that jeopardize patient safety • Safe exiting is a tenet of life safety that carries severe risks for all building occupants when it is compromised

By understanding how environmental factors impact risk, facilities can avoid these high-risk condition level deficiencies and create a safer environment for patients and staff.

Unsafe Injection Practices

Safe injection practices are essential to preventing health care-associated infections and ensuring patient safety (IPC.130). Unsafe injection practices accounted for 7 percent of all Immediate Jeopardies.

% DEF	SOR	SOR DESCRIPTION
IPC INFECTION CONTROL		
7.0%	IPC.130	The written infection prevention and control program describes how infections and transmission of communicable diseases are prevented, identified, and managed.

SURVEYOR FINDINGS	COMPLIANCE GUIDANCE
• *Reuse of Syringes Across Patients*. A syringe containing lidocaine and epinephrine was drawn up at the start of the day and used for multiple patients. The syringe was treated like a vial, accessed repeatedly throughout the day in the OR. It remained in the operating room (OR) during all cases, thereby increasing the risk of contamination • *Improper Use of Medications.* Moxifloxacin was drawn from a dropper bottle labeled "for topical use only" and injected intracamerally. The bottle contained boric acid, a preservative not intended for intraocular use. The physician was unaware and believed Vigamox (approved for intracameral use) was being used • *Pre-Drawn Medications for Future Patients.* While in the OR, a Certified Registered Nurse Anesthetist (CRNA) drew up succinylcholine for the next patient while the current patient was still in the OR • *Pre-Assembled Saline Flushes.* Six saline flush syringes were pre-assembled and connected to heparin locks and tubing. These were prepared the previous week and not disposed of, despite staff stating they would not use them • *Open Multi-Dose Vials.* Multiple open multi-dose vials were found in the OR and storage cabinets. These vials lacked beyond-use dating and were not properly discarded. Staff claimed they would not use them, but their presence still poses a risk • *Single-Dose Vials Used as Multi-Dose.* Single-dose vials were accessed multiple times for different patients, violating safe injection practices. • *Pre-drawn Medications for Next Cases.* Medications (e.g., contrast and lidocaine) were drawn and placed in trays without labels before the physician entered. Both medicines were clear, increasing the risk of a mix-up. The physician had to verify with the nurse before administration	These practices significantly increase the risk of cross-contamination, medication errors, and adverse drug events, any of which could result in serious harm or even death. For example, using a syringe as a multi-use vial or drawing up medications for future patients while another is still in the room creates a high-risk environment for misadministration or infection transmission. Additionally, the presence of unlabeled medications, open multi-dose vials without beyond-use dating, and single-dose vials being reused is contrary to safe medication practices. These actions are egregious and demonstrate a lack of adherence to infection control and medication safety protocols. Safe injection practices are grounded in several key principles: • The rule of "One Needle, One Syringe, Only One Time" mandates that needles and syringes must never be reused, even with a new needle, as both are considered contaminated after a single use • Aseptic technique must always be employed during the preparation and administration of medication to maintain sterility • Regarding vials, single-dose vials are intended for one patient and one procedure only, while multi-dose vials should be accessed with a new sterile needle and syringe each time and, ideally, assigned to a single patient • Medications must be prepared in clean, designated areas away from patient care zones, and all syringes should be clearly labeled with the medication name, concentration, and preparation time if not used immediately • Proper storage according to manufacturer guidelines and immediate disposal of used needles and syringes in puncture-proof sharps containers are also critical Violations of these practices—such as reusing syringes, misusing vials, or failing to label medications—can result in the transmission of bloodborne pathogens like hepatitis B, hepatitis C, and HIV, as well as other serious infections.

Addressing an Immediate Jeopardy Deficiency

1. Take Immediate Corrective Action. Upon receiving an Immediate Jeopardy citation, act swiftly to remove the immediacy of the risk. This involves directly resolving the issue that triggered the deficiency and ensuring patient and staff health and safety are no longer compromised.
2. Develop a Comprehensive Removal Plan. Create a detailed Removal Plan that outlines the steps your organization will take to correct the issue and prevent recurrence. Include specific actions, responsible parties (titles of persons, not names), dates for implementation and monitoring activities.
3. Implement the Plan Immediately. Begin executing the Removal Plan without delay. Ensure that all staff are informed of the changes and consistently follow the new procedures. Document all training and education efforts and be prepared to demonstrate sustained compliance during the revisit. Ongoing monitoring of the plan is essential.
4. Ensure monitoring actions are implemented and monitored for ongoing compliance.

VIII. 2025 Roadmap for Improvement

Use this Report for Benchmarking

Your organization can use the data in this report to compare your survey results versus benchmarks identified in the report. If you have an opportunity for quality improvement, the following resources may be beneficial for intervention and to guide your efforts.

Guidance for Addressing High-Deficiency Themes

Allergy Documentation Study

The AAAHC Institute began offering an *Allergy Documentation Benchmarking Study* in 2020. Initial findings substantiate the need for many organizations to assess their compliance with consistently documenting allergies, sensitivities, and reactions to medications, over the counter medications and supplements, and other materials such as latex and food at each patient encounter. Through participation, organizations can develop quality improvement interventions to improve their compliance with the AAAHC Standards.

In addition to the *Allergy Documentation Benchmarking Study*, AAAHC offers a toolkit on allergy documentation.

Medication Reconciliation Study

The AAAHC Institute began offering a *Medication Reconciliation Benchmarking Study* in 2020. Initial findings substantiate the need for many organizations to assess their compliance with consistently documenting medications, allergies, medication changes, and reviewing with the patient/caregivers at each and every patient visit. Through participation, organizations can develop quality improvement interventions to improve their compliance with the AAAHC Standards.

In addition to the *Medication Reconciliation Benchmarking Study*, AAAHC offers a toolkit on medication reconciliation.

Emergency Preparedness Study

The AAAHC Institute began offering an *Emergency Preparedness Benchmarking Study* in 2021. This study will report findings that assist organizations assess their compliance with consistently documenting staff training, patient evacuation, emergency drills, and awareness of and coordination with community emergency resources. Organizations can develop quality improvement interventions to improve their compliance with the AAAHC Standards.

In addition to the *Emergency Preparedness Benchmarking Study*, AAAHC offers a toolkit on emergency drills.

Safe Injection Practices Study

The AAAHC Institute began offering a *Safe Injection Practices Benchmarking Study* in 2017. Findings substantiate the need for many organizations to assess their compliance with national guidelines for safe injection practices and develop quality improvement interventions to improve their compliance with the guidelines.

In addition to the *Safe Injection Practices Benchmarking Study*, AAAHC offers a toolkit on safe injection practices

Hand Hygiene Practices Study

The AAAHC Institute's newest offering of the *Hand Hygiene Practices Benchmarking Study* began in 2025. Using structured observation, the goal of the *AAAHC Hand Hygiene Benchmarking Study* is to assist organizations, evaluate their compliance with several hand hygiene opportunities during a patient encounter. Using the WHO *5 Moments of Hand Hygiene* and the Centers for Disease Control and Prevention's (CDC) glove donning and doffing recommendations, study participants collect staff observation data.

IX. AAAHC Resources

The *1095 Strong* Philosophy

The *1095 Strong, quality every day* philosophy is a call-to-action that equips ambulatory organizations with the best of what you need to operationalize quality practices. The *1095 Strong* initiative centers on providing accreditation tools, resources, and relevant education to bring meaningful value to organizations and promote compliance with the Standards, all 1,095 days of the accreditation term.

1095 Engage Help Curtain

1095 Engage not only benefits organizations with timely curated Standards and a streamlined renewal process it also provides immediate access to valuable resources that help maintain ongoing compliance. These resources are available through the *1095 Engage* Help Curtain accessible through the gray bar on the lower right part of the *1095 Engage* screen.

Achieving Accreditation

Achieving Accreditation offers an immersive, live education program designed to help you strengthen your tools, assemble your resources, and get more from accreditation.

Learn about upcoming dates at:

https://www.aaahc.org/accelerated-readiness/achieving-accreditation/

1095 Learn Portfolio

1095 Learn, the AAAHC education portal, delivers interactive and engaging education to refresh an organization's knowledge and optimize its quality practices at a personalized pace. AAAHC offers a variety of live and self-paced webinars and eLearning modules that assist organizations in their journey to provide quality patient care every day.

Visit https://www.aaahc.org/accelerated-readiness/1095-learn/ to review our current education opportunities.

Quality Improvement Resources

For more than 45 years, AAAHC has been driving quality improvement in ambulatory patient care by identifying trends and improving AAAHC Standards compliance via meaningful performance measurement, evidence-based tools, and focused educational opportunities.

Kershner QI Award

Quality Institute Toolkits

Quality Roadmap

Benchmarking Studies

If your organization is AAAHC Accredited and has conducted an exemplary QI study, consider applying for the annual Bernard A. Kershner Innovations in Quality Improvement Award. Please visit the AAAHC website www.aaahc.org, choose "Quality Institute" and "Kershner QI Award" to learn more about applying, award criteria, poster presentations, and the Expert and People's Choice awards.

Visit **https://www.aaahc.org/quality-institute/** to learn about AAAHC benchmarking, download the current *Quality Roadmap*, and scroll through an infographic featuring past Kershner QI Award winners.

Triangle Times Today

Receive all the latest AAAHC updates with *Triangle Times Today*, press releases, important announcements, and public comment opportunities. Find news and updates here **https://www.aaahc.org/news/**

Follow AAAHC on LinkedIn and Facebook for more updates and programs to help you stay *1095 Strong!*

X. Glossary of Terms

ACRONYM	ORGANIZATION / TERM
ADS	Association for Dental Safety (formerly OSAP)
AMB	AAAHC Ambulatory Accreditation Program, including Medical and/or Dental Home Recognition
APIC	Association for Professionals in Infection Control and Epidemiology
ASC	Ambulatory Surgery Center
CCN	CMS Certification Number
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
EES	Essential Electrical Systems
EHR	Electronic Health Record
EMR	Electronic Medical Record
EOC	Element of Compliance
EPS	Emergency and Standby Power System
HVAC	Heating, Ventilation, and Air Conditioning
IJ	Immediate Jeopardy
LSC	Life Safety Code
MDS	Medicare Deemed Status Accreditation program
NFPA	National Fire Protection Association
NPDB	National Practitioner Data Bank
OBS	Office-Based Surgery
OSHA	Occupational Safety and Health Administration
PC	Primary Care
PCMH	Patient-Centered Medical Home
QI	Quality Improvement
SEOC	Sub-Element of Compliance
SIP	Safe Injection Practices
SOR	Statement of Requirement
WHO	World Health Organization

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quality every day
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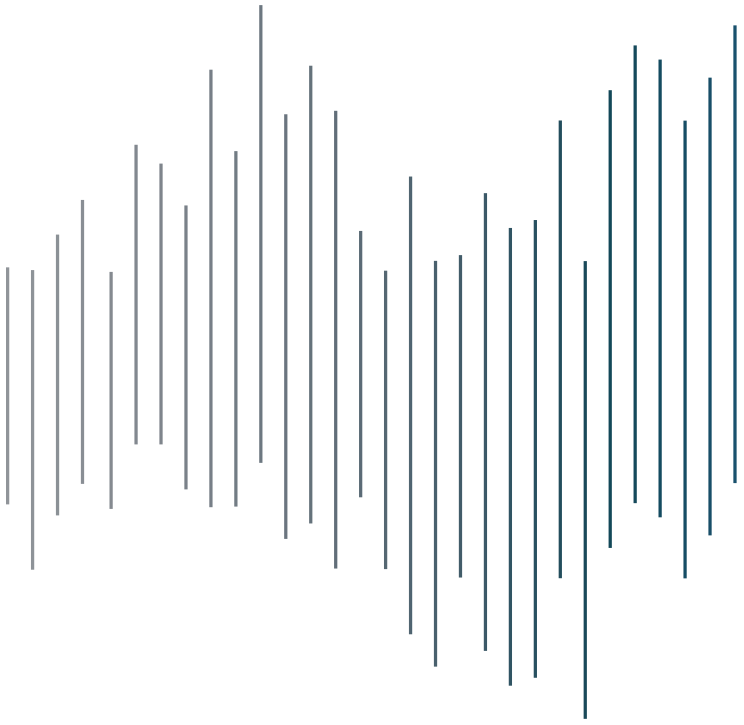

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