Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001059	02/01/2019
Name of Provider or Supplier	**Street Address, City, State**	
Fort Sutter Surgery Center, A Ca Limited Partnership	2801 K Street, Suite 525, Sacramento, CA	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
Q0000	The following reflects the findings of the California Department of Public Health during a federal recertification survey conducted 1/29/19 - 2/1/19. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN) #29821 HFEN #35598 HFEN #39825 Medical Consultant #22710 The sample size was 21.
Q0041	CONTRACT SERVICES CFR(s): 416.41(a) When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.

This STANDARD is not met as evidenced by:
Based on interview and document review, the Ambulatory Surgery Center (ASC) failed to seek and/or validate current health quality and safety certifications for 7 of 8 outside vendors reviewed, in order to ensure the vendors were qualified to perform patient care services in accordance with medical staff rules and regulations. The ASC failed to integrate contracted services into the Quality Assessment and Performance Improvement Program with objective measures of performance for 8 of 8 vendors reviewed, in order to present a valid annual evaluation of each vendor in accordance with governing body bylaws.

These failures put patients at risk for surgical care to be performed by unqualified persons or systems, or in an unsafe environment.

Findings:

In a collaborative review of 8 selected vendor contracts with Administrator 1 (who managed all ASC contracts) on 2/1/19 at 3 p.m., expired certificates for state and federal Clinical Laboratory Improvement Amendments (CLIA), as well as an expired accreditation certificate for College of American Pathologists (CAP), were attached to Vendor 1's (pathology lab vendor) contract materials. The certificates were more than 8 years expired. Administrator 1 stated that he did not routinely collect or update certifications or legal registrations to validate that vendors maintained their qualifications and legitimacy when preparing the evaluation of vendor services for the Governing Body. Of the 8 vendors reviewed, only 1 (Pharmacy Consultant) had evidence of current state licensure to show the vendor's qualifications.

In a collaborative review of a document titled, "Quality Improvement Annual Review, Contractor Service Evaluation Report 2018" on 2/1/19 at 3 p.m., Administrator 1 stated that evaluations for the 36 vendors listed on the report were presented to the Governing Body at their 2018 3rd quarter meeting. The report listed numerical compliance levels for each vendor. Administrator 1 could not present data to support the "compliance of threshold" numbers listed on the report for the 8 vendors reviewed in depth, nor for any others. Administrator 1 indicated that the performance numbers were not based on objective quality measures that matched the terms in each vendor's contract, nor did was any other data collected to verify that each vendor was meeting its obligations. The performance numbers were largely based on perception or estimate of performance, and whether complaints or problems occurred over the previous year, and not data-driven.

Review of the Governing Body Bylaws, adopted 12/7/17, documented under Section 1.02 that the Governing Body was responsible for operation and performance of the ASC. Section 1.05 outlined the Governing Body's goals and objectives to include (j) Ensuring that the quality of care was evaluated, identified problems were

	appropriately and timely addressed, and (n) approving and ensuring compliance of all major service contracts or arrangements affecting patient care. The responsibilities of the Administrator were described in Section 4.03 (e) to include, "ensure that contracted services agreements specifically provide that the contracted service providers will comply with applicable regulations and standards as if the services were provided directly by the Facility." Review of the Medical Staff Rules and Regulations, approved 1/22/19, under Section III-B-5-c directed, "Tissue and specimens removed during a procedure must be sent to an approved laboratory (as an example: CAP accredited and CLIA licensed) for analysis." Per Administrator 1 above, the ordering physicians relied on the results of a laboratories to make subsequent patient care decisions, and the laboratories were not verified to be trusted and reliable, currently licensed and accredited, putting patients at risk for delayed, erroneous or unnecessary treatments.
Q0101	PHYSICAL ENVIRONMENT CFR(s): 416.44(a)(1) The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the Ambulatory Surgery Center (ASC) failed to demonstrate the maintenance of a sanitary and functional environment when 1) Operating room temperatures were not kept within the expected range, and 2) Infrequently-used surgical equipment was not maintained. These failures had the potential to contribute to surgical site infections, patient discomfort, and surgical complications. Findings: 1. Review of recent "Anesthesia Daily Checklists" indicated that operating room temperatures ranges were to be maintained between 68 - 73 degrees Fahrenheit.

Temperatures below the required 68 degrees were recorded in the following operating rooms on the dates noted:

- Operating Room 3 on 1/3/19, 1/7/19, 1/11/19, 1/14 - 1/18/19, 1/21 - 1/25/19, 1/28 - 1/30/19 and 2/1/19,

- Operating Room 4 on 1/3 - 1/4/19, 1/14 - 1/16/19, 1/18/19, 1/21 - 1/22/19, 1/25/19 and 2/1/19, and

- Operating Room 5 on 12/6 - 12/7/18, 12/13/18, 12/19 - 12/20/18, 12/26 - 12/27/18, 1/21/19 and 1/28 - 1/30/19.

The "Comments" section of the checklists did not reflect evidence of action taken to correct the temperature, or any remeasurement.

In a 12:59 p.m., 2/1/19 interview, the Administrator acknowledged the logs lacked consistent documentation of the actions taken when temperatures were out of range. He stated he had spoken with the employee who checked the temperatures and the employee indicated she "probably should be writing down [the corrective measures taken to normalize the temperatures]."

Review of the ASC's 1/18 "IC [Infection Control] - Air Exchanges, Temperature and Humidity Settings in the Operating Room/Procedure Room" policy indicated, "An effective ventilation system is in place to minimize airborne microbial contamination. Temperature...control is in place to maintain integrity of sterile packaging...Room temperature...is recorded on a daily basis for each Operating Room...In the event that the...temperature is outside the acceptable range, the nursing manager will be notified immediately for appropriate action...Room temperature is maintained between 68 - 73 degrees F [Fahrenheit]...."

2) During concurrent observation and interview with the Director of Nursing (DON) on 1/29/19 at 11:15 a.m., a warming cabinet was noted to be in a corridor adjacent to operating rooms. This warming cabinet contained blankets for patient use. A label for preventative maintenance placed on the exterior of the cabinet indicated it was last completed in July of 2017 and was due for scheduled preventative maintenance in August of 2018.

In a 1/29/19, 12:30 p.m. interview with the DON, she stated the preventative maintenance had not been completed because the biomedical engineering department had the equipment listed as "retired".

Q0162

FORM AND CONTENT OF RECORD
CFR(s): 416.47(b)

The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination (as applicable); (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis.

This STANDARD is not met as evidenced by:
Based on interview and document review, the Ambulatory Surgery Center (ASC) failed to ensure medical records were complete and accurate in accordance with medical staff rules and regulations and ASC policies for 4 of 21 patient records reviewed (Patients 3, 11, 12, and 13).

This failure put patients at risk for errors and harm made by providers who relied on the content of these records for care decisions.

Findings:

Review of the ASC's Medical Staff Rules and Regulations, approved 1/22/19, documented the following requirements:

Section II-A-6 - Both the patient and the responsible practitioner shall sign the informed consent document prior to the procedure being performed to indicate that the practitioner has personally provided specific information on which the patient has based his consent.

Section IV-A-1 - Accurate and complete medical records shall be prepared and maintained for each patient receiving care.

Section IV-A-2 - The medical record must be clear, concise, complete and accurate.

Section IV-A-9 - Pertinent progress notes shall be recorded at the time of observation

and shall suffice to assure continuity of care and transferability. They should provide a chronological report of the patient's course in the center and should reflect any change in condition and the results of treatment.

Section IV-A-10 - Allergies and untoward reactions to drugs or adverse drug events must be recorded in the medical record.

Section IV-A-14 - A full procedural or operative report should be dictated as soon as possible after completion of the procedure...contain...condition of patient on conclusion of procedure...When a full procedural or operative report is not immediately available after the procedure, a post-op/procedure note must be written immediately after the procedure, comprehensive enough to permit continuity of care.

Section IV-A-17 - The attending physician shall be responsible for the preparation of a complete medical record for each patient he/she admits. The record should include... diagnosis or diagnostic impression, preoperative testing results, surgical and anesthesia consents, report of surgical procedure...and a discharge summary.

A review of Patient 3's medical record with the Director of Nursing (DON) on 2/1/19 at 1:45 p.m. confirmed the following:

Patient 3,had eye surgery on 1/29/19.

The Universal Protocol- Safe checklist for Surgical and Nonsurgical Invasive Procedures, "Allergies/ sensitivities" listed as "NKA" (no known allergies);

The Medication Reconciliation form, listed "+ food allergies, Gluten...+environmental allergies, everything..." and "Motrin", a non-steroidal anti-inflammatory medication used for pain;

From a history and physical, "Allergies as of 1/16/2019" listed as, "Diovan [valsartan]", (blood pressure lowering medication) with the reaction as "cough", "Lisinopril", (also a blood pressure lowering medication) with the reaction as "cough", and "Statins", (cholesterol lowering class of medications) with the reaction as "muscle pain";

In the Anesthesia Record, the allergies were listed as "Motrin";

The green colored nursing form (untitled) completed intraoperatively, indicated the allergies as "NKA" (no known allergies).

The ASC's policy, Medication Administration (ID 3549439), directed, "II. Patient Information/ Drug Reconciliation 1. Upon or prior to admission to a center, a patient history, including medications, vitamin, and herbals currently being taken and any known drug allergies and reactions they manifest, must be completed and recorded in the medical record. The information shall include at a minimum:... F. Patients allergies and sensitivities..."

Review of medical records with Nurse Manager (NM) 3 on 2/1/19 at 10:30 a.m. confirmed the following:

Pediatric Patient 13 had head and neck surgery on 5/3/18. An ASC form to verify an understanding of the surgical procedure with signed consent by Patient 13's legal representative was not found in the patient record.

Patient 11 had left neck surgery on 8/30/18. A written operative report by the surgeon was not found in the patient record.

Patient 12 had low back spine surgery on 7/18/18. Patient 12 had co-existing high risk conditions of high blood pressure, heart rhythm disorders, asthma and chronic lung disease. A physician assessment office visit record dated 6/12/18 noted Patient 12 reported shortness of breath and the surgeon planned to obtain clearance for surgery from the patient's heart specialist. The clearance documentation was not found in the patient record or referenced by the operating surgeon on his 7/18/18 pre-operative assessment.

The surgery for Patient 12 on 7/18/18 started at 9:19 a.m. Sedative and narcotic pain medications, plus steroid and local anesthetic injections, were administered during the surgery. At the end of surgery, Patient 12 became short of breath with distress. Multiple rescue interventions were ordered and administered over the next 45 minutes. At least two physicians participated in managing Patient 12's care, a surgeon and an anesthesiologist. Patient 12 was transferred to a local hospital at 10:34 a.m.

	A complete and accurate operative report documented immediately after surgery was not found in the patient record. The ASC later presented a typed "Progress Notes" document that was organized like an operative report for the 7/18/18 encounter. That report was printed on 7/19/18 (after transfer) and documented details of Patient 12's breathing event and the results of her care at the hospital. However, that report retained additional language identical to a previous encounter dated 10/31/16 [template language], "There were no apparent complications. The patient tolerated the procedure well and was carefully escorted to the recovery room in stable condition [not accurate]. After meeting discharge criteria, the patient was discharged home [not accurate]." No summary or progress notes written by any of the physicians involved in managing Patient 12's life-threatening condition to accurately portray her condition, at the time of transfer, and to supply to the hospital receiving providers, were filed in the patient record. In a review of the ASC's transfer policy (ID 3549256 titled Hospital Transfers) with the DON on 2/1/19 at 11 a.m., DON confirmed that a physician was responsible to provide a written summary of the patient's condition and care at the ASC to accompany the patient to the hospital. DON acknowledged that Patient 12's record did not contain such documentation.
Q0181	ADMINISTRATION OF DRUGS CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the Ambulatory Surgery Center (ASC) failed to maintain an inventory of effective and properly-stored medications when 1) outdated drugs were found in Operating Room medication carts, and 2) medications were found in a storage room accessible to non-clinical staff. These failures had the potential to allow for the administration of ineffective medications and the misuse of drugs.

Findings:

1.In a 4:17 p.m., 1/29/19 inspection, an unopened vial of furosemide (a medication used to treat fluid retention or swelling) with an expiration date of 11/18 and an unopened vial of metoprolol (a drug for high blood pressure, heart failure and/or heart rhythm disturbances), also with an expiration date of 11/18, were observed in Operating Room 2's medication cart. In a concurrent interview, the Director of Nursing (DON) acknowledged the medications were outdated.

During the inspection, two unopened vials of neostigmine (drug which helps reverse the effects of some muscle relaxing medications) with expiration dates of 10/18 were found in Operating Room 1's medication cart. In a concurrent interview, the Nurse Manager of the Operating Rooms (NM 2) acknowledged the outdated drugs.

During a 10:18 a.m., 1/29/19 tour of the ASC, the DON stated that medications are checked for expiration "on the first business day of the month."

Review of the ASC's 4/26/17 "Disposition of Outdated/Expired Drugs" policy indicated, "All drugs must be tracked for expiration in order to insure proper efficacy and patient safety...Operating Rooms...On a monthly basis, each operating room and anesthesia cart will be inspected for outdated...drugs...Unopened expired drugs will be removed from the area...."

The 4/26/17 "Medication Administration" policy also stated, "Expired drugs...must be removed from stock each month. All expired...medications are segregated and secured until they are removed from the facility."

2. During an observation in Room 1000 on 2/1/19 at 3:30 p.m., 6 vials containing mixed Procaine (a medication used to numb a part of the body during a medical procedure) and Epinephrine (a medication used to prolong the numbing effect of Procaine and to help reduce bleeding) were in an unlocked drawer of a dental cart.

In a 3:35 p.m., 2/1/19 interview, Nurse Manager 2 (NM 2) stated that purchasing staff (non-clinical staff) have access to Room 1000 and that the dental cart, "should be locked."

	Review of the ASC's 4/26/17 "Medication Administration" policy indicated, "Medications shall be secured with access limited to licensed professionals authorized to handle medications."
Q0241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the Ambulatory Surgery Center (ASC) failed to maintain a sanitary environment when 1) A physician did not wear adequate surgical attire during a procedure, and 2) Air exchange measurements were unavailable for two surgical procedure rooms and other clinical areas. These failures potentially placed patients at risk for the development of surgery-related infections. Findings: 1. During an 11:57 a.m., 1/10/19 colonoscopy (test in which a tube with a camera is guided inside the large intestine to look for cancer or pre-cancerous conditions) performed on Patient 2, Medical Doctor 2 (MD 2) was observed without a mask for the duration of the approximately 30 minute-long procedure. The assisting Registered Nurse was noted to be wearing a mask. In an 11:02 a.m., 2/1/10 interview, MD 2 stated that he chose not to wear a mask during the procedure. He denied any potential risk to Patient 2 from his not wearing a mask and noted that colonoscopy was not a procedure performed under sterile conditions. Review of the ASC's 1/18/19 "Dress Code and Work Practices in the Clinical Setting" policy reflected, "The use of personal protective equipment (PPE) provided by the surgery center is required by all clinical staff as appropriate...Protective eyewear, masks or face shields...must be worn whenever staff is at risk for exposure to infectious materials as appropriate...."

Review of the 1/22/19 "Medical Staff Rules and Regulations indicated, "All practitioners must be familiar with and support the facility regarding the requirement for the ASC to maintain an ongoing infection control program...The...program must include documentation that the facility has...implemented nationally recognized infection control guidelines...The facility must provide a...sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice...Surgical masks...must be worn whenever splashes, spray, spatter, or droplets of blood, body fluids, or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated...."

PPE is required by the Bloodborne Pathogens Standard if exposure to blood and other potentially infectious materials (OPIM) is anticipated and where occupational exposure remains, after institution of engineering and work practice controls [29 CFR 1910.1030(d)(2)(i)].

During a 3:10 p.m., 1/29/19 interview, the designated Infection Preventionist, Nurse Manager 2 (NM 2), stated the ASC adhered to standards for infection prevention set by The Association of periOperative Registered Nurses (AORN) and the Association for Professionals in Infection Control and Epidemiology (APIC).

2019 AORN Guidelines' "Surgical Attire Recommendation I" reflects, "Clean surgical attire should be worn in the semi-restricted and restricted areas of the perioperative setting...The collective body of evidence supports wearing clean surgical attire in the perioperative setting to reduce the number of microorganisms in the environment..."

APIC's 2018 guidelines state, "Personnel should wear a clean surgical mask that covers the mouth and nose and is secured in a manner to prevent venting ...when preparing, performing or assisting with surgery and other invasive procedures... Surgical masks worn in the perioperative setting serve two purposes. First, they help protect the patient and environment from microbial contamination by organisms carried in the provider's mouth or nose. Second, they provide protection for the wearer from exposure to...potentially infectious materials...."

The United States Department of Labor Occupational Health and Safety Administration's Bloodborne Pathogens Standard states that "PPE [personal protective equipment such as masks] is required...if exposure to blood and/or other potentially infectious materials (OPIM) is anticipated and where occupational exposure remains, after institution of engineering and work practice controls [29 CFR 1910.1030(d)(2)(i)]."

Review of Section 8.01 of the ASC's 4/26/17 "Governing Body Bylaws" reflected, "... the Governing Body will take all reasonable steps and develop policies to ensure that it and the Facility comply with all applicable federal, state and local laws and regulations, including...all applicable occupational health and safety regulations for health care workers, such as the Occupational Safety and Health Administration (OSHA) rules on Occupational Exposure to Bloodborne Pathogens."

2. Review of a 9/28/18 air handler testing report reflected, "The following is a list of rooms tested for...room airchanges [sic] per hour...ORs [Operating Rooms] - 1 thru OR - 5, G.I rooms 1 & 2 [gastrointestinal, rooms in which procedures involving the digestive tract were completed], Procedure rooms 1 & 2 [areas used for pain management procedures], Clean storage, and Sterile supply."

The report included no detail for air changes per hour (ACH) for the two pain procedure rooms. In addition, there was no documentation indicating ACHs were measured in the surgical instrument decontamination area, the gastrointestinal instrument reprocessing area and the Post-Anesthesia Care Unit (PACU, the after-surgery recovery area).

At 9:25 a.m., 2/1/19, the Administrator stated he would contact the company which performed the testing to obtain additional detail. No further information was provided during the survey.

2019 AORN Guidelines "Design and Maintenance Recommendation XII" states, "The health care organization should create and implement a systematic process for monitoring and maintaining structural surfaces and HVAC [heating/ventilation/air conditioning] system performance...Heating, ventilation, and air conditioning systems control room air quality...The HVAC system reduces the amount of environmental contaminants (eg, microbial-laden skin squames [flakes of dead skin tissue], dust, lint) in the surgical suite by carrying airborne contaminants away from the sterile field...." "Design and Maintenance Recommendation II.e.1 Table 3" reflected minimum air changes per hour standards for the following areas not documented as evaluated in the testing report: [pain] procedure rooms, sterile processing decontamination room, endoscope [gastrointestinal procedure instrument] cleaning room, and the PACU.

Review of the ASC's 1/18 "IC [Infection Control] - Air Exchanges, Temperature and Humidity Settings in the Operating Room/Procedure Room" policy indicated, "An effective ventilation system is in place to minimize airborne microbial contamination... Operating [and surgical procedure] Room air exchanges will be at least 15 per hour. This will be measured and documented at least annually...."

	Additionally, review of the 4/26/17 "Indoor Air Quality" policy reflected, "[The ASC] will take adequate and reasonable measures to ensure that the facility's indoor air quality is safe...for its...patients...The air handling system will be maintained and operated in a manner that promotes a safe and health [sic] environment...A preventive maintenance program and documentation has been established, [sic] that will ensure that all HVAC systems are well maintained...Air balance must be operated correctly and efficiently...."
Q0242	INFECTION CONTROL PROGRAM CFR(s): 416.51(b) The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the Ambulatory Surgery Center (ASC) failed to operationalize infection prevention policies when 1) Unsterile or unsuitable surgical instruments were found to be available for use, and 2) Three of eight physician health records lacked documentation of compliance with immunization requirements. These failures had the potential to cause surgery-related infections and to expose patients to communicable diseases. Findings: 1A. During the surgical instrument sterilization process, indicators and integrators are used to verify that conditions necessary for sterilization (i.e.- time and temperature) have been achieved. For example, in steam sterilization the indicators or integrators turn a different color (in this case black) to indicate sterilization has occurred. Single instruments are placed into peel pouches which are made of plastic and paper which is permeable to sterilization (steam) and are durable and protective for instrument storage.

During an observational tour on 1/29/19 at 11:00 a.m. with the Director of Nursing (DON) and the Regional Clinical Director (RCD), many instruments were noted in a storage area adjacent to the operating rooms. One pair of scissors was examined and the following was noted:

a) The scissors were positioned in an instrument protector card which had an indicator on it. This indicator had not turned black from its original color.

b) The scissors were placed into a double peel pouch packaging. Both indicators on the sequential pouches did not change color.

c)An integrator was placed in the first peel pouch at the instrument level. The integrator did not change color to the desired black to indicate the contents were sterilized.

During a concurrent interview, the DON and the RCD agreed the indicators appeared unchanged.

In an interview at approximately 11:30 a.m. on 1/29/19, the DON and the Sterile Processing Technician (SPT) stated the instrument was not sterilized and was erroneously placed with other sterile instruments and available for use.

A review of the ASC policy, IC [Infection Control]- Sterilization Standards: Preparation of Instruments and Supplies for Sterilization, last revised 8/18/11, directed, "Instruments ... reprossessed by the facility will be prepared in a manner to assure maintenance of sterility and promote delivery to the sterile field in an aseptic manner ...VI. Chemical Indicators/integrators will be placed inside each package and an external chemical indicator will be affixed outside each package to be processed ..."

The above policy references AORN (Association of periOperative Registered Nurses) Standards.

The AORN Guidelines for Sterilization, effective 2018, included, "X.b. Chemical, physical, and biological indicators should be used to monitor sterilization processes. X. c. External and internal chemical indicators (CIs) specific for the sterilization method

should be used with each package. X.d. Physical monitors (eg, time, temperature, pressure, humidity, sterilant concentration) should be reviewed at the end of each cycle. The sterilizer operator should verify that all sterilization parameters were met for every cycle and every sterilization method ... X.g. Process monitoring specific to steam sterilizers should be performed.

1B. During a 10:15 a.m., 2/1/19 inspection of the sterile processing area, an engraved tympano tray microforceps (an instrument used during ear surgery) was observed on the supplemental instruments peg board.

In a concurrent interview, the Sterile Processing Technician (SPT) stated, "everything on the [supplemental instruments peg board], we would use," for a procedure.

During a 3:03 p.m., 2/1/19 re-inspection of the sterile processing area, the engraved tympano tray microforceps was observed still on the supplemental instruments peg board.

In a concurrent interview, the SPT stated that the reason the instrument remained on the board was that she was "waiting to take the [identification] number off of it. Then I will reorder it [a replacement]" and discard the engraved forceps.

Review of Association of periOperative Registered Nurses (AORN): Instrument Cleaning section IX.e.4, indicated, "Damage to the finish of the instrument [such as engraving] can create surface imperfections that can harbor microorganisms and debris."

During a 3:10 p.m., 1/29/19 interview, the designated Infection Preventionist, Nurse Manager 2 (NM 2), stated the ASC adhered to AORN standards for infection prevention.

1C. During a 4:01 p.m., 1/29/19 inspection, an unpackaged laryngoscope blade (equipment used to place an airway) was observed in the anesthesia cart of Operating Room 5. In a concurrent interview, the Nurse Manager of the Operating Rooms (NM 2) acknowledged that the equipment was not sterile.

During a 4:03, 1/29/19 inspection in Operating Room 4, a laryngoscope was observed in an anesthesia cart in packaging which had a tear in it. In a concurrent interview,

NM2 acknowledged that the peel pack was torn and indicated that laryngoscope blades needed to be kept in sterile packaging.

Review of the ASC's 4/26/17 "Processing of Anesthesia Intubation [placement of a breathing tube] Equipment" policy reflected, "The laryngoscope blades will be cleaned, disinfected and sterilized between each use."

2. Review of the ASC's 1/2/18 "Post-Offer/Pre-Placement Medical Assessment Policy" reflected, "Proof of immunity to...varicella (chickenpox) and pertussis is a requirement of employment in an HCP [health care personnel] position...The individual will be asked to present immunization record(s) for the varicella (chickenpox) and pertussis as well as any documentation of previous laboratory titers for...chickenpox...If the individual is unable to provide acceptable proof indicating immunity for...varicella, serological tests [laboratory testing to determine immunity] are performed...When the results of the serological tests indicate no immunity...or the individual is unable to provide proof of immunity to pertussis, the individual shall be... offered recommended vaccinations...which include the Varicella (Chickenpox) Vaccine and the...Pertussis Vaccine...Non-immune individuals must be adequately immunized within 90 days of the start of their employment for...varicella and pertussis...."

The policy defined health care personnel as "Employee who provides direct and indirect patient care...including but not limited to physician medical offices...who has the potential for exposure to patients...."

During a review of eight physician health records provided by the Vice President, Clinical Operations (VPCO), immunization or documentation of immunity to pertussis (whooping cough, an easily-spread and potentially deadly communicable disease preventable with vaccination) was not found for Medical Doctors 1 and 3 (MDs 1 and 3). Evidence of immunization for or immunity to varicella (a highly contagious disease) was not found for MD 4.

In a 1:07 p.m., 2/1/19 interview, the VPCO was requested to provide documentation of the missing health information. None was able to be provided by the end of the survey.

In a 1:31 p.m., 2/1/19 interview, the VPCO stated that the ASC did not have a separate policy for physician immunizations.

	The 1/22/19 "Medical Staff Bylaws" indicated, "Qualifications of Medical Staff Membership...Annual confirmation of...other appropriate immunizations as required by the facility...."