ACCREDITATION PROCESS

OFFICE-BASED SURGERY

ACCREDITATION COMMISSION *for* HEALTH CARE

[1227] Revised 07/20/2023

Table of Contents

I. Introduction

Accreditation Commission for Health Care (ACHC) is an independent, 501(c)(3) nonprofit accrediting organization that is certified to ISO 9001:2015 standards. ACHC is governed by a volunteer Board of Commissioners (Board) that is composed of healthcare professionals and consumers. The Accreditation Process contained in this document pertains to all organizations, whether they are applying for accreditation for the first time, renewing accreditation, adding or eliminating sites, or adding or eliminating services. As a result of changes in industry standards and/or regulatory changes, as well as ACHC's continuous internal review of its processes, ACHC may update its Accreditation Process. Accordingly, ACHC's services will be furnished in accordance with the most current version of the ACHC Accreditation Process in effect on the date of the survey or in effect at the time of any other activity.

II. Requirements

A. ACHC Office-Based Surgery

The Office-Based Surgery (OBS) program provides accreditation for physician offices, dental offices, and clinics that perform procedures requiring various levels of sedation.

B. Eligibility Requirements

The organization may apply for preliminary accreditation if the following eligibility requirements are met. The organization must:

1. Be within the United States and/or its territories.
2. Have applied for a state license.
3. Have a building identified, constructed, and equipped to support services provided.
4. Have policies and procedures developed that at minimum, meet the requirements of the *Accreditation Requirements for Office-Based Surgery* manual in effect.
5. Have identified its chief executive officer/administrator/clinical director.

The organization may apply for accreditation if the following eligibility requirements are met. The organization must:

1. Be currently operating within the United States and/or its territories.
2. Be licensed or approved as meeting standards for licensing as required by the relevant state/locality and compliant with all local licensing requirements.
3. Have or provide professional care by qualified providers.
4. Have an effective governing body that is legally responsible for the conduct of the organization or persons identified as legally responsible for conduct.
5. Have an organized system of documenting and maintaining medical records that is controlled by qualified personnel and appropriate to the scope and complexity of the services provided.
6. Have personnel who are licensed or meet other requirements of state or local laws.
7. Be limited to business occupancy; that is, no greater than three concurrent patients rendered incapable of self-evacuating in the event of an emergency.

III. Principles Governing the Accreditation Survey

A. Compliance

During the accreditation survey, ACHC determines whether the organization is meeting the intent of ACHC Accreditation Standards. Proof of compliance is based upon items such as:

1. Review of records
2. Examination of personnel files
3. Review of policies and procedures
4. Observations
5. Interviews

It is the organization's responsibility to ensure compliance with ACHC Accreditation Standards at all times during the accreditation period. ACHC will release and communicate any updates/changes to ACHC Accreditation Standards every year on or around February 1. The updates/changes will have an effective date of June 1 of the same year in which they are released. However, in response to regulatory changes or requirements, ACHC Accreditation Standards may be updated at any time. Organizations must be compliant with any changes on the effective date.

B. Education

While the organization is preparing for its survey, the organization's Account Advisor is available to assist with the accreditation process. Clinical Managers are available for interpretation of ACHC Accreditation Standards or suggestions on how to implement them. During the survey, ACHC Surveyors will provide education to help the organization achieve optimum performance.

C. Types of Surveys

1. **Preliminary Survey Assessment:** A Preliminary Survey Assessment (PSA) is conducted on an organization that applies for ACHC Accreditation for the first time and has not begun providing care, treatment, or services. A Preliminary Survey Assessment is limited in scope, addressing a subset of administrative and organizational standards. Following this preliminary survey, an organization receives a Preliminary Accreditation status allowing it to serve patients for the purpose of seeking a full accreditation status within six (6) months.
2. **Initial Survey:*** An Initial Survey is conducted on an organization that applies for ACHC Accreditation for the first time. Initial Surveys are announced unless State requires unannounced.
3. **Renewal Survey:*** A Renewal Survey is conducted on an organization that is currently accredited by ACHC. A Renewal Survey is conducted in the same format as an Initial Survey; however, during the Renewal Survey, the Surveyor also reviews previous deficiencies for compliance. Renewal Surveys are announced.
4. **Dependent Survey:** A Dependent Survey is a re-survey conducted on an organization that was not in compliance with ACHC Accreditation Standards. Dependent Surveys are announced.
5. **Focus Survey:** A Focus Survey is conducted on an organization to ensure ongoing and continued compliance with ACHC Accreditation Standards. A Focus Survey can take place at any time throughout the accreditation period or for any organizational changes.

6. **Complaint Survey:** A Complaint Survey is conducted on an organization that has a complaint filed against it. Should ACHC determine during the investigation that a site visit is required, ACHC will conduct a Complaint Survey to determine if the complaint is substantiated. Complaint Surveys are unannounced.
7. **Disciplinary Action Survey:** A Disciplinary Action Survey is conducted on an organization because of noncompliance with previous survey results, ACHC Accreditation Standards and/or Accreditation Process, and/or a breach in the ACHC Business Associate Agreement (BAA). Disciplinary Action Surveys are unannounced.

* Full survey: This is a comprehensive survey examining all ACHC Accreditation Standards.

IV. Accreditation Process Before the Survey

A. **Register for Access to ACHC Through Compass**
   1. Contact customerservice@achc.org for a Customer Information Form.
   2. Complete and return the Customer Information Form.
   3. Receive access to Compass from ACHC.
   4. Receive Customized Pricing Quote.
   5. Sign and return Customized Pricing Quote.

B. **Download ACHC Accreditation Standards**
   1. Available for organizations that have not previously obtained them.
   2. Once purchase is complete, organization has unlimited access to all ACHC Accreditation Standards.

C. **Complete ACHC Accreditation Application**
   1. Complete online Accreditation Application in its entirety in Compass.

D. **Execute Agreements**
   1. The following agreement outlines the obligations of both ACHC and the organization.
      a. Agreement for Accreditation Services
      b. Business Associate Agreement (BAA)
   2. Sign and Return the Accreditation Agreement and BAA to ACHC.
      a. Failure to return the signed agreement within 90 days will void the organization's application in such case, the organization forfeits its application and must begin the application process again.
   3. Failure to meet any terms of the BAA may result in rescheduling or cancellation of the survey, with fees assessed.
   4. Once an agreement is fully executed, the organization will be entitled to a refund of no more than 75% of the residual Agreement fee.

E. **Scheduling**
   1. Upon receipt of the required documents, the scheduling process is initiated.
   2. ACHC does not conduct surveys on the following days:
      a. New Year's Day
      b. Good Friday
      c. Memorial Day

d. Independence Day
e. Labor Day
f. Thanksgiving Day and the following day
g. Christmas Eve
h. Christmas Day

3. ACHC reserves the right to send a Surveyor preceptee as part of the survey team. A preceptee is sent at no charge to the organization. All ACHC Surveyors/preceptees must disclose any potential conflict of interest with the organization to ACHC before they are assigned to conduct the survey. A Surveyor/preceptee with a confirmed conflict will not be used for the survey being scheduled.

F. **Postponement of Survey**

1. Survey postponements must be requested in writing to the organization's Account Advisor. A call with a member of the clinical education team may be required.
   a. An organization may request a survey postponement after the application is sent to scheduling by the Account Advisor. Starting the day before the survey, organizations must follow the refusal process.
   b. If a postponement request is accepted, ACHC will invoice a postponement fee. The postponement fee must be paid before the survey can be rescheduled. The organization is responsible for notifying the Account Advisor in writing of its readiness for survey. When notified, the Account Advisor will proceed with rescheduling the survey by following the ACHC scheduling process. If the organization does not notify the Account Advisor within 180 days of the postponement date, the application may be forfeited, and the organization will be required to reapply for accreditation.

V. Survey Process

A. **Facilities**

1. **Opening Conference:** The opening conference may consist of the following steps, based on the organizational structure:
   a. Introduction of the Surveyor(s)
   b. Explanation of the survey and its purpose
   c. Review of the tentative schedule
   d. Review of questions on any documents from the application process
   e. Q&A from the organization about the survey
2. **Tour of the Organization**
3. **Data Collection**
   a. For ACHC to ensure the organization is compliant with all ACHC Accreditation Standards, the survey focuses on the following:
      i. Personnel file review
      ii. Patient record review
      iii. Financial records
      iv. Service contracts
      v. Risk management

vi. Infection Control practices
vii. Performance Improvement (PI) activities
viii. Policies and procedures
ix. Observations
x. Personnel and patient interviews
xi. Physical Environment and Life Safety

b. The organization authorizes ACHC to access the records that are necessary to ascertain the degree of compliance with ACHC Accreditation Standards. ACHC complies with all HIPAA, privacy, and security regulations.

c. The Surveyor's role is to review information presented and to clarify, observe, and verify data that supports compliance with applicable ACHC Accreditation Standards.

4. **Closing Conference**
The ACHC Surveyor conducts a closing conference with the organization's representatives.

a. This allows a final opportunity to clarify information or present data that may not have been reviewed by the ACHC Surveyor during the survey.

b. The ACHC Surveyor will provide organizational strengths and deficiencies.

c. The ACHC Surveyor does not issue an accreditation decision at the completion of the survey.

d. Once the survey concludes, the organization will no longer be entitled to a refund.

B. Refusal of Survey

1. Organizations have the right to refuse an ACHC survey.

a. Surveys can be refused starting the day before the survey. If an organization wishes to request a survey refusal, it must contact its Account Advisor and complete a Survey Refusal Form. A call with a member of the clinical education team may be required.

b. If an ACHC Surveyor arrives on site and the organization wishes to refuse, does not meet the eligibility criteria for an accreditation survey, or is not in operation during its posted business hours, the Surveyor will notify the Account Advisor of refusal. A call with a member of the clinical education team may be required. If possible, a Survey Refusal Form will be completed on site.

c. If an ACHC survey is refused, ACHC will invoice a refusal fee. The refusal fee is required to be paid prior to the rescheduling of the survey. The organization is responsible for notifying the Account Advisor in writing of its readiness for survey. When notified, the Account Advisor will proceed with rescheduling the survey following the ACHC scheduling process. If the organization does not notify the Account Advisor within 180 days of the refusal date, the application may be forfeited and the organization must reapply for accreditation.

VI. Accreditation Process Post-Survey

A. Reviewing the Data Collected

1. **Scoring:** Following the conclusion of the accreditation survey, the ACHC Surveyor will submit all the data collected to the organization's Account Advisor for processing. The information is entered into an electronic tool that provides objective data for determining the accreditation decision.

2. **Preparing the Deficiency Assessment Report:** The Deficiency Assessment Report is prepared describing all ACHC Accreditation Standards that were marked deficient during the accreditation survey. This will assist the organization in preparing a Plan of Correction to meet ACHC Accreditation Standards.
3. **Accreditation Review:** Any Deficiency Assessment Report that results in a denial decision will be analyzed by the appropriate Clinical Manager or designee and evaluated by the Accreditation Review Committee to ensure consistency before a final decision is rendered.

B. **Accreditation Decisions**

1. **Approval of Accreditation**
   a. Accreditation is approved based on the following criteria:
      i. Results of the data collected during survey
      ii. No deficiencies
      iii. Clinical Manager/designee review and Review Committee's decision
   b. The accreditation effective date for a new or renewal organization that receives an Approval of Accreditation is determined as follows:
      i. **New Organization:** The accreditation effective date is the last day of the survey.
      ii. **Renewal Organization:** The accreditation effective date will continue for an additional 24 or 36 months, depending upon state licensure requirements, from the previous accreditation expiration date if the Renewal Survey is conducted prior to the expiration date. If the organization's survey takes place after the expiration date, the approval date will start from the last date of the survey.
2. **Accreditation Pending**
   a. Accreditation Pending is based on the following criteria:
      i. Results of the data collected during survey
      ii. Number and/or severity of deficiencies
      iii. Clinical Manager/designee review and Review Committee decision
   b. When the organization has not yet fulfilled the requirements for accreditation approval, the organization will be in a pending status until the final accreditation decision is made.
   c. Accreditation cannot be granted until a Plan of Correction is submitted and approved. Due dates are as follows:
      i. The Plan of Correction, with evidence, is due to ACHC within 10 calendar days from the date of the organization's Accreditation Pending letter.
      ii. If adjustments to the Plan of Correction are necessary, the organization must submit modifications to achieve an approved Plan of Correction within 10 days as specified on the notification to the organization.
      iii. Failure to submit an approved Plan of Correction, with evidence, within the required time frame will result in a change of accreditation status from Accreditation Pending to Denial of Accreditation.
      iv. If requested, evidence to support implementation of the Plan of Correction is due to ACHC with 60 calendar days after the date of the Accreditation Pending letter. Failure to submit requested evidence will result in a termination of accreditation.

d. All Plans of Correction are reviewed by the Clinical Manager/designee. After reviewing the Plan of Correction, ACHC may issue:
   i. Approval of Accreditation
   ii. A rejection of the Plan of Correction and require additional information
   iii. Dependent Status (Section VI, B, 3)

e. Following the review of the Plan of Correction, if accreditation is granted, the effective dates for new and renewal organizations are determined as follows:
   i. New Organization: The effective date is the day the approved Plan of Correction is received by ACHC. An approved Plan of Correction is one that has been accepted by the Clinical Manager/designee.
   ii. Renewal Organization: The accreditation effective date will continue for an additional 24 or 36 months, depending upon state licensure requirements, from the previous accreditation expiration date if the Renewal Survey occurs and an acceptable Plan of Correction is received prior to the expiration date. If the organization's survey takes place after the expiration date, the approval date will start from the date the acceptable Plan of Correction was received.

3. **Dependent Status**

a. Dependent Status is determined based on the following criteria:
   i. Results of the data collected during the survey
   ii. Number and/or severity of deficiencies
   iii. Clinical Manager/designee review and Review Committee's decision

b. When the organization has not yet fulfilled the requirements for accreditation approval, the organization will be in a dependent status until the final accreditation decision is made.

c. The Plan of Correction is due to ACHC within 10 calendar days from the date of the Dependent Status letter. The organization must submit written notification to ACHC of its readiness for a Dependent Survey, at the organization's expense, within 90 days of the date of the Dependent letter. If the organization fails to notify ACHC within 90 days, the decision will move to a Denial of Accreditation.

d. The Surveyor submits the findings from the Dependent Survey to the organization's Account Advisor, and a decision will be made by the Clinical Manager/designee. Upon review, ACHC may issue:
   i. Approval of Accreditation
   ii. Accreditation Pending
   iii. Denial of Accreditation (Section VI, B, 4)

e. Following a Dependent Survey, if accreditation is granted, the effective accreditation dates for new and renewal organizations are determined as follows:
   i. New Organization: The effective date of accreditation is the last day of the Dependent Survey if no deficiencies are identified. If deficiencies are identified during the Dependent Survey, the effective date of accreditation is the day the approved Plan of Correction is received by ACHC from the Dependent Survey. An approved Plan of Correction is one that has been accepted by the Clinical Manager/designee.

ii. Renewal Organization: The accreditation effective date will continue for an additional 24 or 36 months, depending upon state licensure requirements, from the previous accreditation expiration date if the Dependent Survey occurs and an acceptable Plan of Correction is received prior to the expiration date. If the organization's survey takes place after the expiration date, the Approval date will start from the date the acceptable Plan of Correction is received.

4. **Denial of Accreditation**
   a. Denial of Accreditation is based on the following factors:
      i. Results of the data collected during the survey
      ii. Number and/or severity of deficiencies
      iii. A minimum of two Clinical Manager/designees reviewing decision
   b. If a Denial of Accreditation is issued, the organization has the option to appeal the decision by following the steps outlined in the Appeals Process (Section VI, E).
   c. If a Denial of Accreditation is issued, the organization has the opportunity to reapply for accreditation at any time it is ready for survey. At the time of re-application, a new application must be submitted.

C. **Accreditation Documentation**

1. Once an accreditation decision is made by the Clinical Manager/designee and the Accreditation Review Committee, the accreditation decision is given to the Account Advisor. The Account Advisor then prepares the proper documentation to send to the organization.
2. Based on the accreditation decision, the Account Advisor sends the following:
   a. **Approval of Accreditation with No Deficiencies:** Accreditation Approval letter, Certificate of Accreditation, Deficiency Assessment Report, digital logos and seals, and a press release for organization use.
   b. **Accreditation Pending:** Accreditation Pending letter, Deficiency Assessment Report, and Plan of Correction instructions.
   c. **Dependent Status:** Dependent Status letter, Deficiency Assessment Report, and Plan of Correction instructions.
   d. **Denial of Accreditation:** Denial letter and Deficiency Assessment Report and, if applicable, Survey Progress Report.
3. The Plan of Correction must be completed in its entirety, with evidence, submitted in Compass, and approved by the Clinical Manager/designee to be acceptable. The Plan of Correction must be completed on the ACHC Plan of Correction template and must contain the following elements:
   a. What actions will be taken
   b. Internal approval process
   c. Education on compliance and process
   d. Monitoring and reporting plan
   e. Data to be collected, monitored, and reported
4. Once an organization receives an Approval decision, the organization's accreditation information can be found on the ACHC website for verification.

D. Dispute Process

Organizations, whether applying for the first time or renewing their accreditation, may formally request to dispute any standard(s) deficiency documented on the Deficiency Assessment Report. If a company wants to dispute a denial decision, it must follow the appeal process (refer to Section VI, F).

The procedure to dispute a standard(s) deficiency is as follows:

1. The organization submits a written request for dispute to its ACHC Account Advisor no later than 10 calendar days from the receipt of the Deficiency Assessment Report. Disputes will not be granted if:
   a. The request is received after the 10-calendar-day time frame.
   b. The organization has an outstanding balance.
   c. The organization has a payment plan that is not current.
2. The written request outlines the standard(s) noted in the Deficiency Assessment Report that the organization believes ACHC incorrectly determined as a deficiency. The organization must also provide evidence to support that, at the time of the survey, the organization was in compliance with the standard(s). Any evidence the organization submits must have been presented to and reviewed by the Surveyor(s) at the time of the survey. Evidence provided with the request letter will not be returned to the organization.
3. Upon receipt of the request for a dispute, ACHC sends an acknowledgment letter to the organization.
4. If the organization is required to submit a Plan of Correction because of its survey, the organization must indicate on the Plan of Correction any deficiency being disputed.
5. The ACHC Review Committee will evaluate and determine whether ACHC followed its stated Accreditation Process in conducting the organization's accreditation survey.
6. Any ACHC Review Committee member who has a conflict of interest with the organization under review refrains from voting on the dispute.
7. Upon completion of the review, the ACHC Account Advisor notifies the organization of the ACHC Review Committee's decision to either uphold or reverse the original standard(s) deficiency noted on the Deficiency Assessment Report.
8. All decisions made by the ACHC Review Committee are final.

E. Appeal Process

An organization, whether applying for the first time or renewing its accreditation, may formally request to appeal a Denial of Accreditation decision. The procedure to appeal a Denial of Accreditation is as follows:

1. The organization submits a written request for appeal to its ACHC Account Advisor no later than 30 calendar days from the date on ACHC's Denial letter. An appeal will not be granted if:
   a. The request is received after the 30-calendar-day time frame.
   b. The organization has an outstanding balance.
   c. The organization has a payment plan that is not current.
2. The written request outlines the standard(s) noted in the Deficiency Assessment Report that the organization believes ACHC incorrectly determined as a deficiency. The organization must also provide evidence to support that, at the time of the survey, the organization was

in compliance with the standard(s). Any evidence the organization submits must have been presented to and reviewed by the Surveyor(s) at the time of the survey. Evidence provided with the request letter will not be returned to the organization.

3. Upon receipt of the request for an appeal, ACHC sends an acknowledgment letter to the organization.
4. The ACHC Appeals Committee is composed of a minimum of three individuals with clinical and/or program expertise who will evaluate and determine whether ACHC followed its stated Accreditation Process in conducting the organization's accreditation survey.
5. Any ACHC Appeals Committee member who has a conflict of interest with the organization under review refrains from voting on the appeal.
6. Upon completion of the review, the ACHC Account Advisor notifies the organization in writing of the ACHC Appeals Committee's decision to either uphold or reverse the original Denial decision.
7. All decisions made by the ACHC Appeals Committee are final.

F. **Continued Compliance**

1. Accreditation is contingent upon continued compliance with ACHC Accreditation Standards and Accreditation Process. After an organization is granted accreditation, ACHC reserves the right to make unannounced Focus Survey visits at any time during the accreditation period to ensure continued compliance with ACHC Accreditation Standards. An Interim Progress Report may also be required.
2. If a Focus Survey reveals noncompliance with any ACHC Accreditation Standards, a Plan of Correction and supporting documentation will be required. Based on the number and/or severity of deficiencies, the organization may be invoiced for the Focus Survey.
3. A Mid-Cycle Compliance Audit may be conducted approximately 12 months after initial accreditation and each reaccreditation is achieved. ACHC requests performance improvement data to review trending and appropriate institution of action plans as indicated.

G. **Renewing Accreditation**

1. Accreditation is not automatically renewable. Approximately twelve months prior to the organization's expiration of accreditation, ACHC will notify the organization about the renewal process.
2. If the organization's renewal application is not submitted by the required due date listed on the renewal email, sufficient time may not exist to schedule and complete a survey prior to the accreditation expiration date.
3. In the event an organization's accreditation expires, the organization's accreditation information will be removed from the accredited organization list located on the ACHC website.

VII. Disciplinary Actions

Disciplinary actions can come from a nonconformance resulting from an ACHC survey and/or failure to remain in compliance with ACHC Accreditation Standards and Accreditation Process, and/or a breach in the ACHC Business Associate Agreement.

A. **Noncompliance Process**

1. The organization may be placed Under Review:
   a. ACHC notifies customer.

b. ACHC determines which of the following actions will be taken:
   i. ACHC may request written documentation.
   ii. ACHC may conduct a Disciplinary Action Survey.
   iii. If ACHC determines that Immediate Jeopardy might be present, the process as described in Section X, C will be followed.
   iv. ACHC may require a Plan of Correction, and evidence, be completed.
   v. ACHC may require a payment.
c. Upon review of any documentation or Plan of Correction, with evidence, ACHC may accept, reject, or require additional information.
d. ACHC will render a decision:
   i. Continuance of Accreditation
   ii. Accreditation remains Under Review
   iii. Termination

2. Accreditation may be terminated based on the number of deficiencies or severity of nonconformance or if it is believed that compliance with ACHC Standards is not possible within a reasonable time frame.

B. Termination

Organizations accredited by ACHC must remain in compliance with ACHC Accreditation Standards; adhere to local, state, and federal legal requirements; ensure the safety of their residents and staff; and meet commonly held standards of professional ethics and conduct.

Accreditation can be terminated at any time during the accreditation cycle. A decision to terminate accreditation does not need to be preceded by a survey because problems with an organization's care/services can become apparent from other sources. Therefore, if ACHC receives evidence of noncompliance with ACHC Accreditation Standards or other pertinent criteria, ACHC may decide to terminate accreditation if, in its judgment, it finds that one or more of the following conditions are present:

1. An immediate threat exists to resident safety, public health, or staff safety. Such an immediate threat can arise from one incident on a single occasion that affects a single patient, a single staff member, or a single member of the public.
2. ACHC determines, in its discretion, that the scope or severity of the organization's noncompliance with ACHC Accreditation Standards is so significant that it is infeasible for the organization to complete corrective action within 10 calendar days or within a reasonable time frame, as ACHC determines in its discretion under the circumstances.
3. The organization falsifies documents or misrepresents information in seeking to achieve or retain accreditation; or in seeking or retaining some other license, certification, or authorization to operate; or in seeking to receive payment for care/services.
4. The organization, or a staff member, engages in any criminal conduct involving a felony, or engages in immoral, unethical, dishonest, incompetent, or other unprofessional behavior that significantly adversely affects, or has the potential to significantly adversely affect, the safety or welfare of any patient, or the safe and effective delivery of the organization's care/services.
5. The organization does not fulfill contractual obligations during the accreditation cycle by failing to comply with post-accreditation obligations, as specified in the Business Associate Agreement.

VIII. Notification of Changes

ACHC requires organizations provide the required documentation described below within 30 days of a change occurring. Changes include site addition or deletion; service addition or deletion; or change in the name, location, ownership, or control of the organization. Failure to submit the required documentation within the 30-day time frame may result in a gap in accreditation.

A. Name Changes

1. If an organization goes through a name change, the organization must notify ACHC within 30 days. The organization must complete and submit the Change of Name form in Compass. The form is located under the Facility Profile/Submit Change Requests page. Select "Notify Name Change," and confirm attestation.
2. ACHC may request additional documentation upon review. If the change is approved, ACHC will issue a new accreditation certificate.
3. If it is determined a survey is necessary, the normal announced survey scheduling process will apply, and the organization is charged a survey fee.
4. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review status.

B. Location Change

1. If an organization goes through a location change, the organization must notify ACHC within 30 days of the change. The organization should complete and submit the Change in Patient Care Services and/or Request Location Change form in Compass.
2. ACHC may request additional documentation upon review. If the change is approved, ACHC will issue a new accreditation certificate.
3. If it is determined a survey is necessary, the normal announced survey scheduling process will apply, and the organization is charged a survey fee.
4. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review status.

C. Cessation or Interruption within the Organization

1. If the organization has a cessation or interruption of all operations or care/services and/or a deletion of any care/service that has received accreditation, the organization must notify ACHC via a notification letter. A cessation additionally requires completion of a notification in Compass. The organization's notification letter to ACHC must include the following:
   a. Effective date of the cessation or interruption.
   b. Detailed description of the reason for the cessation or interruption.
2. Upon receipt of the written notification, ACHC will review and send an acknowledgment to the organization. The notification letter is placed in the organization's file. ACHC may request additional documentation before an acknowledgment letter is sent.
3. The organization notifies ACHC of any change in the status from the acknowledgment of the cessation or interruption of operations. Upon notification, ACHC will review the organization's

accreditation status and determine if a survey is required to ensure compliance with ACHC Accreditation Standards.

D. Site Additions

1. ACHC defines a site as a location serving patients and maintaining patient records and/or personnel files. The organization must complete and submit the "Change in Patient Care Services" in Compass.
2. A review of the documentation is performed, and any missing information is requested from the organization in writing. Additional information may be requested prior to approving the site addition. ACHC holds the site-addition documentation without further processing until the missing information is received from the organization. Once all required documentation has been submitted, the Regulatory Department reviews the submitted documentation, and a decision is made whether a survey is warranted. A survey is based on factors that include the original survey findings, where the organization is in the 24-month or 36-month accreditation cycle, and how many sites have been added from the start of its accreditation.
3. Upon approval of the submitted documentation, ACHC issues accreditation based on the date that all required documentation was submitted. ACHC will not back-date an accreditation for any organization that sends notification after the site opening. All fees must be paid in full before ACHC issues any accreditation documentation.
4. If it is determined a survey is necessary, the normal announced survey scheduling process will apply, and the organization is charged a survey fee. If it is determined a survey is not necessary, the organization will be charged an administrative fee.
5. If the organization is found to have substantial deficiencies during the survey, the accreditation for that site and/or the organization as a whole will be reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review status.

E. Service Addition

1. An organization that requests to add a new service to an already accredited program must complete the Facility Profile/Submit Change Requests/Change in Patient Care Services form in Compass.
2. A review of the documentation is performed, and any missing information is requested from the organization in writing. ACHC holds the Service Addition documentation without further processing until the missing information is received from the organization. Additional information may be requested prior to approving the Service Addition. Once all required documentation has been submitted, the Regulatory Department reviews the submitted documentation, and a decision is made whether a survey is warranted. A survey is based on factors that include the original survey findings, where the organization is in the 24-month or 36-month accreditation cycle, and how many sites have been added from the start of its accreditation.
3. Upon approval of the submitted documentation, ACHC issues accreditation based on the date that all required documentation was submitted. ACHC will not back-date an accreditation for any service addition. All fees must be paid in full before ACHC issues any accreditation documentation.

4. If it is determined a survey is necessary, the normal unannounced survey scheduling process will apply, and the organization is charged a survey fee. If it is determined a survey is not necessary, the organization will be charged an administration fee.
5. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review status.

F. Ownership or Ownership Information Changes

The following process is used when an organization has an ownership or ownership information change of 5% or greater, such as:

a. Stock transfer
b. Asset purchase
c. Acquisition
d. Merger
e. Consolidation

1. The following information is submitted to the organization's ACHC Account Advisor by the proposed new owner:
   a. Letter of attestation, which includes:
      i. Type of change (e.g., acquisition, merger, etc.)
      ii. Details of all changes, including new management and/or owner
      iii. Actual or anticipated date of change
      iv. Statement that policies and procedures will not change, or statement that policies and procedures are changing, plus copies of P&Ps for key standards
      v. Lists of old and new federal tax ID numbers and National Provider Identifier (NPI) number, if applicable
      vi. Names of the new contacts, including owner, Administrator, and liaison, plus the phone numbers and email addresses for each
   b. Documentation that includes:
      i. Completed Notify Ownership Change form in Compass
      ii. Proof new owner/Administrator/organization is not on the Office of Inspector General (OIG) exclusion list
      iii. Pre-transaction and post- transaction ownership organizational charts
      iv. Résumé of new Administrator and/or owner/DON and/or management personnel
      v. Business/state licenses, if applicable
2. A review of the documentation is performed, and any missing information is requested from the organization in writing. ACHC holds the documentation without further processing until the missing information is received from the organization. Once all required documentation has been submitted, it is reviewed by the Regulatory Department and an accreditation decision is made.

3. Upon approval of the submitted documentation, ACHC issues accreditation based on the date that all required documentation was submitted. All fees must be paid before ACHC will issue approval documentation.
4. If it is determined a survey is necessary, the normal announced survey scheduling process will apply, and the organization is charged a survey fee. If it is determined a survey is not necessary, the organization will be charged an administration fee.
5. If the organization is found to have substantial deficiencies during the survey, a Plan of Correction will be required, and/or a follow-up Focus Survey may be required.

IX. Public Information

A. Logo/Advertising Language

An organization must accurately describe only the program(s), service(s) and branch office(s) currently accredited by ACHC and abide by the ACHC Brand Guidelines when displaying accreditation status using ACHC's logos or ACHC's name.

False or misleading advertising represents noncompliance with the ACHC Accreditation Process and will result in penalties up to and including termination of accreditation. The ACHC Brand Guidelines are available on the organization's customer portal. Branch programs and services accredited during the accreditation cycle cannot be advertised as accredited until appropriate accreditation certificates are issued by ACHC.

B. Press Releases

ACHC encourages organizations to publicize their accreditation status. Publicity tips and a sample press release are available to approved organizations upon request to Account Advisor.

X. Nonconformance Policy

A. Handling of Complaints

As required by ACHC Accreditation Standards, accredited organizations must provide ACHC's telephone number to their patients as part of their patient informational material for purposes of reporting complaints.

If complaints cannot be resolved through the organization's complaint process, patients may file complaints with ACHC. These complaints should identify facts or circumstances that relate to each complaint.

ACHC documents and investigates all complaints/allegations received against currently accredited organizations. ACHC follows CMS Complaint Procedure guidelines for conducting investigations, and records of complaints are maintained. ACHC will investigate and maintain records on complaints from any source when an ACHC-accredited organization appears to be out of compliance with its ACHC Accreditation Standards.

Each complaint should include:

a. Name, mailing address, and phone number of the person filing the complaint.
b. Name of the organization involved.
c. A detailed description of the incident that is the subject of the complaint, including identification of date, time, and location of each incident, as well as the identity of other individuals with information about the incident.

While under investigation by ACHC, a complaint is a confidential matter. However, ACHC cannot guarantee the complainants that their identity will remain confidential if the organization determines the identity based on their own internal methods/investigations.

B. Processing a Complaint

ACHC will determine the severity and urgency of the allegations so that appropriate and timely action can be taken. Comprehensive information is collected during the Intake Process. Quality Assurance or an appropriate designee enters pertinent information into the complaint database and then discusses the complaint with the appropriate Clinical Manager who is professionally qualified to evaluate the allegations to ensure that residents are not in danger of abuse, neglect, exploitation, or inadequate care or supervision.

NOTE: If ACHC Clinical Compliance determines that the complaint does not involve patient care and the appropriate investigative method is through a request to the organization for documents rather than a site visit, then ACHC sends the organization a written or verbal request for documents, including specific due dates for documentation. This action may be completed by the Quality Assurance or Clinical Compliance departments.

C. Immediate Jeopardy

Immediate Jeopardy (IJ) is defined as a situation in which the provider's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient" (42 CFR Part 489.3). Complaints and/or issues are assigned this priority if the alleged noncompliance indicates there was serious injury, harm, impairment, or death of a resident, or the likelihood for such, and there continues to be an immediate risk of serious injury, harm, impairment, or death of a patient unless immediate corrective action is taken. The identification and removal of IJ, either psychological or physical, are essential to prevent serious harm, injury, impairment, or death of individuals.

1. In accordance with the Medicare State Operations Manual Appendix Q, ACHC acknowledges the following principles of IJ, including:
    a. Only one individual needs to be at risk. Identification of IJ for one individual will prevent risk to other individuals in similar situations.
    b. Serious harm, injury, impairment, or death does not have to occur before considering IJ. The high potential for these outcomes to occur in the very near future also constitutes IJ.
    c. Individuals must not be subjected to abuse by anyone, including but not limited to the organization's personnel, consultants or volunteers, and family members or visitors.
    d. Serious harm can result from both abuse and neglect.
    e. Psychological harm is as serious as physical harm.
    f. When a Surveyor has established through investigation that a cognitively impaired individual harmed an individual receiving care/services from the organization due to the organization's failure to provide care/services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.
    g. Any time a team cites abuse or neglect, it should consider IJ.
2. When a survey team is on-site, the survey team will initiate an investigation. Otherwise, ACHC will conduct an unannounced survey of the organization to investigate the issues within two business days of receipt of the allegations.

3. If IJ has been identified, a verbal notice is given to the entity, including the specific details and individuals at risk. If corrective measures have not already been implemented, the entity should begin immediate removal of the risk and immediately implement corrective measures to prevent repeat jeopardy situations. Only on-site observation of the entity's corrective actions justifies a determination that an IJ has been removed.
4. A formal written report is then prepared to reflect the findings listed above, and the report is submitted to ACHC within two business days of completion of the on-site review. Documentation is forwarded to and reviewed by the Clinical Compliance Department and Accreditation Review Committee, and a final report of findings is sent to the organization within 10 business days of completion of the on-site review.
5. Decision and Notification to Involved Parties:
    a. If, upon completion of the investigation of a deemed organization, ACHC identifies an IJ situation, then the state licensing and other authorities, as applicable, are notified. The Board Chair and Executive Management are also immediately notified.
    b. If sufficient evidence exists that the organization has violated ACHC Accreditation Standards, the organization may be placed in Under Review status.
    c. If an organization's accreditation is terminated, ACHC will notify the state licensing and other authorities, as applicable, of the termination. The organization will be removed from all listings of ACHC-accredited sites.

D. Non-Immediate Jeopardy – High

Complaints are assigned this priority if the alleged noncompliance with the applicable ACHC Accreditation Standard, if substantiated, would not represent an IJ but would result in a determination of substantial noncompliance. An on-site survey is initiated within 45 calendar days of receipt of the complaint.

A formal written report is then prepared to reflect the findings listed above, and the report is submitted to ACHC within two business days of completion of the on-site review. Documentation is forwarded to and reviewed by the Clinical Compliance Department and Accreditation Review Committee, and the final report of the findings is sent to the organization within 10 business days of the completion of the on-site review.

E. Non-Immediate Jeopardy – Medium

Complaints are assigned this priority if the alleged noncompliance caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical, and/or psychosocial status or function. The incident or complaint, if substantiated, would not result in a determination of substantial noncompliance. An on-site survey must be scheduled no later than when the next on-site survey occurs, or one year after receipt of the complaint and/or incident, whichever comes first.

F. Non-Immediate Jeopardy – Low

Complaints are assigned this priority if the alleged noncompliance may have caused physical, mental, and/or psychosocial discomfort that does not constitute injury or damage. In most cases, an investigation of the allegation can wait until the next on-site survey.

G. Administrative Review/Off-Site Investigation

This priority is used for complaints not needing an on-site investigation initially. This determination can be made through investigative action (written/verbal communication or documentation) initiated by ACHC to the provider to gather additional information that is

adequate in scope and depth to determine that an on-site investigation is not necessary. ACHC has the discretion to review the information at the next on-site survey.

A fee will be processed for Administrative Review/Off-Site Investigations requiring a Plan of Correction.

H. **Referral – Immediate**

This priority is used if the nature and seriousness of the alleged complaints or state/federal procedures require the referral or reporting of this information for investigation to another agency, without delay. This priority may be assigned in addition to one of the priorities listed above.

I. **Referral – Other**

Intakes are assigned this priority when referred to another agency or board for investigation or for informational purposes. This priority may be assigned in addition to one of the priorities listed above.