TECHNICAL CORRECTION CHANGE REPORT
Effective: July 21, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgery Center (ASC) **Office-Based Procedure (OBP)** **Office-Based Surgery (OBS)** **Oral Maxillofacial Surgery (OMS)** **Pediatric Dentistry (PD)** **International Surgery (I-Surg) & International Dental (I-Dent)** **Rural Health Clinics (RHC)**	
7-D-5	The facility monitors the sterilization cycle's effectiveness in accordance with nationally and internationally recognized standards of practice and in conjunction with the manufacturer's instructions for use. This includes but is not limited to: • Monitoring each sterilizer load for the appropriate mechanical indicators (e.g., time, temperature, and pressure); • Using type 1 (external) and type 5 (internal) chemical indicators; • Weekly biological indicator (spore test) for each sterilizer; • Using a biological indicator for every load containing implantable items; and. • Recording evidence of sterilization assurance monitoring for every load, and any corrective action is documented.

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent)	
1-F-3	The facility is up to date with accurate PSDR reporting. Reportable adverse events must be submitted to PSDR, including, but not limited to: • Any unplanned hospital admission; • Any emergency department visit; • Any unscheduled return to the operating room for a complication of a previous surgery; • Any complication such as infection, bleeding, would dehiscence, or inadvertent injury to another body structure; • Any cardiac or respiratory problems during the patient's stay at the facility or within 48 hours of discharge; • Any allergic reactions • Any pre- and post-procedure incorrect instrument, needle or sponge counts • Any patient or family complaint; • Any equipment malfunction leading to injury or potential injury to the patient; • Any death occurring within 30 days of a procedure; • Any iatrogenic dental trauma
1-F-4 through 1-F-14	Removed; Combined into 1-F-3
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD)	
6-E-4	The following medication must be available in the facility at all times as required by the current ACLS/PALS algorithm: Adenosine - 18 mg Epinephrine (1:10,000 solution, 1 mg per 10 ml) - Minimum - 5 mg Anti-Hypertensives – Minimum is per facility policy or facility drug formulary.

	Lidocaine HCl 2% - Minimum 100 mg Atropine - Minimum 3 mg Nitroglycerin (sublingual tablets or spray) – Minimum is per facility policy or facility drug formulary. Narcan – Minimum is per facility policy or facility drug formulary. Intravenous corticosteroids (e.g., dexamethasone) – Minimum is per facility policy or facility drug formulary. Amiodarone - Minimum 450 mg
6-F-2	The following medication must be available in the facility at all times: IV Antihistamines (e.g. Diphenhydramine) – Minimum 50 mg.
6-F-9	Removed; Required in 6-E-4
6-F-11	Removed; Required in 6-E-4
6-F-13	Removed; Required in 6-E-4

TECHNICAL CORRECTION CHANGE REPORT
Effective: July 14, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent) Rural Health Clinics (RHC)	
7-D-2	The facility has at least one (1) autoclave ~~which~~ that uses high-pressure steam and heat, or all sterile items are single-use disposable, or the facility has contracted with an outside vendor to process instruments, if applicable. ~~If soiled instruments are processed immediately for sterilization, they are to be treated with an enzymatic cleaner per~~ Instrument reprocessing and sterilization must follow the manufacturer's instructions for use.
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent)	
6-G-1	If the depolarizing muscle relaxant succinylcholine is present only for use in emergency airway rescue, the facility must document a protocol to manage the possibility of malignant hyperthermia (MH) following its use, and staff training must occur on hire and then annually. ~~In this instance, MH-related components as outlined in standards 6-G-5, through 6-G-11 are **not** required. Section 6-G does **not** apply if anesthetic gases and depolarizing agents that trigger malignant hyperthermia are~~

	~~not present in the facility at all.~~ ~~If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility, standards 6-G-5 through 6-G-11 apply.~~
6-G-2	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: ~~Adequate~~ Screening for MH risk must be documented, that includes but is not limited to a family history of unexpected death(s) following general anesthesia or exercise; a family or personal history of MH, a muscle or neuromuscular disorder, high temperature following exercise; a personal history of muscle spasm, dark or chocolate colored urine, or unanticipated fever immediately following anesthesia or serious exercise.
6-G-5	~~If a facility uses depolarizing agents~~, If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: MH crisis management must be covered in annual staff training. All clinical staff (including contracted healthcare professionals) must be trained. Annual drills are conducted for MH crisis and management including actual dilution of at least one vial of actual Dantrolene (expired OK). Staff should be assigned roles prior to drills and a written protocol outlining those personnel and their roles is on file. Documentation of drills is required.
6-G-6	~~If a facility uses depolarizing agents,~~ If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A supply of sterile water for injection USP (without a bacteriostatic agent) is available to mix with dantrolene before injection (i.e. 60ml/vial for Dantrium® and Revonto®, 5ml/vial for Ryanodex®).
6-G-7	~~If a facility uses depolarizing agents,~~ If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A minimum of 4 ampoules, 50cc's each, of sodium bicarbonate ($NaHCO_3$).
6-G-8	~~If a facility uses depolarizing agents,~~ If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: A minimum supply of dantrolene/Ryanodex should be stocked to treat a patient of average weight (approximately 70kg) with an initial dose: Dantrium®/Revonto® - 12 vials (20 mg/vial) Ryanodex® - 1 vial (250 mg/vial).
6-G-9	~~If a facility uses depolarizing agents~~, If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: An additional* supply of dantrolene/Ryanodex and diluents are stored in the facility, or the facility has a written agreement with another source that will provide additional* dantrolene/Ryanodex and diluents on a STAT basis within 10 minutes for continued treatment and stabilization of a patient experiencing a MH episode. *Additional supply of dantrolene is defined as: Dantrium®/Revonto® - 24 vials (20 mg/vial) Ryanodex® - 2 vial (250 mg/vial)

6-G-10	~~If a facility uses depolarizing agents,~~ If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: Flow sheets for any MH intervention as well as forms to rapidly communicate the progress of intervention with receiving facilities are on the emergency cart, and the facility must document and report any "adverse metabolic or musculoskeletal reaction to anesthesia". This documentation must be transportable with the patient when transferred to the receiving facility.
7-F-1	Combined into 7-F-2; see 7-F-2
7-F-2	The entire operating room suite is cleaned and disinfected according to an established facility policy and procedure, based on industry standards, and includes, at a minimum: • Cleaning schedule • Process for cleaning between cases • Process for terminal cleaning after the last case of the day • Use of intermediate-level, medical-grade disinfectants EPA-registered as virucidal, bactericidal, tuberculocidal, and fungicidal
8-C-1	Properly executed informed consent forms are always obtained from the patient or, if applicable, the patient's representative, which includes: • A description of the proposed surgery, including the anesthesia to be used; • The indications for the proposed surgery; • Risks and benefits; • Treatment alternatives; • The surgeon/proceduralist by name to perform surgery; • Whether physicians other than the operating practitioner will be performing important tasks related to the surgery; and • Whether, as permitted by State law, qualified medical practitioners who are not physicians will perform important parts of the surgery or administer the anesthesia, and if so, the types of tasks each type of practitioner will carry out.
8-C-2	Combined into 8-C-1; refer to 8-C-1
8-F-4 through 8-F-12 (Classes B & C)	Combined into one standard, refer to 8-F-13
8-F-13 (Classes B & C)	An anesthesia care plan is present that is based on, at a minimum, the following: • The patient's medical history; • The patient's prior anesthetic experiences; • Drug therapies; • A medical examination of the patient and assessment of any conditions that might affect the patient's pre-operative risk; and • A review of the medical tests and consultations • The determination of pre-operative medications needed for anesthesia;

	• Providing pre-operative instructions; and, • Allergy history **Interpretive Guidance:** The intent is to ensure the development of a safe individualized anesthesia plan for the patient. The surveyor is not expected to evaluate the practice of anesthesia or make a medical judgment about the anesthesia care plan. Instead, the surveyor is looking for evidence that the plan is based on the required elements. The facility's policy and procedures address how the anesthesia care plan is documented. For example, this may be a checklist, narrative documentation, anesthesia H&P, or a combination. **Evaluating Compliance:** • Interview the anesthesia professionals. • Review the pre-anesthesia assessment and anesthesia care plan in the clinical record for related documentation.
9-A-7	The governing body/facility leadership: Is regulated by a governing document/medical staff by laws that has the consent of each member of the medical staff body.
9-A-8	Removed
9-A-9	Removed
10-D-5 through 10-D-11	Combined into 10-D-15
10-D-15	Peer review is conducted and contains, at a minimum, the following review of each clinical record subject to peer review: • Adequacy and legibility of history and physical exam • Adequacy of the surgical consent • Adequacy of appropriate laboratory, EKG, and radiographic reports • Adequacy of a written operative report • Adequacy of anesthesia and recovery records (with IV sedation or general anesthesia) • Adequacy of instructions for post-operative care • Documentation of the discussion of any complications **Interpretive Guidance:** The intent is to monitor and maintain the administration of patient safety and quality of care, consistent with optimal standards of practice in each clinical record where Peer Review is conducted.

	Evaluating Compliance: • Interview staff. • Review peer review documents to determine if all required elements are included. • Review quality improvement program, peer review, and leadership meeting minutes.
11-B-8	~~The Facility Director is responsible for establishing and enforcing policies that protect patients.~~ The Facility Director monitors medical and facility staff members for compliance with this policy. Also refer to 9-A-14.
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD)	
6-G-11	If potential malignant hyperthermia triggering agents such as isoflurane, sevoflurane, and desflurane, and/or the depolarizing muscle relaxant succinylcholine are ever used, or are present in the facility: Facilities must have a policy for MH transfer including EMS 911 transport to a facility capable of ongoing treatment located within a reasonable distance. A licensed healthcare professional with the ability to continue MH treatment must accompany the patient during transport and provide a report to the receiving facility staff.
Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD)	
9-A-10	No longer applicable
9-A-11	No longer applicable
9-A-15	No longer applicable
9-A-27	No longer applicable
9-A-30	No longer applicable
9-A-31	No longer applicable
11-B-9	No longer applicable; see 9-A-14

Office-Based Procedure (OBP)	
10-D-1	To be HIPAA compliant, a copy of the HIPAA Business Associates Agreement must be signed by each physician working outside the facility participating in such facility's Quality Assurance/Quality Improvement process, including but not limited to Peer Review and Patient Safety Data Reporting, and a copy must be retained on file in the facility.
Outpatient Physical Therapy (OPT)	
2-B-19	Smoking is prohibited in the entire facility.

TECHNICAL CORRECTION CHANGE REPORT
Effective: July 7, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent)	
1-A-1	The facility practices within the Anesthesia Class for which it is accredited and in accordance with facility policies and procedures, ~~and~~ industry standards, regulations, and laws governing the facility.
1-D-1	A copy of the most current QUAD A "Patients' Bill of Rights" is prominently displayed, or a copy is provided to each patient. The QUAD A "Patients' Bill of Rights" is also adhered to by facility personnel. If required, an additional Patients' Bill of Rights must be prominently displayed in accordance with prevailing laws and regulations. **Interpretive Guidance:** The intent and purpose of the Patients' Bill of Rights are to ensure that patients have been advised of their rights following basic rules of conduct between patients and caregivers to address, access to care, respect, dignity, communication, patient confidentiality, and consent for treatments to establish that patients have been of advised of their rights. The most current copy of the Patient's Bill of Rights is to be prominently displayed, or a copy of the Patient's Bill of Rights may be given to the patients or provided at the time of registration. If applicable, the Patient's Bill of Right as required by the local jurisdiction having control is also posted. **Evaluating Compliance:** • Review personnel training documentation to ensure staff have been trained in the Bill of Rights. • Observe that the "Patient's Bill of Rights" is prominently displayed in the facility, or a copy is provided to each Patient. • If copies of the document are provided to each patient, the patient record must reflect this provision. Clinical records will be reviewed for evidence of this documentation, if applicable.

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg)	
8-B-11	The pre-operative clinical record includes documentation of all pre-operative medications and intravenous fluids given to a patient. This record includes the patient's name, date, time, dose, and route of administration.
8-B-12	Removed and combined into 8-B-11

TECHNICAL CORRECTION CHANGE REPORT
Effective: June 30, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent) Outpatient Physical Therapy (OPT) Rural Health Clinic (RHC)	
2-E-3	**Interpretive Guidance:** As applicable to the setting, no outdated medical supplies, instruments, implants, or equipment are used in the provision of patient care. Outdated supplies, instruments, implants, or equipment may not maintain their sterility or integrity. Medical supplies, instruments, implants, and equipment not stored within proper temperature settings may be considered expired for patient use. Some may require certain temperatures to maintain potency. For those facilities that sterilize/reprocess items, sterile items that can be reprocessed a specific number of times (i.e. LMA and implant sizers) per the manufacturer's instructions for use, documentation must be present regarding the number of times the item has been processed. Re-processing “expired” supplies is not acceptable unless the item is implicitly approved for such and the process is documented in the manufacturer’s IFU. When the item does not come with cleaning and re-sterilization instructions, it must be considered a single-use item with a terminal expiration date. When an item does not come with validated reprocessing instructions, it should not be used after the printed manufacturer’s expiration date, nor re-sterilized after use. On-site re-processing of “expired” supplies is not acceptable unless the manufacturer implicitly approves the item and the process is documented in the manufacturer’s instructions for use.

	Evaluating Compliance: • Inspect and check for expired supplies, instruments, implants, and equipment used in the facility. • Check manufacturers' recommendations for accurate best use by date or expiration. • If expired supplies, instruments, implants, or equipment are observed, interview staff to determine if a procedure is in place to check expiration dates on a regular basis. • Are sterile items that can be reprocessed a specific number of times, reprocessed in accordance with the manufacturer's instructions for use? • Is documentation present regarding the number of times the item has been reprocessed? • Interview staff.
3-D-4	**Interpretive Guidance:** The intent is to employ safety practices when sharps are used in the practice setting, to prevent needlestick injuries and the transmission of HIV, hepatitis A and B, and other bloodborne pathogens. Containers for disposing of used sharps should be based on the following National Institute for Occupational Safety and Health (NIOSH) criteria or by applicable federal/national, state, provincial, and local regulations. • **Functionality**: Containers should be puncture-resistant, durable during installation and transport, and an appropriate size and shape. The closure should be secure and minimize exposure during closure. • **Accessibility**: Containers should be upright and easy to operate while preventing the contents from spilling. The container should be placed in a visible location, within easy horizontal reach, and below eye level. The container should also be placed away from any obstructed areas, such as near doors, under sinks, near light switches, etc. • **Visibility**: Containers should be clearly visible to the healthcare worker. The container should be designed so that workers may be able to easily determine the container's fill status and distinguish any warning labels. • **Accommodation**: Containers should facilitate ease of storage and assembly, require minimal worker training, be easy to operate, and have a flexible design. They should also easily accommodate one-handed disposal of a sharps device. Product design should minimize sharp surfaces and cross-infection hazards. Installation and mounting systems should be safe, durable, stable, and cleanable. FDA-cleared sharps containers must be made of heavy-duty plastic, feature a tight-fitting, puncture-resistant lid, remain upright and stable during use, be leak-resistant, and be properly labeled with a hazardous waste warning. Additionally, sharps disposal containers should be disposed of when they are three-quarters full. Information regarding the mounting of sharps containers is based on general safety practices and recommendations from the FDA and OSHA guidelines. While there is no explicit regulation stating that sharps containers must be mounted, it is recommended to place them in stable and secure locations to prevent spills and ensure ease of access. Mounting is one way to achieve this stability and accessibility.

~~If a large sharps container is on the floor, it must be secured to prevent accidental tipping. Sharp containers cannot be on wheels for the same reason.~~ If a large sharps container is used on the floor, it should be on a cart or a base with wheels to achieve stability and minimize the risk of tipping. There are many options available to ensure stability.

Sharps should not protrude out of the disposal container. Sharps containers should be changed out when they are three-quarters full to prevent overfilling, as recommended by the FDA. This helps avoid spills and reduces the risk of needlestick injuries. The Department of Transportation (DOT) has regulations concerning sharps disposal, particularly for containers transported off-site for disposal. These containers must be puncture-resistant and securely closeable to prevent leaks. For sharps containers to be eligible for reuse, they must meet stringent requirements: they must be FDA-approved as reusable medical devices, permanently marked to indicate their suitability as reusable containers, and disinfected effectively based on the type of infectious substance they previously contained.

Evaluating Compliance:

- Review facility policy and procedures on the disposal of used sharps.
- Are sharps disposal containers puncture-proof?
- Are sharps disposal containers secured to prevent accidental tipping of the container?
- Observe employees discarding used sharps.
- Observe the placement of sharp containers. (i.e., Are they located close to the use of sharps?
- Are they placed at the appropriate height level (height of 52-56 inches?)
- Are used sharps disposed of properly?

The Department of Transportation (DOT) has regulations concerning sharps disposal, particularly for containers transported off-site for disposal. These containers must be puncture-resistant and securely closeable to prevent leaks. For sharps containers to be eligible for reuse, they must meet stringent requirements: they must be FDA-approved as reusable medical devices, permanently marked to indicate their suitability as reusable containers, and disinfected effectively based on the type of infectious substance they previously contained.

Evaluating Compliance:

- Review facility policy and procedures on the disposal of used sharps.
- Are sharps disposal containers puncture-proof?
- Are sharps disposal containers secured to prevent accidental tipping of the container?
- Observe employees discarding used sharps.
- Observe the placement of sharp containers. (i.e., Are they located close to the use of sharps? Are they placed at the appropriate height level (height of 52-56 inches?)
- Are used sharps disposed of properly?

	CDC - Bloodborne Infectious Diseases - Stop Sticks : Sharps Disposal - NORA Workplace Safety and Health Topic FDA Sharps Disposal Containers https://www.fda.gov/medical-devices/safely-using-sharps-needles-and-syringes-home-work-and-travel/sharps-disposal-containers Department of Transportation (DOT) Regulations https://www.hercenter.org/regsandstandards/dot.php NIOSH - Selecting, Evaluating, and Using Sharps Disposal Containers https://stacks.cdc.gov/view/cdc/6386 USDA - Safely Using Sharps https://www.fda.gov/medical-devices/safely-using-sharps-needles-and-syringes-home-work-and-travel/sharps-disposal-containers Sharps Contain Regulations: Your Guide, 2024 https://www.danielshealth.com/knowledge-center/sharps-container-regulations-your-guide WHO Injection Safety https://www.who.int/teams/integrated-health-services/infection-prevention-control/injection-safety WHO Minimum requirements for infection prevention and control programmes https://www.who.int/publications/i/item/9789241516945
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent)	
2-B-4	**Interpretive Guidance:** The intent is to minimize areas where contaminants can be left behind after cleaning. Contaminants could create a dirty and unsafe environment. The facility has cleaning policies and procedures in place that address cleaning and maintenance of walls, countertops, blinds and shades, cubicle curtains, and flooring. Cabinets and countertops must be made of non-porous and non-absorbent materials. Laminate, stainless steel, and glass are examples of acceptable materials. ~~Floors in clinical areas (does not apply to the operating room) are made of non-porous and non-absorbent~~

	~~materials. Examples of acceptable materials include luxury vinyl tile, vinyl composite tile, and sheet vinyl. These examples do not apply to the operating room flooring.~~ The Facility Guidelines Institute recommends that the operating room have monolithic (seamless) floor with an integral base. Flooring should also be non-porous and non-absorbent. ~~Homogenous sheet vinyl and homogenous sheet rubber, are the best options for operating room floors. Sheet format products must have heat-welded seams~~ ~~where the sheets are thermally fused via the use of a vinyl or rubber heat weld applied with a heat weld gun. This is how the sheet becomes monolithic or seamless.~~ Surfaces must be able to be cleaned with a hospital-grade EPA-approved disinfectant. Cubicle curtains and blinds and shades are often made of a fabric material. In this case, the fabric must be washable or otherwise cleanable. Easy-to-clean carpets may be used in non-clinical areas, including offices, waiting rooms, lobbies, and public corridors. **Evaluating Compliance:** • During the facility tour, observe walls, floors and countertops. Are they smooth and easy to clean? • Note any walls, floors, blinds and shades, cubicle curtains, and countertops that have tears, breaks, or cracks. Are they repaired or replaced when damaged? • Does the flooring have seams? Does the facility provide documentation that the seams have been sealed with an impermeable sealant other than silicone? • Review the facility's cleaning policies and procedures. • Interview staff.
2-C-5	There is adequate storage space within the operating room to hold equipment, supplies and medications. Unused equipment, supplies and medications are ~~covered~~ stored in a manner to avoid contamination. **Interpretive Guidance:** The intent of the standard is to ensure adequate storage in the operating room to avoid contamination and minimize the need for staff to leave the operating room for frequently used supplies, equipment, and medications. Equipment is stored out of the way. If kept in the operating room, unused supplies and medications are covered (E.g., in cabinets, drawers, bins, dust covers, etc.) to avoid contamination. Patient equipment kept in the operating room is cleaned between cases and at the end of the day, according to the facility's policy and procedure. Consumable or sterile-wrapped/packaged equipment must be covered to reduce the risk of surgical smoke, spray, or splatter contamination. **Evaluating Compliance:** • Observe operating room storage space.

	• Interview staff regarding the adequacy of storage space and the frequency at which staff must leave the operating room for frequently used supplies, equipment, and medications. • Are unused equipment, supplies, and medications covered?
4-B-3	The operating room is provided with ~~sufficient and adequately~~ functioning lighting in the ceiling based on the types of cases performed. ~~Adequate~~ Illumination for patients, machines, and monitoring equipment, and access to ~~which must include~~ battery-powered illuminating systems, are present. **Interpretive Guidance:** The intent is to ensure proper lighting for surgical cases. Failure of the emergency circuit feeder that supplies an operating room will ordinarily plunge the room into darkness. Unless an uninterruptible power supply is installed, a delay in the restoration of illumination could occur until the alternate source of the essential electrical system comes on-line. Even though such a delay is limited to 10 seconds, loss of illumination at a critical point in a surgical procedure could result in danger to the patient or operating room personnel. To safeguard against being thrust into complete darkness upon interruption of normal power, at least one (1) battery-operated emergency lighting unit is installed. This type of unit provides immediate illumination upon loss of power, helping to mitigate the impact of sudden interruption of the normal illumination. It is permitted to connect the lighting unit to the critical branch circuit. The use of an emergency back up generator is required for lighting in the OR per standard 4-B-3. **Evaluating Compliance:** • Observe all operating room lighting. Is it adequate for the types of cases performed? • Interview staff regarding the adequacy of ceiling lighting and illumination for patients, machines, and monitoring equipment. • Are battery-powered illuminating systems present?
8-L-5	An operative log must include record of surgery(ies) and other invasive procedures to be conducted during the case.
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) International Surgery (I-Surg) & International Dental (I-Dent)	
4-B-8	"Forced air warmers," blanket warmers, or other ~~devices~~ interventions are used to maintain the patient's temperature when the procedure lasts more than 60 minutes. The patient's temperature is monitored periodically to ensure normothermia.
8-H-10	No longer applies; see 8-H-11

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD)	
4-E-7	Central/Plumbed/Piped Anesthesia gas systems, including nitrous delivery systems, are checked by a qualified inspector annually, and written reports are available stating that the equipment is safe and operates according to the manufacturer's specifications.
3-C-1	All explosive and combustible materials and supplies are stored and handled in a safe manner with appropriate ventilation according to state, provincial, local, and national laws and regulations, and/or National Fire Protection Association (NFPA) codes and OSHA regulations, and the material's safety data sheet (SDS).
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) International Surgery (I-Surg)	
4-B-6	No longer applies to Anesthesia Class B
Ambulatory Surgery Center (ASC) Office-Based Surgery (OBS) International Surgery (I-Surg)	
8-B-23	For patients receiving general anesthesia or surgical procedures scheduled for 60 minutes or longer or for patients with a history of venous thromboembolism (VTE), the pre-operative clinical record includes a written screening protocol for VTE risk. This protocol and assessment tool are to be placed in the facility manual for reference.

TECHNICAL CORRECTION CHANGE REPORT
Effective: June 23, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent)	
5-A-1	**Interpretive Guidance:** The intent is to have all necessary equipment together in one place and immediately available to manage an emergency in the ~~OR or PACU~~ facility at all times a patient is in the facility. For procedural/surgical facilities, this also means that if a contract anesthesia provider brings any emergency medications or equipment into the facility and removes any of these items when leaving the facility, the contract anesthesia provider must remain in the facility until all patients have been discharged from the PACU. RHCs may consider conducting a risk assessment to assist in determining the additional emergency equipment required for their clinic based on the population served in addition to the required AED. **Evaluating Compliance:** • Inspect the emergency cart to ensure that it is equipped with the required working equipment, medications, and other CPR equipment. • Interview staff regarding the emergency cart/equipment location and contents • Review risk assessment, if applicable.
5-C-1	**Interpretive Guidance:** The best way to protect staff and patients is to expect the unexpected and to carefully develop an emergency action plan to guide everyone in the workplace when immediate action is necessary with a clear set of roles and responsibilities. Planning in advance helps ensure that everyone knows what to do when an emergency occurs. Drills and training are two (2) separate educational components. Drills are not expected to be conducted on hire for new staff. Not all staff are expected to participate in each scheduled drill, as staff may not be scheduled to work on the day of the drill. For each drill, the facility is expected to have a documented list of the staff that

	participated in the drill, the date/time of the conducted drill, the type of drill, and a documented after-action report. ~~For annual drills, it is recommended that the facility conduct one drill per quarter – emergency evacuation, fire safety, security, and CPR emergencies~~. The protocol is reviewed and tested annually and updated as necessary. All staff are expected to have received training on this protocol: upon hire, annually, and as any updates or revisions to the protocol are made. **Evaluating Compliance:** • Review the facility protocol for emergency evacuation of the facility. Is the protocol reviewed annually. • Interview staff to assess knowledge of this protocol. • Review drill documentation. Are records retained for at least 3 years? • Are drills conducted at least annually? • Review personnel records to determine that the appropriate training has been provided initially upon hire and annually thereafter, and any time updates occur. Cite deficiencies in training at 11-I-4.
5-C-2	**Interpretive Guidance:** There is a written protocol that outlines required activities in the event there is a security emergency. Security emergencies would include: Intruders Unruly patient or visitor Bomb threat Other threats to staff or patients Drills should reflect different locations and scenarios. An after-action report is completed. Drills and training are two (2) separate educational components. Drills are not expected to be conducted on hire for new staff. Not all staff are expected to participate in scheduled drills, as staff may not be scheduled to work on the day of the drill. The facility is expected to have a documented list of the staff that participated in the drill, the date/time of the conducted drill, the type of drill, and a documented after-action report. The protocol is reviewed and tested annually and updated as necessary. As with any policy and procedure, staff are expected to be trained on this protocol upon hire and annually. The protocol itself should be reviewed and updated (as necessary) annually. **Evaluating Compliance:** • Review the facility protocol for security emergencies and that the protocol has been reviewed annually. • Interview staff regarding what they would do in various scenarios. • Review drill documentation. Are records retained for at least 3 years?

	• Review personnel records to determine the appropriate training has been provided initially upon hire and annually thereafter, and anytime updates occur.
8-B-9	The ~~patient~~ pre-procedural/operative assessment ~~should~~ includes documentation regarding special needs such as physical impairments, disabilities, religious and/or ethnic concerns.
8-B-21	No longer applicable due to redundancy of 8-B-22; please see 8-B-22.
8-H-2	Clinical records must contain evidence of circulation monitored by continuous EKG during procedures. Note: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.
8-H-3	Clinical records must contain evidence of circulation monitored by blood pressure documented at least every five (5) minutes. Note: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.
8-H-4	Clinical records must contain evidence of circulation monitored by heart rate documented at least every five (5) minutes. Note: This standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication.
8-K-8	Written discharge instructions, including procedures for emergency situations, are given to the responsible adult who is responsible for the patient's care and transportation following a procedure or the patient has received discharge instructions prior to receiving sedation/anesthesia. A signed copy of the instructions ~~by the responsible adult~~ is maintained in the patient's chart. The standard does not apply if only topical and/or local anesthetic is used without the use of an oral premedication. **Interpretive Guidance:** The intent is to ensure that the patient and/or a responsible adult receives complete discharge instructions to support the patient's safe recovery. The importance of providing adequate discharge instructions to communicate with patients and primary care physicians cannot be overstated. All discharge instructions must be in writing, and a copy should be provided to the patient's primary care provider. Generally, discharge instructions address the following: discharge diagnosis, follow-up appointments, contact numbers in case of emergency, diet, activity level, level of supervision needed, wound care, specific actions the patient should take in the immediate post-discharge period to promote their recovery from the surgery (wound care, application of heat/cold, warning signs of complications), pre-operative medications and prescriptions, and

	when driving is permitted. Medication instructions should also address when to resume pre-operative medications and new prescriptions. Age is not the only factor in determining whether an individual is a responsible adult. A responsible adult is an individual who is capable of providing post-procedure care at home and reporting any post-procedure or post-anesthesia complications that may be considered for inclusion in the facility's policies and procedures. Patients are increasingly taking Uber, Lyft, cab, or another transportation source to go home. The facility must have clear written policies regarding patient discharge and notify patients of these requirements. Should a patient insist on taking Uber, Lyft, or a cab, the facility must document the patient's willful deviation from the facility's policies in the patient's clinical record and have a staff member assist the patient to the vehicle. In such a case, discharge instructions are given to the patient and signed by the patient. **Evaluating Compliance:** • Interview staff. • Review clinical records for related documentation. • Observe practice.
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg)	
11-I-5	**Interpretive Guidance:** The intent of this standard is that each clinical staff member, including physicians/surgeons, be minimally certified in BLS with evidence of this in their personnel file. This standard does not apply to administrative staff. The certification training completed is intended for healthcare professionals. Training courses for lay people are not acceptable. Acceptable training includes didactics (may be completed online) and a hands-on skills session. Not all training courses include a hands-on session. Initial and subsequent ACLS certification is obtained from the American Heart Association or another vendor that includes hands-on training and skills demonstration of airway management and automated external defibrillator (AED) use.

	Perioperative Life Support (PeRLS) along with BLS may be accepted for all perioperative physicians and members of the surgical team including Anesthesiologists, Certified Anesthesia Assistants, and CRNAs. **Evaluating Compliance:** • Interview staff. • Clarify which staff are required to have ACLS and/or PALS certification. • Review personnel files
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD)	
8-E-2	**Interpretive Guidance:** The intent is to ensure that laboratory results are reviewed and that the anesthesia professional ~~and~~ or surgeon/proceduralist review and initial any abnormal laboratory results. The facility identifies abnormal results are documented in both hard copy and/or electronic clinical records. In an electronic medical record, the reviewed results must indicate an electronic authentication that the licensed professional has reviewed the results. This includes the name and title of the licensed professional, along with the date and time the licensed healthcare professional reviewed the result or an electronic signature. **Evaluating Compliance:** • Interview staff. • If an RN reviews the laboratory results and abnormal results have been reported, is there documentation in the patient's clinical record that abnormal results have been reported to the anesthesia provider or surgeon/proceduralist? • Is there documentation that the anesthesia professional and surgeon/proceduralist reviewed abnormal results? • Review clinical records to validate documentation.
11-B-2	The **Facility Director** must have an MD, DO, DPM, DMD, DDS, APRN, CRNA, or an RN degree. *One person may fill both the Medical Director and Facility Director roles, or the roles can be filled by two separate people.*
11-C-5	Each physician, advanced practice registered nurse, and physician assistant, including both directly employed and contract practitioners using the facility, is credentialed and qualified for the ~~procedures~~ scope of practice they perform.

11-D-8	The anesthesia professional(s) or the registered nurse providing sedation cannot function in any other capacity (e.g., procedure assistant or circulating nurse) during the procedure, except for oral and maxillofacial surgery where the operator/anesthetist model has been established utilizing a two-person team for Moderate sedation and a three-person team for Deep sedation. All personnel must abide by all state and federal regulations and laws governing the administration of anesthesia. **Interpretive Guidance:** The intent is to ensure the safe administration of anesthesia and sedation. During the procedure, an anesthesia professional or the registered nurse providing sedation cannot function in any other capacity. The anesthesia professional or the registered nurse providing sedation is responsible for monitoring the patient during the procedure. Any qualified clinician who administers and monitors deep sedation must be dedicated to that task and different from the individual performing the diagnostic or therapeutic procedure. ASA recommends that those requesting privileges to provide deep sedation must be able to recognize in a timely manner that a patient has entered a state of general anesthesia and be able to maintain a patient's vital functions until appropriate recovery to a desired level of sedation or alertness. Further, it is recommended that the granting, appraisal, and revision of these clinical privileges be awarded on a procedure-specific and time-limited basis that accounts for the type and complexity of the procedures the qualified person may administer in accordance with the rules and regulations of the health care facility, and local, state, and federal governmental agencies. Dental and Oral and maxillofacial surgery When moderate sedation is employed in a dental setting, the dentist anesthesiologist, when simultaneously involved in the conduct of the dental procedure or surgery, must have at least 1 appropriately trained support staff whose responsibility is to monitor appropriate physiological parameters and to assist in any supportive or resuscitation measures, if required. The individual(s) may also be responsible for assisting with interruptible patient-related tasks of short duration. The identity of each dental team member present throughout the administration of minimal and moderate sedation is documented. The team should consist of the surgeon who must be trained and certified in ACLS and one additional person trained in BLS for Healthcare Providers who monitors the patient’s level of sedation. The individual assigned to monitor the patient may only assist with minor, interruptible tasks within the procedure room once the patient’s level of sedation/analgesia and vital signs have stabilized. **Evaluating Compliance:** • Interview staff. • Observe practice.

Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD)	
8-F-12	The anesthesia care plan is based on allergy history. **Interpretive Guidance:** The intent is to ensure the development of a safe individualized anesthesia plan for the patient. The surveyor is not expected to evaluate the practice of anesthesia or make a medical judgment about the anesthesia care plan. Instead, the surveyor is looking for evidence that the plan is based on the elements listed in standards 8F4 – 8F12. **Evaluating Compliance:** • Interview the anesthesia professionals. • Review the pre-anesthesia assessment and anesthesia care plan in the clinical record for related documentation.
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS)	
11-C-9	All individuals, including both directly employed and contract employees, using the facility must meet one of the following criteria: • A doctor of medicine currently certified, previously certified, or eligible for certification by one of the member boards of the American Board of Medical Specialties (ABMS). • A doctor of osteopathy currently certified, previously certified, or eligible for certification by the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS). • A podiatrist currently certified, previously certified, or eligible for certification by the American Board of Foot and Ankle Surgery (ABFAS) or The American Board of Podiatric Medicine (ABPM). • An oral and maxillofacial surgeon currently certified, previously certified, or eligible for certification by the American Board of Oral and Maxillofacial Surgery (ABOMS). • A certified registered nurse anesthetist (CRNA) currently certified or eligible for certification with the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA). • A nurse practitioner (NP) currently certified or eligible for certification with the American Academy of Nurse Practitioners Certification Board (AANPCB) or The American Nurses Credentialing Center Certification (ANCC).

	• A physician assistant (PA) with national certification.
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS)	
11-C-14	Removed; see 11-C-13
Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) International Surgery (I-Surg) & International Dental (I-Dent)	
8-G-1	**Interpretive Guidance:** The intent is to ensure patient safety. A time-out is the surgical team's short pause just before starting an invasive procedure or making the incision to confirm that they are about to perform the correct procedure on the correct body part of the correct patient. The purpose of a systematic and standardized time-out is to refocus on the patient in the OR just before beginning a surgical procedure (i.e., just before the incision). The entire surgical team is encouraged to participate in the time-out. A systematic time-out in the operating room just before the incision has helped prevent wrong site surgeries and other surgical never events. A time-out is the surgical team's short pause, just before incision, to confirm that they are about to perform the correct procedure on the correct body part of the correct patient and the correct implant, if applicable. Correct diagnostic imaging studies are available. The entire surgical team is encouraged to participate in the time-out process. Patient involvement in the time-out process is preferred, when possible, has been introduced to increase compliance. A time-out can be performed easily, does not require any specific qualification or educational courses, can be repeated as many times as necessary, and costs nothing. Its mean duration has been measured to be 36 seconds, leaving no room for excuses for its omission, with the argument that it is time-consuming. Team member introductions help to promote team spirit during operation. Finally, pre-OR time-outs have been shown to significantly increase the rate of on-time first surgical starts.

	A time-out and a pre-operative checklist are two (2) different processes. However, a time-out can be addressed in a pre-operative checklist. A pre-operative checklist may be completed prior to the patient's transfer to the OR. A time-out occurs immediately before the start of the procedure. The entire surgical team participates in the time-out. **Evaluating Compliance:** • Interview staff. • Review clinical records for related documentation. • Review policy and procedure. • Is corrective action taken when a discrepancy is identified? • Observe a time-out being performed by staff. ASC Quality Collaboration – Prevention of Wrong Site Surgery Toolkit https://ascquality.org/toolkits/wrong-site-surgery/ WHO Safety Checklist Tool https://cdn.who.int/media/docs/default-source/patient-safety/safe-surgery/starter_kit-sssl.pdf?sfvrsn=9cef94b8_7 WHO Surgical Safety Checklist https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-surgery/tool-and-resources
Rural Health Clinics (RHC)	
5-A-1	**Interpretive Guidance:** The intent is to have all necessary equipment together in one place and immediately available to manage an emergency in the ~~OR or PACU~~ facility at all times a patient is in the facility. For procedural/surgical facilities, this also means that if a contract anesthesia provider brings any emergency medications or equipment into the facility and removes any of these items when leaving the facility, the contract anesthesia provider must remain in the facility until all patients have been discharged from the PACU. RHCs may consider conducting a risk assessment to assist in determining the additional emergency equipment required for their clinic based on the population served in addition to the required AED. **Evaluating Compliance:** • Inspect the emergency cart to ensure that it is equipped with the required working equipment, medications, and other CPR equipment. • Interview staff regarding the emergency cart/equipment location and contents. • Review risk assessment, if applicable.

TECHNICAL CORRECTION CHANGE REPORT

Effective: June 16, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgery Center (ASC) Office-Based Procedure (OBP) Office-Based Surgery (OBS) Oral Maxillofacial Surgery (OMS) Pediatric Dentistry (PD) International Surgery (I-Surg) & International Dental (I-Dent)	
1-F-2	For each surgeon/proceduralist operating in the facility, the random sample of cases must include the first case performed by such surgeon/proceduralist each month during the reporting period. The facility must submit into the online Patient Safety Data Reporting portal a minimum of three (3) cases, or all cases performed by surgeons who have performed fewer than three (3) in the respective period, every three (3) months. If a surgeon/proceduralist performed fewer than three (3) cases, an exemption form must be submitted. **Interpretive Guidance:** The intent is to ensure patient safety through PSDR reporting. When a surgeon/proceduralist has performed fewer than three (3) cases during the reporting period, complete the **Patient Safety Data Reporting Exemption Form. Before submitting this document,** make sure to submit all cases online (www.quada.org). **Evaluating Compliance:** • Ask the facility to log in to the PSDR system and open previous periods to demonstrate compliance or refer to printed confirmations of PSDR reporting. • If there is any question about whether the facility has submitted the required cases, please call the QUAD A office at 224.643.7704. • Review quality improvement program, peer review, and leadership meeting minutes to verify that the first case performed by each surgeon/proceduralist each month is included in the peer review process.
1-F-3	All adverse events that occur within thirty (30) days of any procedure are submitted contemporaneously with the facility learning of the occurrence of such adverse events to the online Patient Safety Data Reporting (PSDR) portal.

	Interpretive Guidance: The intent of this standard is to ensure that the details of adverse events that occur within thirty (30) days of the procedure are reported to QUAD A within the required timeframes so that the circumstances may be reviewed and investigated when necessary. Adverse events must be reported to QUAD A irrespective of the perceived nature or cause. Adverse events must be defined in facility policy and procedures. At a minimum, include those adverse events addressed in Sub-Section E: QUAD A Mandated Reporting and Sub-Section F: Patient Safety Data Reporting and any other adverse events determined by the facility are included, along with severity guidance. **Evaluating Compliance:** • Interview the Quality Coordinator to determine the facility's process to document, investigate and report adverse events • Review Quality data and Governing Body meeting minutes for evidence of adverse events in the past twelve (12) months. Compare cases noted in the facility's documentation to those reported to QUAD A • Review the facility's adverse event documentation and request the facility to provide evidence that the adverse events were reported via the PSDR system. • Ask the facility to log in to the PSDR system and open previous periods to demonstrate compliance. • If there is any question about whether the facility has submitted the required cases, please call the QUAD A office at 224.643.770. • Review quality improvement program, peer review, and leadership meeting minutes to verify that adverse events are included in the peer review process.
10-B-6	The facility has a written quality improvement program that includes documentation of Peer Review meetings for the prior three (3) years, which must be available for the surveyor. Facilities with a monthly case volume of 50 or fewer cases must conduct peer review meetings no less than twice per year. Facilities with a monthly case volume in excess of 50 cases must conduct peer review meetings no less than quarterly. ~~The minimum sample size is 10% of the average monthly case volume reviewed quarterly.~~
10-D-4	Peer review and the associated peer review meetings ~~should~~ include, at a minimum, the same random cases and adverse events submitted to the Patient Safety Data Reporting since the preceding peer review meeting. **Interpretive Guidance:** The intent is to ensure that the minimum elements of peer review are addressed. Peer review and Patient Safety Data Reporting are two (2) separate and independent processes. At a minimum, Peer Review must be conducted on the first case each month performed by each surgeon/proceduralist, as required by QUAD A standard 1-F-2, **and** on all reportable adverse events, as required by QUAD A standard 1-F-3. The facility must define in its policies and procedures which cases, outside the minimum random cases and reported adverse events, Peer Review must be conducted. **Evaluating Compliance:** • Interview staff. • Review peer review documents to determine if all required elements are included. • Review Patient Safety Data Reporting. • Review quality improvement program, peer review, and leadership meeting minutes.

TECHNICAL CORRECTION CHANGE REPORT
Effective: June 9, 2025

Ambulatory Surgery Center (ASC)	
4-C-14 **Applicability now includes Class B in addition to Class C**	The operating room is equipped with an end tidal carbon dioxide monitor with an audible alarm to indicate values outside the normal range which is used on all moderate sedation, deep sedation, and general anesthesia cases. **Interpretive Guidance:** The intent is to ensure adequate ventilation of the patient receiving moderate and deep sedation and general anesthesia cases. End-tidal carbon dioxide (ETco2) monitoring provides valuable information about CO2 production and clearance (ventilation). Also called capnometry or capnography, this noninvasive technique provides a breath-by-breath analysis and a continuous recording of ventilatory status. It is commonly called the “ventilation vital sign.” During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment. **Evaluating Compliance:** • Observe the operating room. Is there an end-tidal carbon dioxide monitor? Does it have an audible alarm to indicate values outside the range? • Interview staff. Is it used on all moderate and deep sedation, and general anesthesia cases? • Review clinical records to validate end-tidal monitoring on all moderate and deep sedation, and general anesthesia cases?
5-C-1	No longer applicable. Fire Drills for ASC are addressed in Life Safety Code K712 – Fire Drills
6-C-2	Intravenous blood and blood products must be administered only by physicians, anesthesia professionals, or registered nurses.
8-B-6	The pre-operative clinical record includes a medical evaluation when warranted by the patient's medical history and/or procedure to be performed or is required by the facility policy.
9-B-1	The facility must provide the local hospital with written notice of its operations and patient population served upon opening and at least every 24 months.

11-C-5	**Medical/Nursing Students:** Students are not licensed and may not perform ~~or assist in~~ procedures independently. ~~Their role is observational only.~~ If a student is doing a rotation as part of a medical/nursing school program, the facility must have a written agreement with the school that includes detailed information as to what the student may or may not do in the facility under the direct supervision of a licensed credential provider (i.e. physician, registered nurse, etc.). Depending upon this, facilities may need to include the role of the student in the written informed consent~~. along with a signed BAA~~. There must be a signed BAA between the medical/nursing school and the facility~~. agreement must address the student's observational role at the facility. If part of a medical/nursing school program, the student does not need to sign a BAA.~~ If ~~a~~ the student is ~~in the facility~~ not part of a medical/nursing school clinical rotation (i.e. job shadow), their role is observational only. The facility should consider having this type of student sign a facility confidentiality statement. Minimally, the facility conducts primary source verification of education and training. Facilities should consult with their risk manager for further guidance related to any type of student educational experience conducted in the facility.
Office-Based Procedure (OBP)	
4-C-14 **Applicability now includes Class B in addition to Class C**	The operating room is equipped with an end tidal carbon dioxide monitor with an audible alarm to indicate values outside the normal range which is used on all moderate sedation, deep sedation, and general anesthesia cases. **Interpretive Guidance:** The intent is to ensure adequate ventilation of the patient receiving moderate and deep sedation and general anesthesia cases. End-tidal carbon dioxide (ETco2) monitoring provides valuable information about CO2 production and clearance (ventilation). Also called capnometry or capnography, this noninvasive technique provides a breath-by-breath analysis and a continuous recording of ventilatory status. It is commonly called the "ventilation vital sign." During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment. **Evaluating Compliance:** • Observe the operating room. Is there an end-tidal carbon dioxide monitor? Does it have an audible alarm to indicate values outside the range?

	• Interview staff. Is it used on all moderate and deep sedation, and general anesthesia cases? • Review clinical records to validate end-tidal monitoring on all moderate and deep sedation, and general anesthesia cases?
8-B-6	The pre-operative clinical record includes a medical evaluation when warranted by the patient's medical history and/or procedure to be performed or is required by the facility policy.
11-C-5	**Interpretive Guidance** (Medical Nursing Student section): **Medical/Nursing Students:** Students are not licensed and may not perform ~~or assist in~~ procedures independently. ~~Their role is observational only.~~ If a student is doing a rotation as part of a medical/nursing school program, the facility must have a written agreement with the school that includes detailed information as to what the student may or may not do in the facility under the direct supervision of a licensed credential provider (i.e. physician, registered nurse, etc.). Depending upon this, facilities may need to include the role of the student in the written informed consent~~. along with a signed BAA~~. There must be a signed BAA between the medical/nursing school and the facility~~. agreement must address the student's observational role at the facility. If part of a medical/nursing school program, the student does not need to sign a BAA.~~ If ~~a~~ the student is ~~in the facility~~ not part of a medical/nursing school clinical rotation (i.e. job shadow), their role is observational only. The facility should consider having this type of student sign a facility confidentiality statement. Minimally, the facility conducts primary source verification of education and training. Facilities should consult with their risk manager for further guidance related to any type of student educational experience conducted in the facility.
Office-Based Surgery (OBS)	
4-C-14 **Applicability now includes Class B in addition to Class C**	The operating room is equipped with an end tidal carbon dioxide monitor with an audible alarm to indicate values outside the normal range which is used on all moderate sedation, deep sedation, and general anesthesia cases. **Interpretive Guidance:** The intent is to ensure adequate ventilation of the patient receiving moderate and deep sedation and general anesthesia cases. End-tidal carbon dioxide (ETco2) monitoring provides valuable information about CO2 production and clearance (ventilation). Also called capnometry or capnography, this noninvasive technique provides a breath-by-breath analysis and a continuous recording of ventilatory status. It is commonly called the "ventilation vital sign."

	During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment. **Evaluating Compliance:** • Observe the operating room. Is there an end-tidal carbon dioxide monitor? Does it have an audible alarm to indicate values outside the range? • Interview staff. Is it used on all moderate and deep sedation, and general anesthesia cases? • Review clinical records to validate end-tidal monitoring on all moderate and deep sedation, and general anesthesia cases?
6-A-6	Medications are stored in a secured area away from patient and visitor access.
8-B-6	The pre-operative clinical record includes a medical evaluation when warranted by the patient's medical history and/or procedure to be performed or is required by the facility policy.
11-C-5	**Interpretive Guidance** (Medical Nursing Student section): **Medical/Nursing Students:** Students are not licensed and may not perform ~~or assist in~~ procedures independently. ~~Their role is observational only.~~ If a student is doing a rotation as part of a medical/nursing school program, the facility must have a written agreement with the school that includes detailed information as to what the student may or may not do in the facility under the direct supervision of a licensed credential provider (i.e. physician, registered nurse, etc.). Depending upon this, facilities may need to include the role of the student in the written informed consent~~. along with a signed BAA~~. There must be a signed BAA between the medical/nursing school and the facility~~. agreement must address the student's observational role at the facility. If part of a medical/nursing school program, the student does not need to sign a BAA.~~ If ~~a~~ the student is ~~in the facility~~ not part of a medical/nursing school clinical rotation (i.e. job shadow), their role is observational only. The facility should consider having this type of student sign a facility confidentiality statement. Minimally, the facility conducts primary source verification of education and training. Facilities should consult with their risk manager for further guidance related to any type of student educational experience conducted in the facility.

Oral Maxillofacial Surgery (OMS)	
8-B-6	The pre-operative clinical record includes a medical evaluation when warranted by the patient's medical history and/or procedure to be performed or is required by the facility policy.
11-C-5	**Interpretive Guidance** (Medical Nursing Student section): **Medical/Nursing Students:** Students are not licensed and may not perform ~~or assist in~~ procedures independently. ~~Their role is observational only.~~ If a student is doing a rotation as part of a medical/nursing school program, the facility must have a written agreement with the school that includes detailed information as to what the student may or may not do in the facility under the direct supervision of a licensed credential provider (i.e. physician, registered nurse, etc.). Depending upon this, facilities may need to include the role of the student in the written informed consent~~. along with a signed BAA~~. There must be a signed BAA between the medical/nursing school and the facility~~. agreement must address the student's observational role at the facility. If part of a medical/nursing school program, the student does not need to sign a BAA.~~ If ~~a~~ the student is ~~in the facility~~ not part of a medical/nursing school clinical rotation (i.e. job shadow), their role is observational only. The facility should consider having this type of student sign a facility confidentiality statement. Minimally, the facility conducts primary source verification of education and training. Facilities should consult with their risk manager for further guidance related to any type of student educational experience conducted in the facility.
Pediatric Dentistry	
4-C-14 **Applicability now includes Class B in addition to Class C**	The operating room is equipped with an end tidal carbon dioxide monitor with an audible alarm to indicate values outside the normal range which is used on all moderate sedation, deep sedation, and general anesthesia cases. **Interpretive Guidance:** The intent is to ensure adequate ventilation of the patient receiving moderate and deep sedation and general anesthesia cases. End-tidal carbon dioxide (ETco2) monitoring provides valuable information about CO2 production and clearance (ventilation). Also called capnometry or capnography, this noninvasive technique provides a breath-by-breath analysis and a continuous recording of ventilatory status. It is commonly called the "ventilation vital sign."

	During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment. **Evaluating Compliance:** • Observe the operating room. Is there an end-tidal carbon dioxide monitor? Does it have an audible alarm to indicate values outside the range? • Interview staff. Is it used on all moderate and deep sedation, and general anesthesia cases? • Review clinical records to validate end-tidal monitoring on all moderate and deep sedation, and general anesthesia cases?
8-B-6	The pre-operative clinical record includes a medical evaluation when warranted by the patient's medical history and/or procedure to be performed or is required by the facility policy.
11-C-5	**Interpretive Guidance** (Medical Nursing Student section): **Medical/Nursing Students:** Students are not licensed and may not perform ~~or assist in~~ procedures independently. ~~Their role is observational only.~~ If a student is doing a rotation as part of a medical/nursing school program, the facility must have a written agreement with the school that includes detailed information as to what the student may or may not do in the facility under the direct supervision of a licensed credential provider (i.e. physician, registered nurse, etc.). Depending upon this, facilities may need to include the role of the student in the written informed consent~~. along with a signed BAA~~. There must be a signed BAA between the medical/nursing school and the facility~~. agreement must address the student's observational role at the facility. If part of a medical/nursing school program, the student does not need to sign a BAA.~~ If ~~a~~ the student is ~~in the facility~~ not part of a medical/nursing school clinical rotation (i.e. job shadow), their role is observational only. The facility should consider having this type of student sign a facility confidentiality statement. Minimally, the facility conducts primary source verification of education and training. Facilities should consult with their risk manager for further guidance related to any type of student educational experience conducted in the facility.

RHC	
8-A-6 **8-A-8** **8-A-9** **8-A-10** **8-B-1**	No longer applicable.
OPT	
8-A-6 **8-A-8** **8-A-10** **8-B-1**	No longer applicable.
International Surgery & International Dental	
4-C-14 **Applicability now includes Class B in addition to Class C**	The operating room is equipped with an end tidal carbon dioxide monitor with an audible alarm to indicate values outside the normal range which is used on all moderate sedation, deep sedation, and general anesthesia cases. **Interpretive Guidance:** The intent is to ensure adequate ventilation of the patient receiving moderate and deep sedation and general anesthesia cases. End-tidal carbon dioxide (ETco2) monitoring provides valuable information about CO2 production and clearance (ventilation). Also called capnometry or capnography, this noninvasive technique provides a breath-by-breath analysis and a continuous recording of ventilatory status. It is commonly called the “ventilation vital sign.” During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment. **Evaluating Compliance:** • Observe the operating room. Is there an end-tidal carbon dioxide monitor? Does it have an audible alarm to indicate values outside the range? • Interview staff. Is it used on all moderate and deep sedation, and general anesthesia cases? • Review clinical records to validate end-tidal monitoring on all moderate and deep sedation, and general anesthesia cases?

TECHNICAL CORRECTION CHANGE REPORT
Effective: June 2, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgical Center (ASC)	
1-C-5	No more than **5000 cc's** of aspirate may be removed while performing liposuction in a Class B or C facility~~. unless the patient is monitored overnight within the facility. The more stringent requirement applies if state law differs.~~ **Interpretive Guidance:** The intent is a safety measure to minimize the risks of fluid shifts, cardiovascular issues, and other complications that can arise from large-volume liposuction in an outpatient setting. ~~If more than 5000cc of aspirate is removed during liposuction, the patient must be properly monitored overnight in the facility.~~ This standard does not allow for the use of a "recovery hotel" for observation. This 5,000 ccs includes the total amount of aspirate removed including fat and any fluid removed during the procedure. **Evaluating Compliance:** Interview facility staff to determine whether there have been any cases of liposuction in which more than 5000 cc of aspirate have been removed. Review the clinical record for documentation of the amount of aspirate removed. ~~and documentation of appropriate overnight monitoring, if applicable.~~ Include at least one (1) liposuction case in the clinical record sample to be reviewed
11-H-8	(missing in the manual) Each personnel record contains date of employment.
11-C-14	(missing in the manual) Pain management procedures in the facility are performed only by a board certified or a board eligible anesthesiologist, and/or an appropriately credentialed oral and maxillofacial surgeon for head and neck pain management.

Office-Based Procedural (OBP)	
1-C-5	No more than **5000 cc's** of aspirate may be removed while performing liposuction in a Class B or C facility~~. unless the patient is monitored overnight within the facility. The more stringent requirement applies if state law differs.~~ **Interpretive Guidance:** The intent is a safety measure to minimize the risks of fluid shifts, cardiovascular issues, and other complications that can arise from large-volume liposuction in an outpatient setting. ~~If more than 5000cc of aspirate is removed during liposuction, the patient must be properly monitored overnight in the facility.~~ This standard does not allow for the use of a "recovery hotel" for observation. This 5,000 ccs includes the total amount of aspirate removed including fat and any fluid removed during the procedure. **Evaluating Compliance:** Interview facility staff to determine whether there have been any cases of liposuction in which more than 5000 cc of aspirate have been removed. Review the clinical record for documentation of the amount of aspirate removed. ~~and documentation of appropriate overnight monitoring, if applicable.~~ Include at least one (1) liposuction case in the clinical record sample to be reviewed
8-L-6	(missing in the manual) An operative log must include the surgeon/proceduralist's name.
11-C-14	(missing in the manual) Pain management procedures in the facility are performed only by a board certified or a board eligible anesthesiologist, and/or an appropriately credentialed oral and maxillofacial surgeon for head and neck pain management.
Office-Based Surgery (OBS)	
1-C-5	No more than **5000 cc's** of aspirate may be removed while performing liposuction in a Class B or C facility~~. unless the patient is monitored overnight within the facility. The more stringent requirement applies if state law differs.~~ **Interpretive Guidance:** The intent is a safety measure to minimize the risks of fluid shifts, cardiovascular issues, and other complications that can arise from large-volume liposuction in an outpatient setting. ~~If more than 5000cc of aspirate is removed during liposuction, the patient must be properly monitored overnight in the facility.~~ This standard does not allow for the use of a "recovery hotel" for observation. This 5,000 ccs includes the total amount of aspirate removed including fat and any fluid removed during the procedure.

	Evaluating Compliance: Interview facility staff to determine whether there have been any cases of liposuction in which more than 5000 cc of aspirate have been removed. Review the clinical record for documentation of the amount of aspirate removed. ~~and documentation of appropriate overnight monitoring, if applicable.~~ Include at least one (1) liposuction case in the clinical record sample to be reviewed.
11-C-14	(missing in the manual) Pain management procedures in the facility are performed only by a board certified or a board eligible anesthesiologist, and/or an appropriately credentialed oral and maxillofacial surgeon for head and neck pain management.
Oral Maxillofacial Surgery (OMS)	
7-F-6	(missing in the manual) Instrument handling and reprocessing areas are cleaned and maintained.
11-C-13	(missing in the manual) Practitioners of Pain Management must meet all of the following criteria: • Have an M.D. or D.O. degree • Appropriate fellowship training in pain management • Possess ABMS Board certification in one of the following specialties: Anesthesiology, Physical Medicine and Rehabilitation (PM&R), Psychiatry/Neurology • Possess a sub-specialty certification from the American Board of Anesthesiology or the AOABOS CRNAs, as permitted by state law, who have completed a one year academic pain fellowship accredited by the Council on Accreditation for Nurse Anesthesia Educational Programs and possess a subspecialty (non-surgical) board certification from the National Board for Certification and Recertification of Nurse Anesthetists.
Pediatric Dentistry	
11-B-3	(missing in the manual) The Medical Director and Facility Director must be a provider currently licensed by the state in which the facility is located.

RHC	
5-D-33	(missing in the manual) The training program must demonstrate staff knowledge of emergency procedures.
International Surgery & International Dental	
1-C-5	No more than **5000 cc's** of aspirate may be removed while performing liposuction in a Class B or C facility~~. unless the patient is monitored overnight within the facility. The more stringent requirement applies if state law differs.~~ **Interpretive Guidance:** The intent is a safety measure to minimize the risks of fluid shifts, cardiovascular issues, and other complications that can arise from large-volume liposuction in an outpatient setting. ~~If more than 5000cc of aspirate is removed during liposuction, the patient must be properly monitored overnight in the facility.~~ This standard does not allow for the use of a "recovery hotel" for observation. This 5,000 ccs includes the total amount of aspirate removed including fat and any fluid removed during the procedure. **Evaluating Compliance:** Interview facility staff to determine whether there have been any cases of liposuction in which more than 5000 cc of aspirate have been removed. Review the clinical record for documentation of the amount of aspirate removed. ~~and documentation of appropriate overnight monitoring, if applicable.~~ Include at least one (1) liposuction case in the clinical record sample to be reviewed

TECHNICAL CORRECTION CHANGE REPORT
Effective: May 27, 2025

Legend: **Red** = New change

~~**Strikeout**~~ = Language Removed/No longer applies

Ambulatory Surgical Center (ASC)	
4-E-8	Nitrous oxide**/**oxygen delivery safety system checks: Annual documented checks of ambient nitrous oxide levels should be less than 25 ppm, according to NIOSH. The facility's policies and procedures document these system checks and address who is qualified to perform them, their frequency, the method of testing, and the action to be taken if the nitrous oxide levels are greater than 25 ppm in accordance with the manufacturer's instructions for use. Note: this standard applies only to standalone systems.
6-E-4	The following medication must be available in the facility at all times as required by the current ACLS/PALS algorithm: Adenosine Epinephrine (1:10,000 solution, 1 mg per 10 ml) Anti-Hypertensives Lidocaine (2% plain) Atropine Nitroglycerin (sublingual tablets or spray) Narcan Intravenous corticosteroids (e.g., dexamethasone) Amiodarone
Office-Based Procedural (OBP)	
4-E-8	Nitrous oxide**/**oxygen delivery safety system checks: Annual documented checks of ambient nitrous oxide levels should be less than 25 ppm according to NIOSH. The facility's policies and procedures document these system checks and address who is qualified to perform them, their frequency, the method of testing, and the action to be taken if the nitrous oxide levels are greater than 25 ppm in accordance with the manufacturer's instructions for use. Note: this standard applies only to standalone systems.

6-E-4	The following medication must be available in the facility at all times as required by the current ACLS/PALS algorithm: Adenosine Epinephrine (1:10,000 solution, 1 mg per 10 ml) Anti-Hypertensives Lidocaine (2% plain) Atropine Nitroglycerin (sublingual tablets or spray) Narcan Intravenous corticosteroids (e.g., dexamethasone) Amiodarone
Office-Based Surgery (OBS)	
4-E-8	Nitrous oxide**/**oxygen delivery safety system checks: Annual documented checks of ambient nitrous oxide levels should be less than 25 ppm according to NIOSH. The facility's policies and procedures document these system checks and address who is qualified to perform them, their frequency, the method of testing, and the action to be taken if the nitrous oxide levels are greater than 25 ppm in accordance with the manufacturer's instructions for use. Note: this standard applies only to standalone systems.
6-E-4	The following medication must be available in the facility at all times as required by the current ACLS/PALS algorithm: Adenosine Epinephrine (1:10,000 solution, 1 mg per 10 ml) Anti-Hypertensives Lidocaine (2% plain) Atropine Nitroglycerin (sublingual tablets or spray) Narcan Intravenous corticosteroids (e.g., dexamethasone) Amiodarone
Oral Maxillofacial Surgery (OMS)	
4-E-8	Nitrous oxide**/**oxygen delivery safety system checks: Annual documented checks of ambient nitrous oxide levels should be less than 25 ppm according to NIOSH. The facility's policies and procedures document these system checks and address who is qualified to perform them, their frequency, the method of testing, and the action to be taken if the nitrous oxide levels are greater than 25 ppm in accordance with the manufacturer's instructions for use. Note: this standard applies only to standalone systems.

6-E-4	The following medication must be available in the facility at all times as required by the current ACLS/PALS algorithm: Adenosine Epinephrine (1:10,000 solution, 1 mg per 10 ml) Anti-Hypertensives Lidocaine (2% plain) Atropine Nitroglycerin (sublingual tablets or spray) Narcan Intravenous corticosteroids (e.g., dexamethasone) Amiodarone
Pediatric Dentistry	
4-E-8	Nitrous oxide/oxygen delivery safety system checks: Annual documented checks of ambient nitrous oxide levels should be less than 25 ppm according to NIOSH. The facility's policies and procedures document these system checks and address who is qualified to perform them, their frequency, the method of testing, and the action to be taken if the nitrous oxide levels are greater than 25 ppm in accordance with the manufacturer's instructions for use. Note: this standard applies only to standalone systems.
6-E-4	The following medication must be available in the facility at all times as required by the current ACLS/PALS algorithm: Adenosine Epinephrine (1:10,000 solution, 1 mg per 10 ml) Anti-Hypertensives Lidocaine (2% plain) Atropine Nitroglycerin (sublingual tablets or spray) Narcan Intravenous corticosteroids (e.g., dexamethasone) Amiodarone

Anesthesia Class Requirements

1. Class A (Facility must meet every Class "A" requirement)**:**

All surgical and procedural cases are performed in the facility under local, topical anesthesia, minimal sedation, or nitrous oxide using a standalone system for administration.
NOTE: Endotracheal tubes and supraglottic airways are permitted in the facility for emergency use only.

Local or Topical Anesthesia may be administered by any of the following:

- Surgeon/Proceduralist
- Physician Anesthesiologist
- Dental Anesthesiologist
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA) under the supervision of an anesthesiologist
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Registered Nurse (RN) under the direct supervision of a credentialed physician as permitted by state law.

Nitrous Oxide may be administered using a Nitrous-Oxide Delivery System with required safety features by a credentialed:

- Surgeon/Proceduralist
- Physician Anesthesiologist
- Pediatric Dentist
- Dental Anesthesiologist
- Oral and Maxillofacial Surgeon (OMS)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Anesthesiologist Assistant (CAA)
- Dental Assistant under the supervision of a Pediatric Dentist or Dental Anesthesiologist in accordance with State law.
- Registered Nurse, Nurse Practitioner, or Physician Assistant under the direct supervision of a credentialed physician as permitted by state law.

Clarifications:

- All cases performed in a Class A facility must be performed using local anesthesia with minimal sedation only. A Class A facility is not permitted to perform any cases with moderate sedation.
- No more than 500cc of liposuction aspirate may be removed.
- A single dose of analgesic or minimal sedation (anxiolytic) drug may be administered preoperatively, which results in minimal sedation, and one (1) dose of the same medication may be administered postoperatively. Any additional doses or agents are considered Moderate Sedation, requiring the facility to be accredited under Class B or C standards. This includes doses taken by patients prior to arriving at the facility.
- The use of propofol, spinal anesthesia, epidural anesthesia, endotracheal intubation anesthesia, laryngeal mask airway anesthesia, and/or inhalation general anesthesia (excluding nitrous oxide) is prohibited.
- Nitrous oxide and minimal sedation are not permitted to be administered together in a Class A facility; they are only permitted in Class B and C facilities.
- If a facility performs procedures by administering oral medications (e.g., Valium) and~~/or~~ performing nerve blocks (inter scalene, supraclavicular, femoral, etc.) or field blocks (e.g., retrobulbar, digital, Bier, etc.), this practice is considered Class B. The use of field or nerve blocks is **not** permitted in facilities accredited under facility Class A accreditation standards. Digital blocks are permitted in Class A.

TECHNICAL CORRECTION CHANGE REPORT
Effective: May 19, 2025

Ambulatory Surgical Center (ASC)	
2-C-3	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards. **Interpretive Guidance:** Temperature, humidity, and airflow in ORs must be maintained within acceptable industry standards to inhibit microbial growth, reduce risk of infection, reduce the risk of fire, control odor, and promote patient and staff comfort. ~~Logs should be maintained to show temperature/humidity readings are regularly monitored. Records should describe the facility's corrective actions when they fall outside of acceptable ranges.~~ ~~**Minimum industry standards:**~~ ~~Humidity maintained between 20%-60% (ASHRE, standard 170), Ventilation:15-20 air exchanges per hour (FGI), and Temperature 68-75 F (AORN).~~ **Evaluating Compliance:** • Review facility policy. • ~~Review temperature, humidity and ventilation logs to ensure appropriate parameters are maintained.~~ • ~~If documented readings are not within parameters, interview staff on what interventions were implemented to address low or high measurements.~~ • ~~Review reports of air exchanges and confirm air exchanges are compliant.~~
7-A-10	The interpretive guidance has been updated to the following: The intent is to minimize the risk of infection. The appropriate use of surgical attire is essential to preventing the transmission of pathogens and protecting staff. The goal of using the proper surgical attire is to reduce microbial contamination throughout the continuum of care in the surgical suite to prevent surgical site infections. The proper surgical attire should be worn in the semi-restricted and restricted areas of the facility. ~~Surgical practitioners working in the operating room include the following attire for the purpose of self-protection: disposable surgical caps; scrub trousers and tops; jackets; disposable shoe covers; surgical clogs or shoes; and surgical masks. Personal protective equipment (PPE), which protects staff from cross-infection or cross-contamination, includes gowns, gloves, masks, aprons, eye protection and disposable, fluid-resistant shoe covers. Facility policies and procedures usually identify the need to wear PPE during surgical procedures, and~~

	~~so normally certain items of PPE would always be used during surgical cases. All surgical practitioners working in the operating room have the authority and responsibility to monitor proper surgical attire compliance in case staff do not wear the correct attire or PPE. Any issues that arise must be corrected immediately.~~ ~~Wearing scrub attire that is laundered at a healthcare–accredited laundry facility or at the facility in accordance with state regulatory requirements and nationally recognized guidelines and standards of care provides control of the laundering process and helps ensure that effective laundering standards have been met.~~ ~~Home laundering of surgical attire is not acceptable. Home laundering is not monitored for quality, consistency, or safety. Home washing machines may not have the adjustable parameters or controls required to achieve the necessary thermal measures (eg, water temperature); mechanical measures (eg, agitation); or chemical measures (eg, capacity for additives to neutralize the alkalinity of the water, soap, or detergent) to reduce microbial levels in soiled scrub attire.~~ ~~Scrubs worn outside the facility may not be used in the operating/procedure room.~~ ~~Scrub attire should be removed before leaving the facility. Changing out of scrub attire into street clothes when leaving the building reduces the potential for healthcare workers to transport pathogenic microorganisms from the facility or healthcare organization into the home or community~~ **Evaluating Compliance:** • Review the facility's surgical attire policies and procedures. ~~Are they consistent with nationally recognized guidelines and standards of practice?~~ ~~• If surgical attire is laundered in-house, is laundering consistent with nationally recognized guidelines and standards of care?~~ ~~• Interview staff regarding surgical attire practices.~~ ~~• Observe clinical practice to determine if surgical attire is used in accordance with the facility's policies and procedures.~~ ~~• Are scrubs worn outside the facility also used in the operating/procedure room?~~
11-H-8	This standard was inadvertently omitted from the ASC manual. Each personnel record contains date of employment.
Office-Based Procedural (OBP)	
2-C-3	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards. **Interpretive Guidance:** Temperature, humidity, and airflow in ORs must be maintained within acceptable industry standards to inhibit microbial growth, reduce risk of infection, reduce the risk of fire, control odor, and promote patient and staff comfort. ~~Logs should be maintained to show temperature/humidity readings are regularly monitored. Records~~

	~~should describe the facility's corrective actions when they fall outside of acceptable ranges.~~ ~~**Minimum industry standards:**~~ ~~Humidity maintained between 20%-60% (ASHRE, standard 170), Ventilation:15-20 air exchanges per hour (FGI), and Temperature 68-75 F (AORN).~~ **Evaluating Compliance:** • Review facility policy. • ~~Review temperature, humidity and ventilation logs to ensure appropriate parameters are maintained.~~ • ~~If documented readings are not within parameters, interview staff on what interventions were implemented to address low or high measurements.~~ • ~~Review reports of air exchanges and confirm air exchanges are compliant.~~
6-A-1	No longer applies due to scoring issues. A new standard, 6-A-8, has been created with the same standard language.
6-A-8	The facility must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services. **Interpretive Guidance:** Medication errors are the most reported type of medical error. They are preventable events that can result in serious patient harm (e.g., disability, death) and occur during any phase of the medication-use process (i.e., from procuring the medication to monitoring the patient after administration). Adherence to national standards of practice is critical.
7-A-10	The interpretive guidance has been updated to the following: The intent is to minimize the risk of infection. The appropriate use of surgical attire is essential to preventing the transmission of pathogens and protecting staff. The goal of using the proper surgical attire is to reduce microbial contamination throughout the continuum of care in the surgical suite to prevent surgical site infections. The proper surgical attire should be worn in the semi-restricted and restricted areas of the facility. ~~Surgical practitioners working in the operating room include the following attire for the purpose of self-protection: disposable surgical caps; scrub trousers and tops; jackets; disposable shoe covers; surgical clogs or shoes; and surgical masks. Personal protective equipment (PPE), which protects staff from cross-infection or cross-contamination, includes gowns, gloves, masks, aprons, eye protection and disposable, fluid-resistant shoe covers. Facility policies and procedures usually identify the need to wear PPE during surgical procedures, and so normally certain items of PPE would always be used during surgical cases. All surgical practitioners working in the operating room have the authority and responsibility to monitor proper surgical attire compliance in case staff do not wear the correct attire or PPE. Any issues that arise must be corrected immediately.~~

	~~Wearing scrub attire that is laundered at a healthcare–accredited laundry facility or at the facility in accordance with state regulatory requirements and nationally recognized guidelines and standards of care provides control of the laundering process and helps ensure that effective laundering standards have been met.~~ ~~Home laundering of surgical attire is not acceptable. Home laundering is not monitored for quality, consistency, or safety. Home washing machines may not have the adjustable parameters or controls required to achieve the necessary thermal measures (eg, water temperature); mechanical measures (eg, agitation); or chemical measures (eg, capacity for additives to neutralize the alkalinity of the water, soap, or detergent) to reduce microbial levels in soiled scrub attire.~~ ~~Scrubs worn outside the facility may not be used in the operating/procedure room.~~ ~~Scrub attire should be removed before leaving the facility. Changing out of scrub attire into street clothes when leaving the building reduces the potential for healthcare workers to transport pathogenic microorganisms from the facility or healthcare organization into the home or community~~ **Evaluating Compliance:** • Review the facility's surgical attire policies and procedures. ~~Are they consistent with nationally recognized guidelines and standards of practice?~~ • ~~If surgical attire is laundered in-house, is laundering consistent with nationally recognized guidelines and standards of care?~~ • ~~Interview staff regarding surgical attire practices.~~ • ~~Observe clinical practice to determine if surgical attire is used in accordance with the facility's policies and procedures.~~ • ~~Are scrubs worn outside the facility also used in the operating/procedure room?~~
Office-Based Surgery (OBS)	
1-B-1	No longer applies due to scoring issues. A new standard, 1-B-10, has been created with the same standard language.
1-B-10	The facility is in compliance with all state laws including state licensure requirements. **Interpretive Guidance:** This standard's intent is that facilities are aware of all state laws and that there is evidence of compliance. **Evaluating Compliance:** • Interview staff to determine knowledge of state laws. • Review personnel files to evaluate compliance.
2-C-3	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards.

	Interpretive Guidance: Temperature, humidity, and airflow in ORs must be maintained within acceptable industry standards to inhibit microbial growth, reduce risk of infection, reduce the risk of fire, control odor, and promote patient and staff comfort. ~~Logs should be maintained to show temperature/humidity readings are regularly monitored. Records should describe the facility's corrective actions when they fall outside of acceptable ranges.~~ ~~**Minimum industry standards:**~~ ~~Humidity maintained between 20%-60% (ASHRE, standard 170), Ventilation:15-20 air exchanges per hour (FGI), and Temperature 68-75 F (AORN).~~ **Evaluating Compliance:** • Review facility policy. ~~• Review temperature, humidity and ventilation logs to ensure appropriate parameters are maintained.~~ ~~• If documented readings are not within parameters, interview staff on what interventions were implemented to address low or high measurements.~~ ~~• Review reports of air exchanges and confirm air exchanges are compliant.~~
6-A-1	No longer applies due to scoring issues. A new standard, 6-A-8, has been created with the same standard language.
6-A-8	The facility must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services. **Interpretive Guidance:** Medication errors are the most reported type of medical error. They are preventable events that can result in serious patient harm (e.g., disability, death) and occur during any phase of the medication-use process (i.e., from procuring the medication to monitoring the patient after administration). Adherence to national standards of practice is critical.
7-A-10	The interpretive guidance has been updated to the following: The intent is to minimize the risk of infection. The appropriate use of surgical attire is essential to preventing the transmission of pathogens and protecting staff. The goal of using the proper surgical attire is to reduce microbial contamination throughout the continuum of care in the surgical suite to prevent surgical site infections. The proper surgical attire should be worn in the semi-restricted and restricted areas of the facility. ~~Surgical practitioners working in the operating room include the following attire for the purpose of self-protection: disposable surgical caps; scrub trousers and tops; jackets; disposable shoe covers; surgical clogs or shoes; and surgical masks. Personal protective equipment (PPE), which protects staff from cross-infection or cross-contamination, includes gowns, gloves, masks, aprons, eye protection and disposable, fluid-resistant shoe covers. Facility policies and procedures usually identify the need to wear PPE during surgical procedures, and so normally certain items of PPE would always be used during surgical cases. All surgical practitioners working~~

	~~in the operating room have the authority and responsibility to monitor proper surgical attire compliance in case staff do not wear the correct attire or PPE. Any issues that arise must be corrected immediately.~~ ~~Wearing scrub attire that is laundered at a healthcare–accredited laundry facility or at the facility in accordance with state regulatory requirements and nationally recognized guidelines and standards of care provides control of the laundering process and helps ensure that effective laundering standards have been met.~~ ~~Home laundering of surgical attire is not acceptable. Home laundering is not monitored for quality, consistency, or safety. Home washing machines may not have the adjustable parameters or controls required to achieve the necessary thermal measures (eg, water temperature); mechanical measures (eg, agitation); or chemical measures (eg, capacity for additives to neutralize the alkalinity of the water, soap, or detergent) to reduce microbial levels in soiled scrub attire.~~ ~~Scrubs worn outside the facility may not be used in the operating/procedure room.~~ ~~Scrub attire should be removed before leaving the facility. Changing out of scrub attire into street clothes when leaving the building reduces the potential for healthcare workers to transport pathogenic microorganisms from the facility or healthcare organization into the home or community~~ **Evaluating Compliance:** • Review the facility's surgical attire policies and procedures. ~~Are they consistent with nationally recognized guidelines and standards of practice?~~ • ~~If surgical attire is laundered in-house, is laundering consistent with nationally recognized guidelines and standards of care?~~ • ~~Interview staff regarding surgical attire practices.~~ • ~~Observe clinical practice to determine if surgical attire is used in accordance with the facility's policies and procedures.~~ • ~~Are scrubs worn outside the facility also used in the operating/procedure room?~~
Oral Maxillofacial Surgery (OMS)	
1-B-1	No longer applies due to scoring issues. A new standard, 1-B-10, has been created with the same standard language.
1-B-10	The facility is in compliance with all state laws including state licensure requirements. **Interpretive Guidance:** This standard's intent is that facilities are aware of all state laws and that there is evidence of compliance. **Evaluating Compliance:** • Interview staff to determine knowledge of state laws. • Review personnel files to evaluate compliance.

2-C-3	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards. **Interpretive Guidance:** Temperature, humidity, and airflow in ORs must be maintained within acceptable industry standards to inhibit microbial growth, reduce risk of infection, reduce the risk of fire, control odor, and promote patient and staff comfort. ~~Logs should be maintained to show temperature/humidity readings are regularly monitored. Records should describe the facility's corrective actions when they fall outside of acceptable ranges.~~ ~~**Minimum industry standards:**~~ ~~Humidity maintained between 20%-60% (ASHRE, standard 170), Ventilation:15-20 air exchanges per hour (FGI), and Temperature 68-75 F (AORN).~~ **Evaluating Compliance:** •Review facility policy. ~~•Review temperature, humidity and ventilation logs to ensure appropriate parameters are maintained.~~ ~~•If documented readings are not within parameters, interview staff on what interventions were implemented to address low or high measurements.~~ ~~•Review reports of air exchanges and confirm air exchanges are compliant.~~
6-A-1	No longer applies due to scoring issues. A new standard, 6-A-8, has been created with the same standard language.
6-A-8	The facility must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services. **Interpretive Guidance:** Medication errors are the most reported type of medical error. They are preventable events that can result in serious patient harm (e.g., disability, death) and occur during any phase of the medication-use process (i.e., from procuring the medication to monitoring the patient after administration). Adherence to national standards of practice is critical.
7-A-10	The interpretive guidance has been updated to the following: The intent is to minimize the risk of infection. The appropriate use of surgical attire is essential to preventing the transmission of pathogens and protecting staff. The goal of using the proper surgical attire is to reduce microbial contamination throughout the continuum of care in the surgical suite to prevent surgical site infections. The proper surgical attire should be worn in the semi-restricted and restricted areas of the facility. ~~Surgical practitioners working in the operating room include the following attire for the purpose of self-protection: disposable surgical caps; scrub trousers and tops; jackets; disposable shoe covers; surgical clogs or shoes; and surgical masks. Personal protective equipment (PPE), which protects staff from cross-infection or cross-~~

	~~contamination, includes gowns, gloves, masks, aprons, eye protection and disposable, fluid-resistant shoe covers. Facility policies and procedures usually identify the need to wear PPE during surgical procedures, and so normally certain items of PPE would always be used during surgical cases. All surgical practitioners working in the operating room have the authority and responsibility to monitor proper surgical attire compliance in case staff do not wear the correct attire or PPE. Any issues that arise must be corrected immediately.~~ ~~Wearing scrub attire that is laundered at a healthcare–accredited laundry facility or at the facility in accordance with state regulatory requirements and nationally recognized guidelines and standards of care provides control of the laundering process and helps ensure that effective laundering standards have been met.~~ ~~Home laundering of surgical attire is not acceptable. Home laundering is not monitored for quality, consistency, or safety. Home washing machines may not have the adjustable parameters or controls required to achieve the necessary thermal measures (eg, water temperature); mechanical measures (eg, agitation); or chemical measures (eg, capacity for additives to neutralize the alkalinity of the water, soap, or detergent) to reduce microbial levels in soiled scrub attire.~~ ~~Scrubs worn outside the facility may not be used in the operating/procedure room.~~ ~~Scrub attire should be removed before leaving the facility. Changing out of scrub attire into street clothes when leaving the building reduces the potential for healthcare workers to transport pathogenic microorganisms from the facility or healthcare organization into the home or community~~ **Evaluating Compliance:** • Review the facility's surgical attire policies and procedures. ~~Are they consistent with nationally recognized guidelines and standards of practice?~~ • ~~If surgical attire is laundered in-house, is laundering consistent with nationally recognized guidelines and standards of care?~~ • ~~Interview staff regarding surgical attire practices.~~ • ~~Observe clinical practice to determine if surgical attire is used in accordance with the facility's policies and procedures.~~ • ~~Are scrubs worn outside the facility also used in the operating/procedure room?~~
Pediatric Dentistry	
1-B-1	No longer applies due to scoring issues. A new standard, 1-B-10, has been created with the same standard language.
1-B-10	The facility is in compliance with all state laws including state licensure requirements. **Interpretive Guidance:** This standard's intent is that facilities are aware of all state laws and that there is evidence of compliance.

	Evaluating Compliance: • Interview staff to determine knowledge of state laws. • Review personnel files to evaluate compliance.
6-A-1	No longer applies due to scoring issues. A new standard, 6-A-8, has been created with the same standard language.
6-A-8	The facility must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services. **Interpretive Guidance:** Medication errors are the most reported type of medical error. They are preventable events that can result in serious patient harm (e.g., disability, death) and occur during any phase of the medication-use process (i.e., from procuring the medication to monitoring the patient after administration). Adherence to national standards of practice is critical.
2-C-3	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards. **Interpretive Guidance:** Temperature, humidity, and airflow in ORs must be maintained within acceptable industry standards to inhibit microbial growth, reduce risk of infection, reduce the risk of fire, control odor, and promote patient and staff comfort. ~~Logs should be maintained to show temperature/humidity readings are regularly monitored. Records should describe the facility's corrective actions when they fall outside of acceptable ranges.~~ ~~**Minimum industry standards:**~~ ~~Humidity maintained between 20%-60% (ASHRE, standard 170), Ventilation:15-20 air exchanges per hour (FGI), and Temperature 68-75 F (AORN).~~ **Evaluating Compliance:** • Review facility policy. • ~~Review temperature, humidity and ventilation logs to ensure appropriate parameters are maintained.~~ • ~~If documented readings are not within parameters, interview staff on what interventions were implemented to address low or high measurements.~~ • ~~Review reports of air exchanges and confirm air exchanges are compliant.~~
7-A-10	The interpretive guidance has been updated to the following: The intent is to minimize the risk of infection. The appropriate use of surgical attire is essential to preventing the transmission of pathogens and protecting staff. The goal of using the proper surgical attire is to reduce microbial contamination throughout the continuum

	of care in the surgical suite to prevent surgical site infections. The proper surgical attire should be worn in the semi-restricted and restricted areas of the facility. ~~Surgical practitioners working in the operating room include the following attire for the purpose of self-protection: disposable surgical caps; scrub trousers and tops; jackets; disposable shoe covers; surgical clogs or shoes; and surgical masks. Personal protective equipment (PPE), which protects staff from cross-infection or cross-contamination, includes gowns, gloves, masks, aprons, eye protection and disposable, fluid-resistant shoe covers. Facility policies and procedures usually identify the need to wear PPE during surgical procedures, and so normally certain items of PPE would always be used during surgical cases. All surgical practitioners working in the operating room have the authority and responsibility to monitor proper surgical attire compliance in case staff do not wear the correct attire or PPE. Any issues that arise must be corrected immediately.~~ ~~Wearing scrub attire that is laundered at a healthcare–accredited laundry facility or at the facility in accordance with state regulatory requirements and nationally recognized guidelines and standards of care provides control of the laundering process and helps ensure that effective laundering standards have been met.~~ ~~Home laundering of surgical attire is not acceptable. Home laundering is not monitored for quality, consistency, or safety. Home washing machines may not have the adjustable parameters or controls required to achieve the necessary thermal measures (eg, water temperature); mechanical measures (eg, agitation); or chemical measures (eg, capacity for additives to neutralize the alkalinity of the water, soap, or detergent) to reduce microbial levels in soiled scrub attire.~~ ~~Scrubs worn outside the facility may not be used in the operating/procedure room.~~ ~~Scrub attire should be removed before leaving the facility. Changing out of scrub attire into street clothes when leaving the building reduces the potential for healthcare workers to transport pathogenic microorganisms from the facility or healthcare organization into the home or community~~ **Evaluating Compliance:** • Review the facility's surgical attire policies and procedures. ~~Are they consistent with nationally recognized guidelines and standards of practice?~~ ~~• If surgical attire is laundered in-house, is laundering consistent with nationally recognized guidelines and standards of care?~~ ~~• Interview staff regarding surgical attire practices.~~ ~~• Observe clinical practice to determine if surgical attire is used in accordance with the facility's policies and procedures.~~ • ~~Are scrubs worn outside the facility also used in the operating/procedure room?~~
International Surgery (I-Surg) & International Dentistry (I-Dent)	
2-C-3	Each operating room is ventilated, temperature and humidity controlled. The facility policy defines parameters based on patient population, procedure, and monitoring frequency in accordance with industry standards.

	Interpretive Guidance: Temperature, humidity, and airflow in ORs must be maintained within acceptable industry standards to inhibit microbial growth, reduce risk of infection, reduce the risk of fire, control odor, and promote patient and staff comfort. ~~Logs should be maintained to show temperature/humidity readings are regularly monitored. Records should describe the facility's corrective actions when they fall outside of acceptable ranges.~~ ~~**Minimum industry standards:**~~ ~~Humidity maintained between 20%-60% (ASHRE, standard 170), Ventilation:15-20 air exchanges per hour (FGI), and Temperature 68-75 F (AORN).~~ **Evaluating Compliance:** • Review facility policy. ~~• Review temperature, humidity and ventilation logs to ensure appropriate parameters are maintained.~~ ~~• If documented readings are not within parameters, interview staff on what interventions were implemented to address low or high measurements.~~ ~~• Review reports of air exchanges and confirm air exchanges are compliant.~~
6-A-1	No longer applies due to scoring issues. A new standard, 6-A-8, has been created with the same standard language.
6-A-8	The facility must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services. **Interpretive Guidance:** Medication errors are the most reported type of medical error. They are preventable events that can result in serious patient harm (e.g., disability, death) and occur during any phase of the medication-use process (i.e., from procuring the medication to monitoring the patient after administration). Adherence to national standards of practice is critical.
7-A-10	The interpretive guidance has been updated to the following: The intent is to minimize the risk of infection. The appropriate use of surgical attire is essential to preventing the transmission of pathogens and protecting staff. The goal of using the proper surgical attire is to reduce microbial contamination throughout the continuum of care in the surgical suite to prevent surgical site infections. The proper surgical attire should be worn in the semi-restricted and restricted areas of the facility. ~~Surgical practitioners working in the operating room include the following attire for the purpose of self-protection: disposable surgical caps; scrub trousers and tops; jackets; disposable shoe covers; surgical clogs or shoes; and surgical masks. Personal protective equipment (PPE), which protects staff from cross-infection or cross-contamination, includes gowns, gloves, masks, aprons, eye protection and disposable, fluid-resistant shoe covers. Facility policies and procedures usually identify the need to wear PPE during surgical procedures, and~~

	~~so normally certain items of PPE would always be used during surgical cases. All surgical practitioners working in the operating room have the authority and responsibility to monitor proper surgical attire compliance in case staff do not wear the correct attire or PPE. Any issues that arise must be corrected immediately.~~ ~~Wearing scrub attire that is laundered at a healthcare–accredited laundry facility or at the facility in accordance with state regulatory requirements and nationally recognized guidelines and standards of care provides control of the laundering process and helps ensure that effective laundering standards have been met.~~ ~~Home laundering of surgical attire is not acceptable. Home laundering is not monitored for quality, consistency, or safety. Home washing machines may not have the adjustable parameters or controls required to achieve the necessary thermal measures (eg, water temperature); mechanical measures (eg, agitation); or chemical measures (eg, capacity for additives to neutralize the alkalinity of the water, soap, or detergent) to reduce microbial levels in soiled scrub attire.~~ ~~Scrubs worn outside the facility may not be used in the operating/procedure room.~~ ~~Scrub attire should be removed before leaving the facility. Changing out of scrub attire into street clothes when leaving the building reduces the potential for healthcare workers to transport pathogenic microorganisms from the facility or healthcare organization into the home or community~~ **Evaluating Compliance:** • Review the facility's surgical attire policies and procedures. ~~Are they consistent with nationally recognized guidelines and standards of practice?~~ • ~~If surgical attire is laundered in-house, is laundering consistent with nationally recognized guidelines and standards of care?~~ • ~~Interview staff regarding surgical attire practices.~~ • ~~Observe clinical practice to determine if surgical attire is used in accordance with the facility's policies and procedures.~~ • ~~Are scrubs worn outside the facility also used in the operating/procedure room?~~
10-B-1	No longer applies, due to scoring issues.
Outpatient Physical Therapy (OPT)	
2-B-1	No longer applies, due to scoring issues.
Rural Health Clinic	
2-B-1	No longer applies, due to scoring issues.
6-A-1	No longer applies, due to scoring issues.

Glossary – the below terms and definitions have been added	
Random Sample	An unbiased representation of a group. Example: • For PSDR reporting, QUAD A recommends entering the first case as performed each month to obtain a random sample of cases entered into the quarterly reporting system. If no cases are performed in a given month, any other case can be selected at random from the period
Significant	Having or likely to have influence or effect; or of a noticeably or measurably large amount. Examples: • As determined by both the surgeon/proceduralist and anesthesia provider, the patient and procedural risk must be assessed pre-operatively. If this risk level is above a facility's defined threshold, then the patient should be referred to an alternative, safer facility for the operation. • Current safe levels of ethylene oxide or glutaraldehyde exposure must be identified. Badge testing to maintain exposure under the threshold must be performed and monitored.
Sufficient/sufficiently	Means enough to meet the needs of a situation or a proposed end. E.g., A hallway would be sufficiently wide if healthcare providers can wheel a patient in a gurney and all necessary medical equipment with the gurney in case of emergency. Example: • A hallway would be sufficiently wide if healthcare providers can wheel a patient in a gurney and all necessary medical equipment with the gurney in case of emergency.
Track and Trend	Track, as in keep track of, is to follow specific record(s) or specific types of information over a defined period. To trend means to follow the general movement over time of a statistically detectable change. Tracking and trending are commonly used together which means a trail of data is followed to identify changes in outcomes over time. Examples: • Each facility's written QI program must follow identified records or types of information over a lengthy period of time to identify changes. Based on those changes, or lack thereof, the facility must evaluate and resolve problems, then adjust the identified records or types of information as appropriate. • Each facility's risk management program must perform an annual risk assessment. This assessment should cover risks as related to patients and staff by medication management, fall hazards, infection control, equipment safety, patient risk resulting from long term conditions, and nutrition if any food or beverage services are available to patients. The trends of these risks across the years should be noted. • Adverse events are to be noted and discussed during periodic peer review meetings. • All adverse events should be looked at cumulatively.

TECHNICAL CORRECTION CHANGE REPORT
Effective: April 7, 2025

Anesthesia Class Definitions & Standards Document
Nitrous Oxide (Class A) and Intravenous Sedation, and Oral or Intranasal Sedation may be administered by: Registered Nurse, Nurse Practitioner, or Physician Assistant under the direct supervision of a credentialed physician.
Facilities using total intravenous anesthesia (TIVA) and have no inhalation anesthetics present in the facility are not required to have an anesthesia machine; see standard 4-C-18.

Application of Class A Standards	
The following standards do **not** apply to Class A: • **2-C-2, 2-C-3** • **4-C-9, 4-C-12** • **8-B-24** • **8-C-3** • **8-F-4 through 8-F-11** • **8-H-14, 8-H-15** • **8-J-2, 8-J-9** • **11-I-8**	
2-B-4	Also applies to OBP
2-C-9	Delete; see standard 2-C-3
6-F-7	Delete
7-C-4	Note added: Note: The FDA requirement does not apply to international facilities. International facilities must comply with local, state/provincial or federal/national requirements regarding reprocessing single-use devices.
10-B-6	The minimum sample size is 10% of the average monthly case volume to be reviewed quarterly.
11-C-9	Revised Standard: A nurse practitioner (NP) currently certified or eligible for certification with the American Academy of Nurse Practitioners Certification Board (AANPCB) **or** The American Nurses Credentialling Center Certification (ANCC).
11-C-11	Revised to permit primary source verification and re-credentialing to be performed every three (3) years instead of every two (2) years

11-C-17	Revised to permit primary source verification and re-credentialing to be performed every three (3) years instead of every two (2) years
11-H-10	Revised Standard: Each personnel record contains on-going records of inoculations or refusals in accordance with local, state/provincial or federal/national requirements.
Rural Health Clinics (RHC)	
1-A-1	Does not apply
1-A-2	Does not apply
Anesthesia Classes, do not apply to RHCs	
6-E-5	Added
6-F-9	Does not apply; see standard 14-F-18
6-F-10	Does not apply; see standard 14-F-18
6-F-13	Does not apply; see standard 14-F-18
Outpatient Physical Therapy (OPT)	
15-D-14	Corrected standards language *The rehabilitation agency must establish procedures to be followed by personnel in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.*
8-A-9	Does not apply; see standard 15-J-13

* Various other minor corrections have been made such as typos and punctuation.

The requirements in the current version of the QUAD A standards supersede previous versions, including any interpretive guidance provided in past newsletters and responses to standards-related questions.