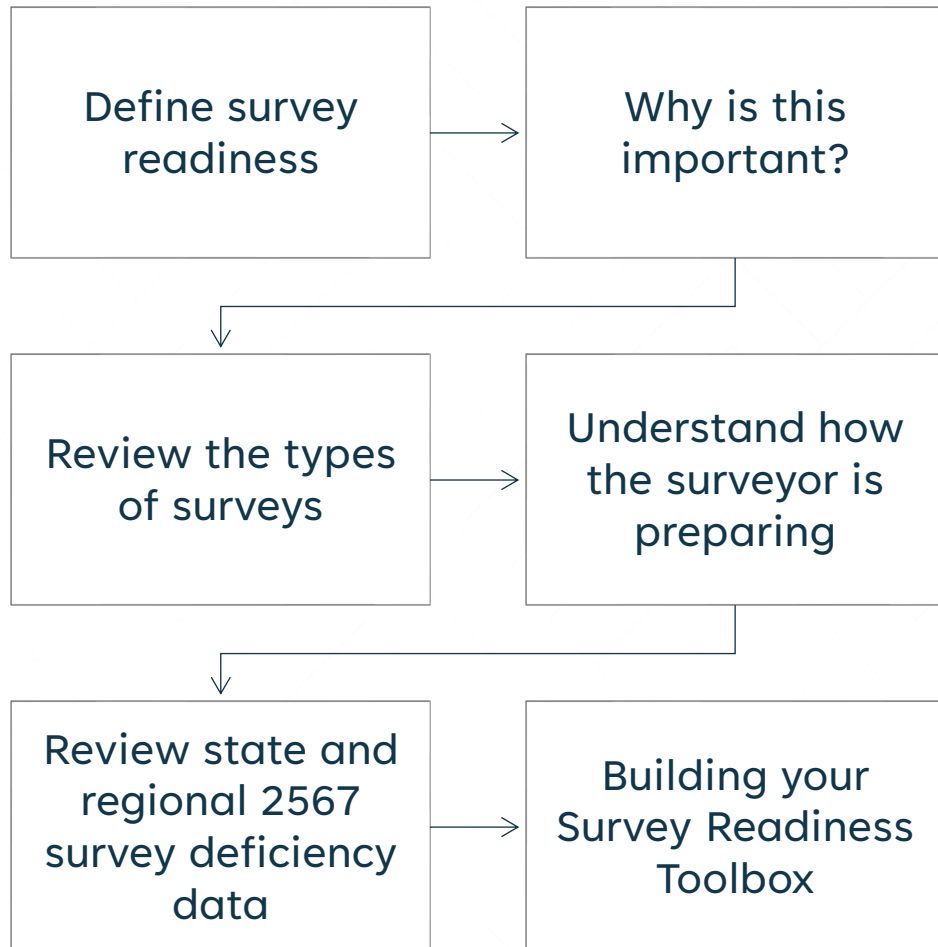




**SURVEY READINESS: REDUCING REGULATORY
RISK AND STRENGTHENING ORGANIZATIONAL
CONFIDENCE**

June 11, 2026

OBJECTIVES FOR TODAY



Survey Readiness: Achieving and maintaining an ongoing “prepared” state in which an organization can confidently ensure compliance with regulatory requirements, patient safety, and quality standards.

POLLING QUESTION #1



WHY IS “READINESS” IMPORTANT?



Health and Safety

- Patients, Caregivers, Staff



Financial Consequences

By the numbers

70.0M

Total Medicare Enrollment

51.0%

Enrolled in MA & Other Health Plans

90.7%

Age 65 and Over

81.1%

With Medicare Part D Coverage

As the U.S. population ages, the number of Medicare beneficiaries is projected to grow by more than one-third, from 68 million in 2024 to more than 93 million in 2060. (KFF, 10-8-2025)

Per [Data.cms.gov](https://data.cms.gov), as of January 2026

Sources: <https://data.cms.gov/tools/medicare-enrollment-dashboard>; <https://www.kff.org/medicare/health-policy-101-medicare/?entry=table-of-contents-who-is-covered-by-medicare>

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READINESS IMPACT ON HEALTH AND SAFETY

Delayed or Inconsistent Care

- Critical processes like timely assessments, medication reconciliation, infection control, and patient monitoring may not be followed properly, leading to worse clinical outcomes.

Increased Risk of Harm:

- Noncompliance with standards increases the likelihood of patient safety events, such as falls, medication errors, hospital-acquired infections, or delayed recognition of clinical deterioration.

Poor Patient Experience:

- Gaps in communication, care coordination, and responsiveness can cause patient dissatisfaction, anxiety, and lower trust in the hospital.

Regulatory Citations & Financial Penalties:

- Survey deficiencies can lead to CMS sanctions, including loss of Medicare/Medicaid funding, fines, or being placed under a systems improvement agreement, all of which divert resources from patient care.

READINESS IMPACT ON HEALTH AND SAFETY, CONT.

Higher Readmission Rates:

- Poor discharge planning and education can lead to patients returning unnecessarily to the hospital, resulting in increased readmissions and poorer long-term health outcomes.

Staff Morale and Turnover:

- Operating in a state of crisis or under corrective actions can cause staff burnout, resentment, and turnover, which further destabilizes patient care.

Reputation Damage:

- Survey findings become public and can negatively impact the hospital's reputation in the community, leading to out-migration of patients to other facilities.

Loss of Accreditation:

- Severe findings can threaten the hospital's accreditation status, further affecting the ability to attract providers, patients, and funding.



TYPES OF CAH SURVEYS



CERTIFICATION
SURVEYS



VALIDATION
SURVEYS



REVISIT
SURVEYS



COMPLAINT
SURVEY



CERTIFICATION SURVEY



Certification surveys include both **initial** certification and **recertification** surveys.



CMS describes: “These surveys determine if a prospective or current participant in Medicare and Medicaid meets all applicable requirements for participation and to evaluate the performance and effectiveness of the participant’s care.”



VALIDATION SURVEY



CMS uses validation surveys to validate the performance of an Accrediting Organization (AO) and to make sure all requirements to participate in Medicare are met.

Currently, there are 4 CMS Approved Accrediting Organizations for CAHs

- Accreditation Commission for Health Care (ACHC)
- The Joint Commission (TJC)
- Center for Improvement in Healthcare Quality (CIHQ)
- Det Norske Veritas- Healthcare (DNV)



CMS selects providers or suppliers for validation surveys on a random basis.



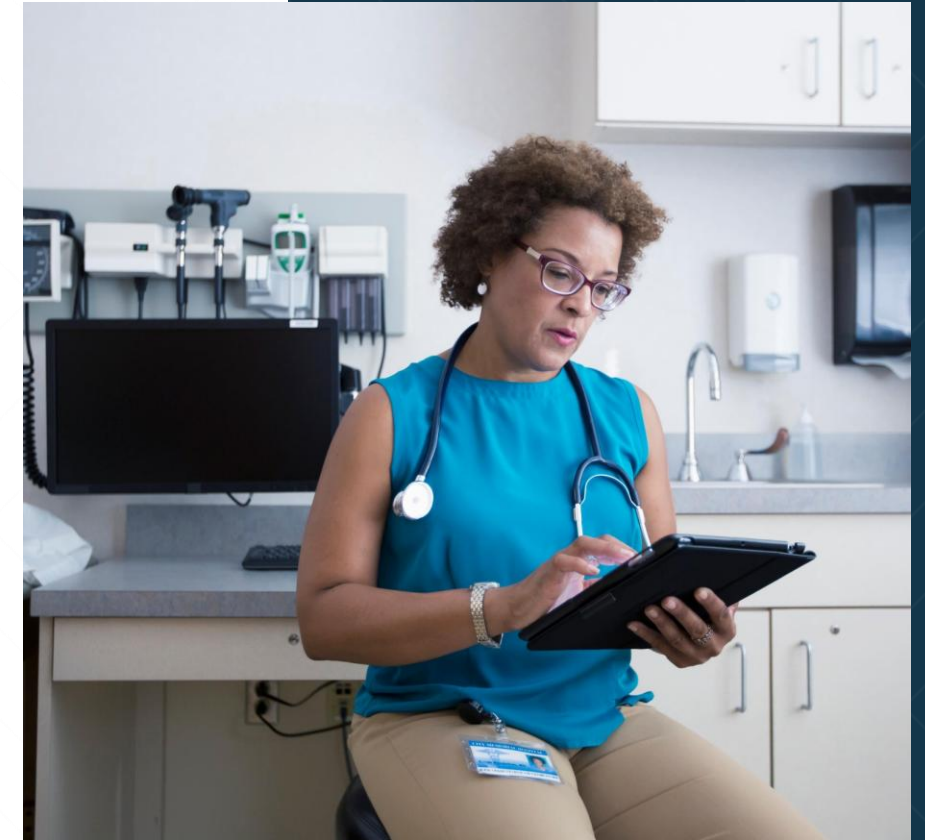
CMS has also put in place measures to strengthen the oversight of AOs.



REVISIT SURVEY

A revisit survey is one in which a survey team re-evaluates a specific deficient area that was cited during a certification survey or a substantiated complaint survey.

The revisit survey verifies that the previously cited deficiencies have been corrected.



COMPLAINT SURVEY

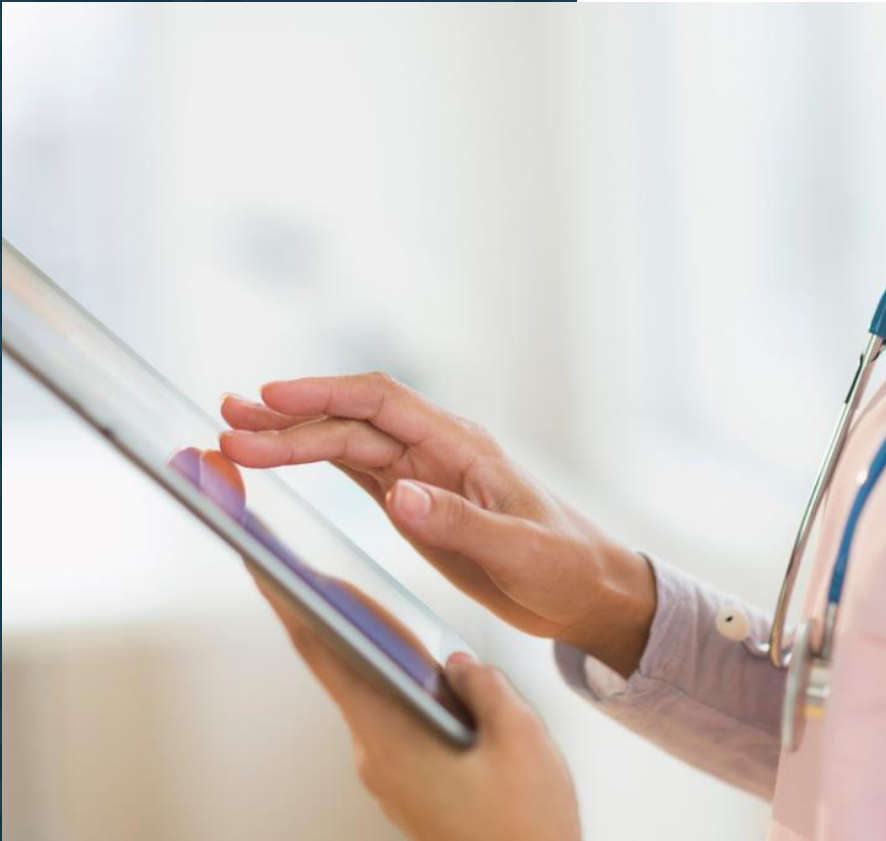
A complaint survey is conducted after a complaint is filed, which is an allegation of noncompliance with Federal or State requirements or both.

A State Survey Agency can conduct complaint investigations, referred to as an SA, by the applicable CMS location, an approved State program or State licensure program, or an Accrediting Organization (AO).

Investigation into a complaint may or may not result in an onsite survey.



FULL SURVEYS



Certification and validation surveys are always **full surveys that assess an entity's compliance with all Conditions of Participation (CoPs)**.

Generally, complaint surveys and revisit surveys are more **focused**; however, they can be expanded if the findings **warrant further** investigation.



HOW DOES THE SURVEYOR PREPARE?

Surveyors review information about your hospital

- Special features
 - Swing beds, psychiatric, rehabilitation DPUs, off-site locations
- Prior application forms
- Previous survey results
 - POC
- Licensure records
- Media reports
 - Facebook
- Organization website

Surveyors prepare for observations, interviews, record review





During a survey, a surveyor notices a damaged blood pressure machine. A brief interview with the nursing staff reveals that the machine malfunctions frequently and has been broken multiple times in the past few months, preventing the staff from using it. One nurse tells the surveyor that staff have submitted numerous requests for it to be fixed, but no one seems to be working on the issue.

<https://qsep.cms.gov/>





At the beginning of a survey, a surveyor reviews the facility's incident log and finds several reports of medication errors related to antibiotics. Two of the errors were not caught in time and caused harm to the patients. While at the facility, the surveyor conducts interviews with the pharmacy staff and with staff who were involved in patient care. During the interviews, the surveyor learns the pharmacy is using a new label and barcode system, but staff claim they were not trained on how to read the new labels before implementation.

<https://qsep.cms.gov/>



STATEMENTS OF DEFICIENCIES (CMS-2567)

Statement of deficiency data is available for Skilled Nursing Facilities, Nursing Facilities, Hospitals & Critical Access Hospitals.

2567 is the number associated with the official document used, “Form CMS-2567, Statement of Deficiencies and Plans of Correction.”

When state survey agencies conduct surveys of acute hospitals, Critical Access Hospitals, and psychiatric hospitals on behalf of CMS, they assess compliance with Medicare health and safety regulations for the hospitals, known as the “Conditions of Participation (CoPs).”

The surveyors prepare their survey report on an electronic version of Form CMS-2567 available in a CMS data system that supports survey work. This system contains the text of the regulations, broken down by surveyors into smaller sections called “tags” to facilitate the work of the surveyors to identify regulatory deficiencies and choose the applicable tag.

The system generates a Form CMS-2567 with the regulatory text associated with that tag, and then surveyors enter a summary of the evidence for the noncompliance they observed. The survey report is released to the hospital, which, depending on the survey findings, may be required to return the Form CMS-2567 with a plan of correction for each area of deficiency.



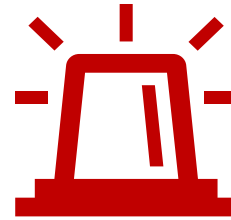
STATEMENTS OF DEFICIENCIES (CMS-2567)



CMS can issue two different types of citations.

A “**standard-level**” deficiency means that the hospital may be out of compliance with one aspect of the regulations, but it is considered less severe than a condition-level deficiency.

The more serious, known as “**condition-level,**” means that a hospital is not in substantial compliance with the CoP.

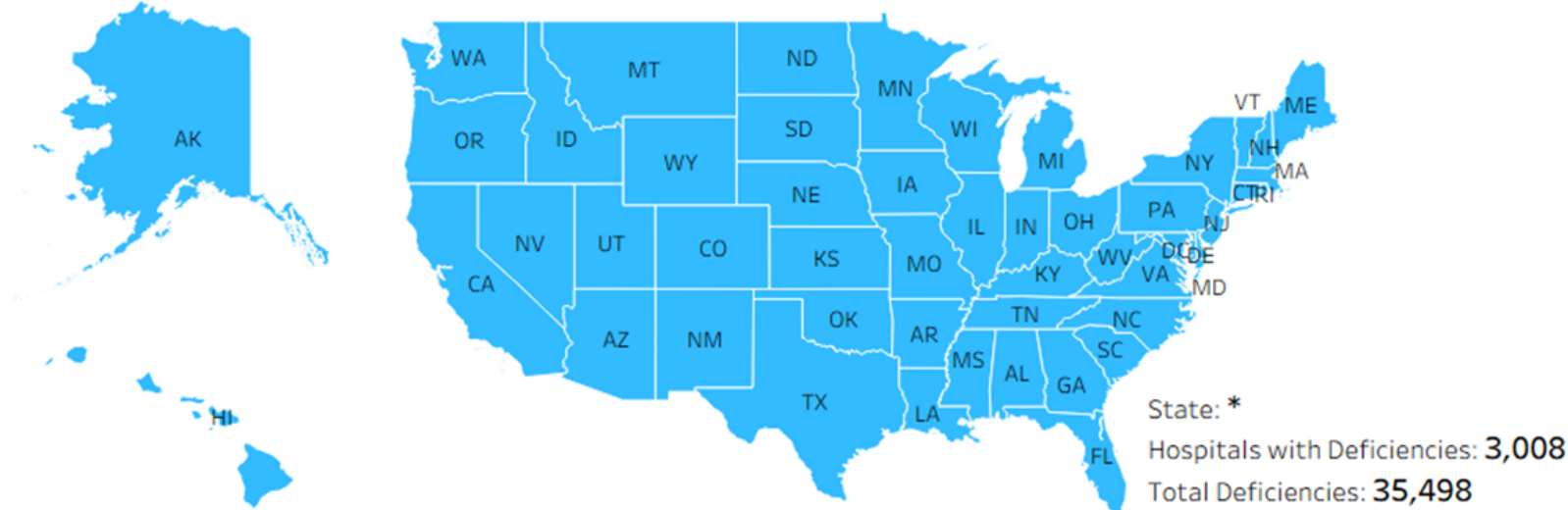


There is an additional level of noncompliance called “**immediate jeopardy**” that arises when surveyors determine that the hospital’s deviation from regulatory standards constitutes an immediate threat to patients’ health and safety.

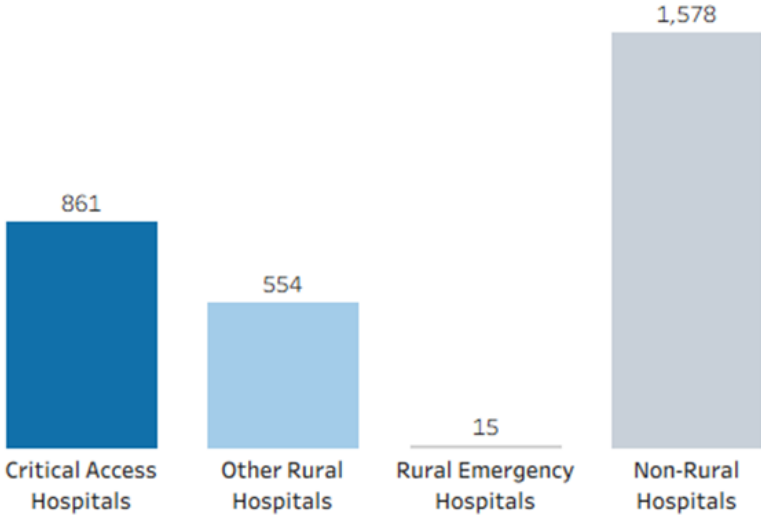
An immediate jeopardy determination forces a hospital to correct the underlying problems quickly. Termination of participation in Medicare and Medicaid can result in a 23-day period if the hospital fails to correct the problems.



Hospital Deficiencies, 1/1/2021 - 05/07/2026



Deficiency Description	Hospitals	Total #
	3,008	35,498
Compliance With 489.24	1,058	1,762
Patient Rights: Restraint Or Seclusion	517	1,685
Medical Screening Exam	961	1,509
Patient Rights: Care In Safe Setting	706	1,327
Patient Rights	663	1,245
Rn Supervision Of Nursing Care	603	1,210
Nursing Services	675	1,173
Supervision Of Contract Staff	402	800
QAPI	345	608
Appropriate Transfer	394	506
Patient Rights: Free From Abuse/Harassment	280	482
Infection Control Program	336	475
Nursing Care Plan	280	470
Administration Of Drugs	294	455
Patient Care Policies	291	443



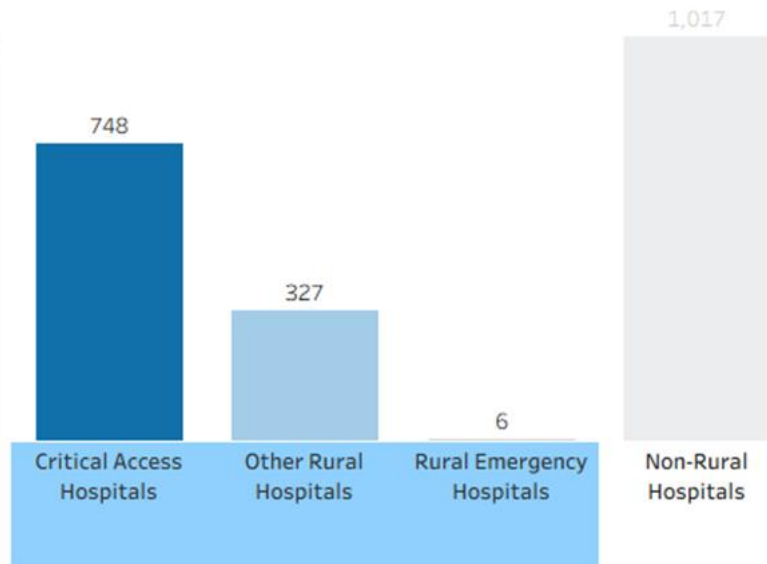
Source: <https://www.cms.gov/files/document/hospital-surveys-2567-statement-deficiencies-through-2025-q2.xlsx>



Hospital Deficiencies, 1/1/2021 - 05/07/2026



Deficiency Description	Hospitals	Total #
	1,430	13,300
Compliance With 489.24	430	534
Medical Screening Exam	383	465
Patient Care Policies	291	443
Sprinkler System - Maintenance And Testing	309	338
Nursing Services	251	333
Electrical Systems - Essential Electric Systems	264	301
QAPI	131	241
Hazardous Areas - Enclosure	221	236
Infection Prevent Surveil & Control Of HAIs	213	227
Subdivision Of Building Spaces - Smoke Barriers	197	224
Fire Drills	201	216
Records System	157	207
Fire Alarm System - Testing And Maintenance	179	194
Appropriate Transfer	168	179
Patient Rights: Restraint Or Seclusion	76	175



- The top 10 Deficiency Descriptions among Critical Access Hospitals, Rural Emergency Hospitals, and other rural acute care hospitals are:

- Compliance With 489.24
- Medical Screening Exam
- Patient Care Policies
- Sprinkler System - Maintenance And Testing
- Nursing Services
- Electrical Systems - Essential Electric Systems
- QAPI
- Hazardous Areas - Enclosure
- Infection Prevent Surveil & Control Of HAIs
- Subdivision Of Building Spaces - Smoke Barriers

Source: <https://www.cms.gov/files/document/hospital-surveys-2567-statement-deficiencies-through-2025-q2.xlsx>



CMS 2567 TOP TEN CAH DEFICIENCIES

	Deficiency Description	Distinct Count of CCN	Total Deficiencies
1	Patient Care Policies	291	443
2	Sprinkler System- Maintenance and Testing	258	275
3	Nursing Services	186	254
4	Compliance with 489.24	210	241
5	Electrical Systems - Essential Electric System	217	240
6	Infection Prevention- Surveillance & Control of HAIs	213	227
7	QAPI	103	208
8	Records System	157	207
9	Medical Screening Exam	189	207
10	Hazardous Areas - Enclosure	193	203

1/1/2021 through 5/7/2026



TAG DESCRIPTIONS

- C-Tags are regulatory citation tags used during surveys to evaluate Critical Access Hospitals (CAHs) against the Medicare Conditions of Participation (CoPs)
- Some CoPs have many tags
- Under Provision of Services, Patient Care Policies has nine tags
 - C-1006
 - C-1008
 - C-1010
 - C-1012
 - C-1014
 - C-1016
 - C-1018
 - C-1020
 - C-1022



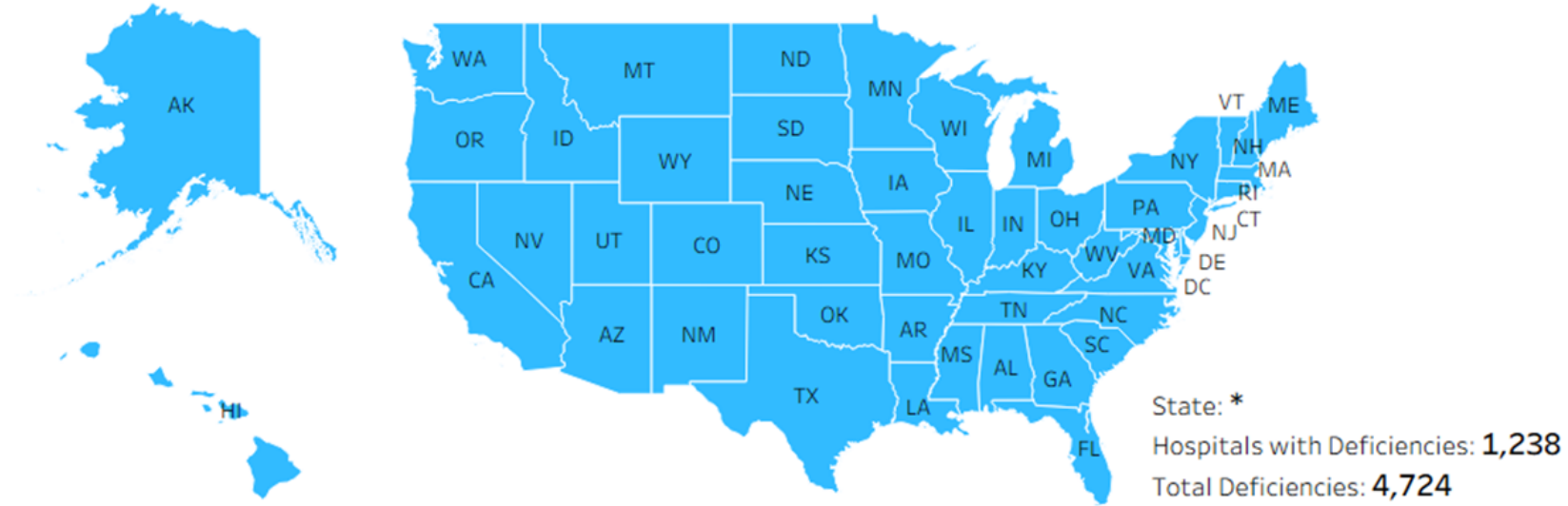
TAG DESCRIPTIONS

C-1006

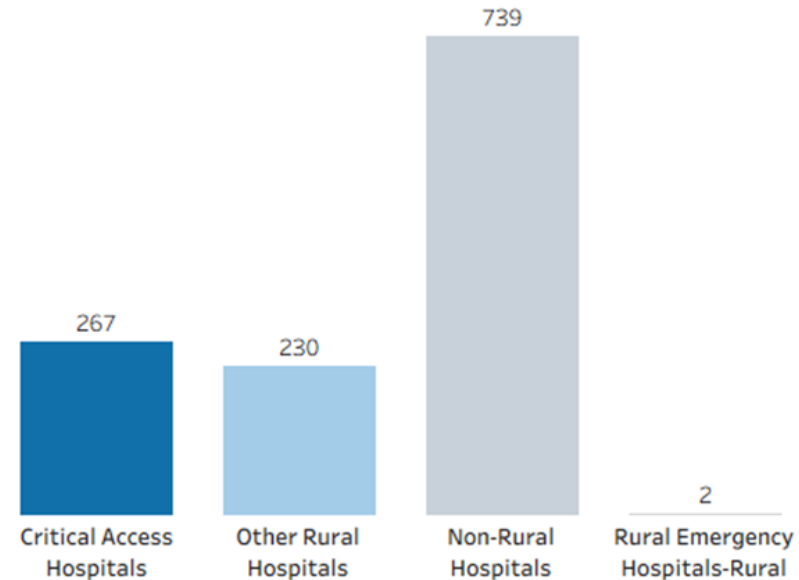
- **§485.635(a) Standard: Patient Care Policies**
 - (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.
- Interpretive Guidelines §485.635(a)(1)
 - The CAH must have written policies governing the health care services the CAH furnishes and these policies must be consistent with applicable State law.
- Surveyors should
 - Verify that the CAH has written policies covering the health care services that are furnished in the CAH.
 - Observe staff delivering health care services to patients. Is the actual provision of services consistent with the CAH's written policies?



EMTALA Hospital Deficiencies, Jan 2021 - Jan 2026



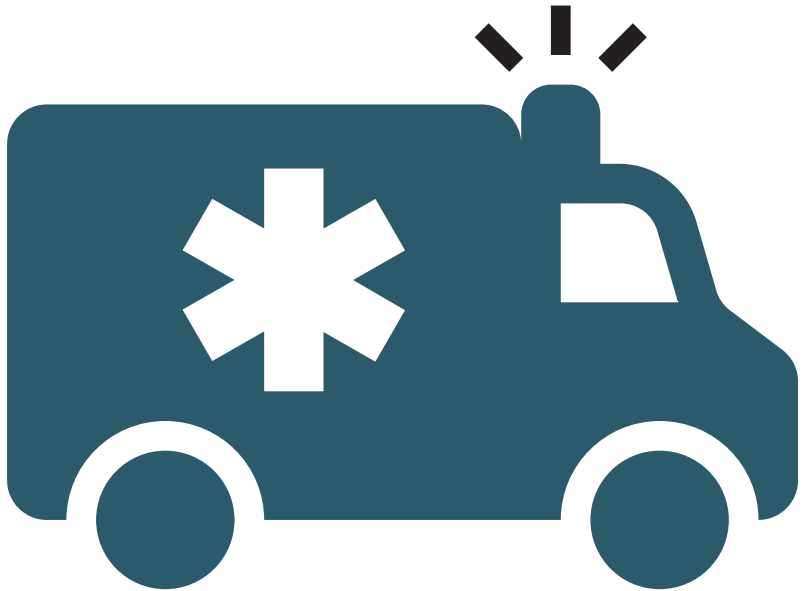
Deficiency Description	Hospitals	Total #
	1,238	4,724
Compliance With 489.24	981	1,587
Medical Screening Exam	901	1,390
Appropriate Transfer	360	450
Stabilizing Treatment	308	411
Emergency Room Log	290	383
Posting Of Signs	189	222
Recipient Hospital Responsibilities	71	100
On Call Physicians	76	96
Delay In Examination Or Treatment	53	62
Hospital Must Maintain Records	11	14
Receiving An Inappropriate Transfer	7	9



Source: <https://www.cms.gov/files/document/emtala-hospital-surveys-only-2567-statement-deficiencies-through-2025-q1.xlsx>



TAG DESCRIPTIONS



A2400/C2400 – Compliance with 489.24

- Special responsibilities of Medicare hospitals in emergency cases: EMTALA
- According to John Berry, Specialist Principal Consultant, CMS at Joint Commission Resources, one of the areas in which healthcare facilities are most often found lacking in a CMS survey is EMTALA.



EMTALA FOOD FOR THOUGHT: EXAMPLE 1



- **Example 1: Refusal to Provide Medical Screening**
 - A patient arrives at the Emergency Department complaining of chest pain. Because the patient appears disheveled and mentions not having insurance, the front desk staff turns the patient away and advises them to visit a free clinic across town.
- **Why this is an EMTALA violation:**
 - Hospitals must provide a medical screening examination (MSE) to any individual who presents to the ED requesting care, regardless of their insurance status or appearance. Denying or delaying an MSE based on assumptions about ability to pay violates EMTALA.



EMTALA FOOD FOR THOUGHT: EXAMPLE 2



- **Example 3: Delaying Care for Registration Purposes**
 - A pregnant woman arrives at the ED in active labor. Instead of immediately taking her back for triage or evaluation, the registration clerk insists on completing all financial paperwork and obtaining insurance information before notifying medical staff or initiating care.
- **Why this is an EMTALA violation:**
 - EMTALA prohibits delaying the medical screening examination or stabilizing treatment to inquire about insurance or payment information.



USE THE DATA

Addressing the top CMS deficiencies in a specific state/region

Provides insights into common areas of non-compliance	Can help you prioritize efforts to address potential organizational compliance gaps	Helps you be proactive and prevent or mitigate these deficiencies before a CMS survey occurs	Tailor training and focus on areas identified as high risk for non-compliance	Develop a targeted action plan to address specific deficiencies and improve overall compliance throughout the hospital
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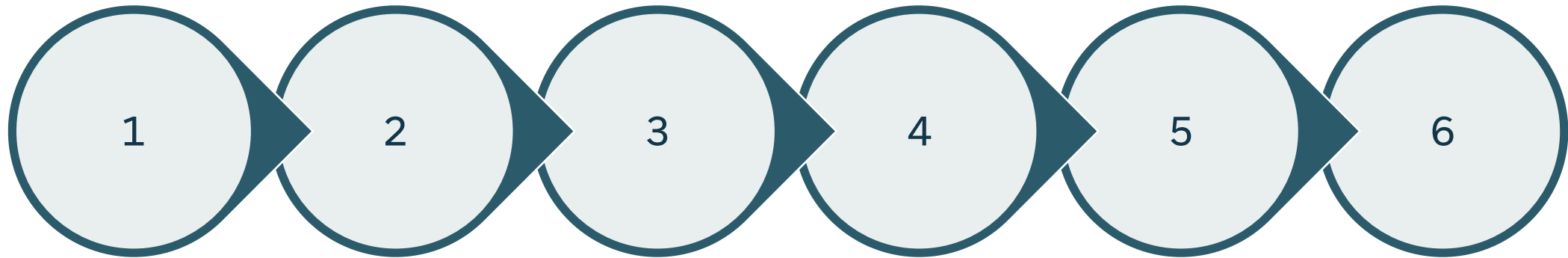
POLLING QUESTION #2





BUILDING YOUR TOOLBOX

SIX KEY TOOLS



- Utilize your past survey plan of correction

- Maintain document checklist and assign owners

- Develop a revolving calendar by month for policy review/revision. Assign owners.

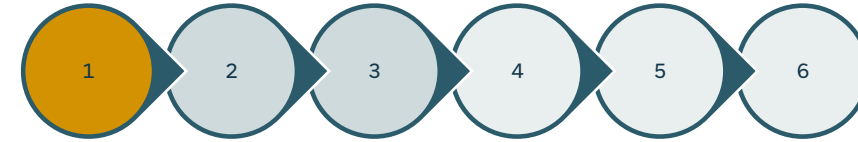
- Conduct internal “Tracers” (Ideally teams are multi-disciplinary)

- Create a “daily checklist” and assign specific areas at the daily huddle

- Design and print a “pocket guide” for staff



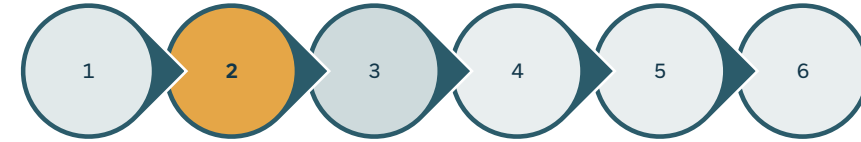
UTILIZE YOUR PAST SURVEY: PLAN OF CORRECTION



- **Regulation: CMS State Operations Manual § 485.635(d)(3)**
 - (1) 485.635(d)(3) All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.
 - This STANDARD is not met as evidenced by:
- **Finding**
 - Based on document review, observation, and interview, the facility did not adhere to the protocol used for administering aerosol-generating treatments (a technique for administering medication into the lungs)
- **Plan of Correction**
 - It was determined that the Nursing staff needs additional education on the proper administration of aerosol therapy
 - To ensure ongoing compliance, we will develop an audit process to assess whether proper elements of performance are being followed during the administration of aerosol therapy. Beginning in December 2022, audits will continue monthly for 6 months, or longer, if needed to achieve 100% compliance for 3 consecutive months.
 - Audit results are being reported to the Chief Nursing Officer



MAINTAIN DOCUMENT CHECKLIST



- **Divide into categories and assign an owner to each one.**
 - **General Organizational Detail**
 - Org chart, etc.
 - Bylaws
 - **Meeting Minutes and Reports**
 - **Plans and Policies**
 - Emergency Management Plan
 - Medication Management Policy
 - **Contracted Services**
 - **Logs**
 - ED Log
 - Incident
 - Grievances
 - Daily Census
 - Staffing Matrix
 - **Measurement Data, KPIs, Analyses**
 - QAPI
 - Scorecards

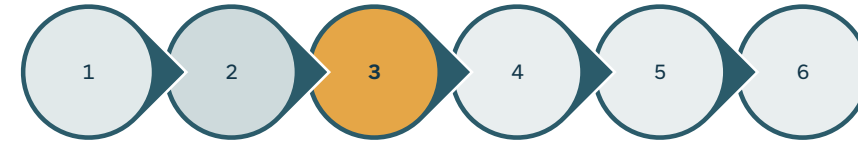
EXAMPLE

Meeting Minutes and Reports

- Med Exec meeting minutes
- P&T
- Board meeting minutes
- Quality Committee Meeting Minutes
- Fire Drill Documentation-Evaluations
- Infection Prevention/Antibiotic Stewardship



DEVELOP REVOLVING CALENDAR FOR POLICY REVIEW/REVISION



- Divide into logical categories/departments and assign an owner to each.
 - Human Resources (Jan.)
 - Environment of Care (Feb.)
 - Information Management (Mar.)
 - Life Safety (Apr.)
 - Medication Management (May)
 - Nursing (June)
 - Provision of Care (July)
 - Patient Rights/Responsibilities (Aug.)
 - Document Management (Sept.)

EXAMPLE

Medication Management (May)

- Acceptable Medication Orders
- Medication Administration Process
- Disposal of Expired Medication
- Wasting of Narcotics

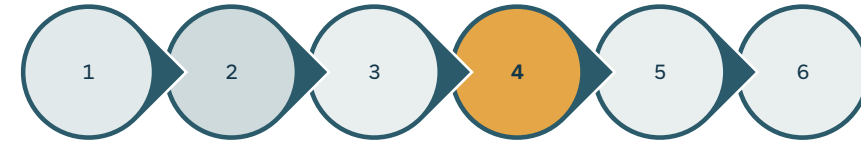
Ensure Review/Revision Date

Appropriate Signatures

Updated References



CONDUCT INTERNAL TRACERS



- **Convene “Tracer” Team**

- *Tracer methodology*—A targeted approach used during hospital surveys to assess compliance with regulatory standards and identify areas for improvement.
- Follow the path of patient care, from admission to discharge, to evaluate the implementation of policies and procedures.
- Provides a comprehensive understanding of how policies are translated into practice.
- Identifies potential gaps in compliance and patient safety.
- Promotes staff engagement and accountability.
- Offers actionable insights for quality improvement initiatives.

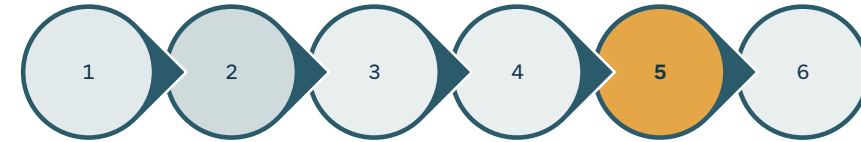


EXAMPLE

- Leadership — Select tracers **MONTHLY** based on high-risk areas, sentinel events, or regulatory focus.
- Team—Observe patient care processes, including interactions with staff, documentation, and protocol adherence in “real-time.”
- Team—Document findings
- Team and key members — Review findings and develop a Proactive Plan of Correction (PPoC).



CREATE DAILY CHECKLIST



- Create a checklist of items to be checked daily. Assign a few items to huddle members each morning.
 - Medications
 - Nutrition area
 - Dirty Utility Room
 - Clean Utility Room
 - Patient Rooms
 - Medical Record Check
 - Equipment Maintenance
 - Egress
 - Warmers
 - Refrigerators
 - Documentation audit

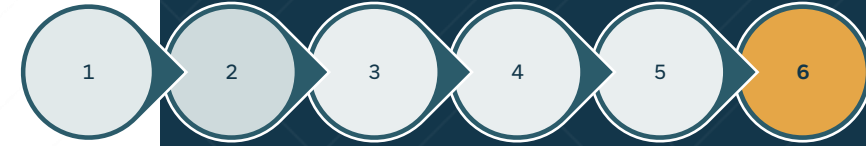
EXAMPLE

Assign Medications to a team member at huddle with the list below

- Medication room locked if in unsupervised area
- Correct medication refrigerator thermometer setting
- Medication refrigerator log complete with actions for any out-of-range temperatures documented
- Medications secure with no medications unattended
- Multi-dose vials dated with 28-day expiration date
- No open single-dose vials available for reuse
- Cleaned pill cutters and mortar/pestles
- No unwrapped IV fluids (unless dated with a 24-hour use date)



DESIGN AND PRINT A POCKET GUIDE FOR STAFF



- Organization-specific information
- May include, but not limited to:
 - Mission/Vision/Values
 - Human Resources/Staffing-Orientation
 - Unacceptable abbreviations
 - Medication Management
 - ALL Emergency Codes
 - Environmental Safety
 - Fire Safety Codes and information
 - Infection Prevention
 - QAPI-Quality Measures
 - Patient Safety
 - Patient Rights
 - HIPAA
 - Advance Directives
 - Potential survey questions





“Failing to prepare is preparing to fail”

Benjamin Franklin



PROACTIVE PLAN OF CORRECTION (PPOC)

Risk mitigation and regulatory compliance

Cost savings from prevention

Efficiency and staff readiness

PPOCs often address core quality issues



POLLING QUESTIONS #3 AND #4





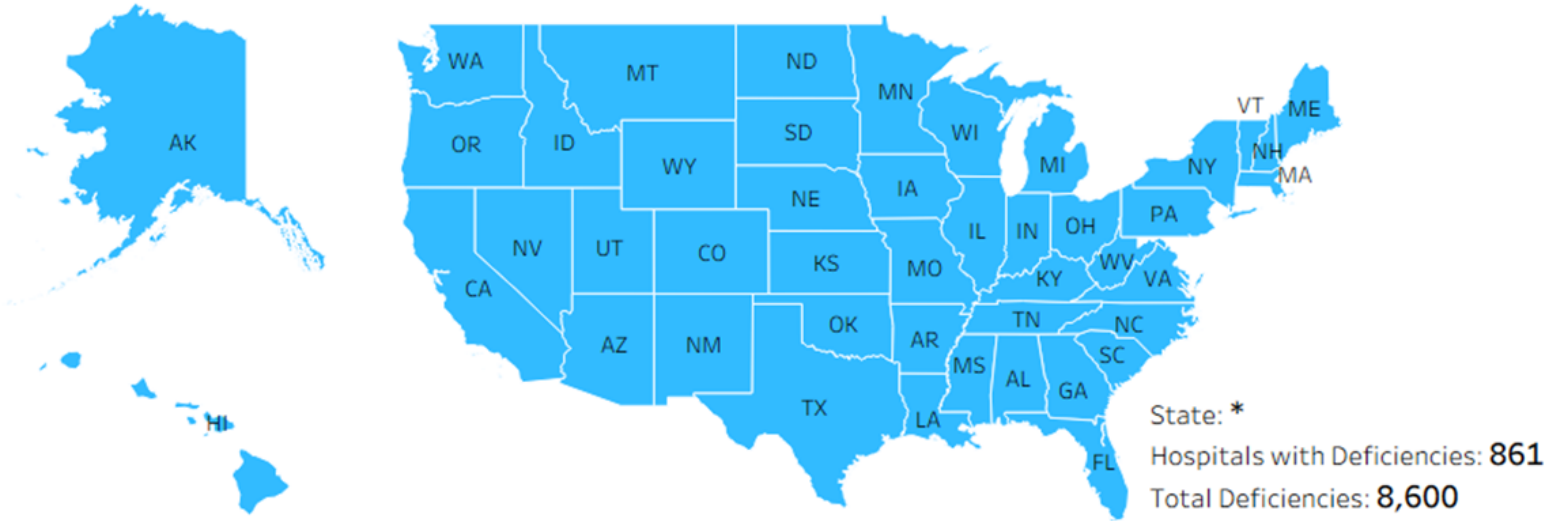
APPENDIX

RESOURCES

- [Accrediting Organization Proposed Rule Fact Sheet | CMS](#)
- [Federal Register: Medicare Program; Strengthening Oversight of Accrediting Organizations \(AOs\) and Preventing AO Conflict of Interest, and Related Provisions](#)
- [QSEP - Driving Healthcare Quality](#)
- [Accrediting Organization Contacts for Prospective Clients](#)

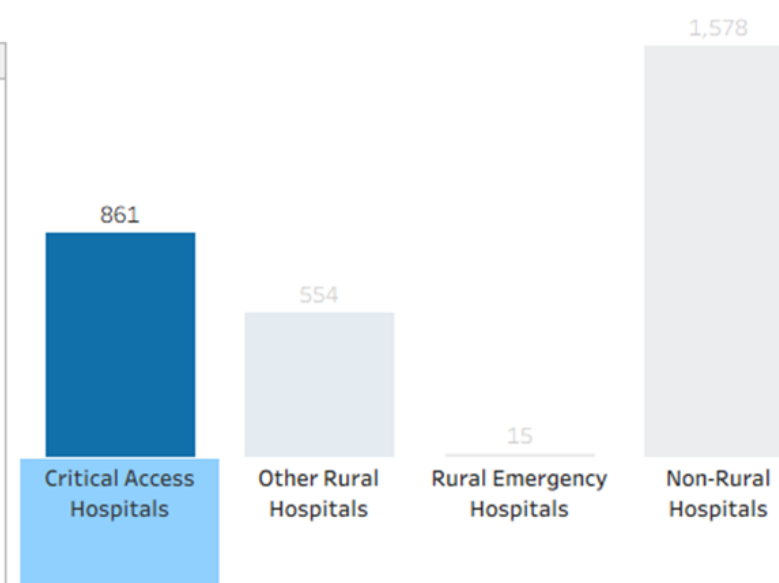


Hospital Deficiencies, 1/1/2021 - 05/07/2026



- Between January 1, 2021, and May 7, 2026, 861 **Critical Access Hospitals** were tagged with 8,600 deficiencies.
- The highest number of deficiencies for CAHs is for Patient Care Policies.

Deficiency Description	Hospitals	Total #
	861	8,600
Patient Care Policies	291	443
Sprinkler System - Maintenance And Testing	258	275
Nursing Services	186	254
Compliance With 489.24	210	241
Electrical Systems - Essential Electric Systems	217	240
Infection Prevent Surveil & Control Of HAIs	213	227
QAPI	103	208
Records System	157	207
Medical Screening Exam	189	207
Hazardous Areas - Enclosure	193	203
Fire Drills	179	193
Subdivision Of Building Spaces - Smoke Barriers	157	172
Maintenance	150	154
Infection Prevent & Control Policies	141	154
Fire Alarm System - Testing And Maintenance	144	153



Source: <https://www.cms.gov/files/document/hospital-surveys-2567-statement-deficiencies-through-2025-q2.xlsx>







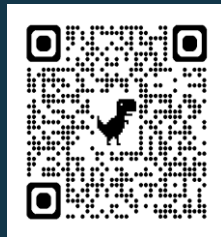
COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.



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