Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001059	05/07/2026
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. The facility census was 101, and the sample size was 20.
Q0060	SURGICAL SERVICES CFR(s): 416.42 Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC This CONDITION is not met as evidenced by: Based on observation, interview, and document review the Ambulatory Surgery Center (ASC) failed to ensure surgical services were provided in a safe manner in accordance with approved policies and procedures as evidenced by: 1. An anesthesiologist provided anesthesia services for nine patients at the ASC and did not have clinical privileges (specific types of procedures a physician can perform) granted by the governing body at the time those services were provided. (Refer - Q-0064) 2. Expired surgical supplies were available for patient use. (Refer- Q-0064)

	These deficient practices posed a safety hazard for patients undergoing procedures and had the potential to compromise optimal patient outcomes. The cumulative effects of these systemic failures resulted in the ASCs inability to comply with the statutorily-mandated Conditions for Coverage: Surgical Services.
Q0064	STANDARD LEVEL TAG FOR SURGICAL SERVICES CFR(s): 416.42 Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the Ambulatory Surgery Center (ASC) failed to ensure surgical procedures were performed in a safe manner for all surgical patients when: 1. Expired items were found in the supply areas available for patient use during surgical procedures, and 2. An anesthesiologist (ANES 2) provided anesthesia services for nine patients at the ASC and did not have clinical privileges (specific types of procedures a physician is allowed to perform) granted by the governing body at the time these services were provided. These failures posed safety hazards for patients undergoing procedures and had the potential to compromise optimal patient outcomes. Findings: 1. During an observation on 5/5/26 at 3:05 p.m. in the Sterile Supply Rooms (a room specifically meant to store sterile supplies in a way that protects them from contamination, moisture, and damage) the following four types of sterile (free from living microorganisms like bacteria, fungi, viruses, and spores) supplies were found: a. two packages containing ultrasound transmission gel (applied to the skin during ultrasound exams to eliminate air pockets between the transducer and the body to ensure high-frequency sound waves travel directly to tissues, allowing for clear imaging) with an expiration date of 12/25, b. three packages containing [product name] (a product used to stop bleeding during surgery) with an expiration date of 4/26, c. eight packages containing penrose drains (a soft, flexible, latex tube used in surgery to prevent infection by allowing blood, pus, or other fluids to passively drain away from a wound) with an expiration date of 9/28/25, and d. one package containing [product name] or U- Drape (a medical sheet that creates a sterile barrier between a patients wound or surgical site and the surrounding

environment to prevent infection and contamination during a procedure) with an expiration date of 10/25.

During a concurrent interview and observation on 5/5/26 at 3:30 p.m. with the Sterile Processing Technician (SPT) in the Sterile Supply Room, the SPT stated the four types of sterile items observed as noted above were expired.

During an interview on 5/6/26 at 9:43 a.m. with the Operating Room Manger (ORM), the ORM stated using these expired supplies in the Operating Room could cause an infection for the patient.

During a review of the facilitys policy and procedure (P&P) titled, Medical Supply Expiration Audit Process Policy, dated 3/31/25, the P&P indicated, Adhering to the Expiration Date is essential to preserve quality and avoid potential risks associated with expired items... Identify items with less than thirty (30) days and coordinate with clinical staff to remove them

2. During a concurrent interview and document review on 5/5/26 at 10:30 a.m. with the Administrator (ADM), the [name of ASC] PSR LOG 2026 was reviewed. The log had eight entries dated 1/14/26 with the type of event noted as Error in Providing Privaliges (sic). The ADM stated the anesthesiologist (ANES 2) listed for those eight cases did not have clinical privileges at the facility at the time these procedures were performed. The ADM went on to state ANES 2 should not have provided patient care without clinical privileges. A review of the OR Master Daily Schedule, dated 1/14/26, indicated ANES 2 provided care for nine patients on this date. The ADM confirmed ANES 2 provided care to nine patients on 1/14/26 without the required clinical privileges.

During a concurrent interview and document review on 5/5/26 with the Medical Staff Manager (MSM manages the verification, appointment, and reappointment of physicians), ANES 2s credential file (CF-a centralized file to include the physicians education, licensure, and approved clinical privileges) was reviewed. ANES 2s CF indicated, Retired as of 8/1/25. MEC/GB (medical executive committee/governing body) approved to make inactive as of 8/1/25. MSM confirmed ANES 2 was made inactive as of 8/1/25.

During a review of the [Name of ASC] Medical Executive Committee 3rd Quarter 2025 Meeting Minutes [MECMM], dated 10/14/25, the MECMM indicated, Medical Staff CredentialingResignations/Retirements/Automatic Term [termination] from Medical Staff [ANES 2].

During a review of the [Name of ASC] Governing Body Minutes [GBM], dated 10/14 /25, the GBM indicated, Upon recommendation of the MEC the Governing Board made a motion to: ApproveMedical Staff Credentialing Recommendations....

During a review of the Medical Staff Bylaws of [name of ASC], undated, the Medical Staff Bylaws indicated, Clinical Privilegesa Medical Staff member who practices Clinical Privileges at the facility shall be entitled to exercise only those Clinical Privileges specifically granted.

During a review of the Governing Body Bylaws [GBB]," dated 12/20/17, the GBB indicated, The Governing Body shall have the following goals and objectives: Appointing members to the Medical StaffRequiring the Medical Staff to abide by the

	rules, regulations and bylaws of the Facility.
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 ensure a safe, functioning environment for 62 of 62 surgical patients when staff in the operating room (OR) did not have immediate access to the video laryngoscopes (VL- specialized equipment used by healthcare professionals to access patients airways, especially in difficult airway situations) that were being stored at the end of a long hallway located on the back side of five ORs that on one side contained large metal racks used for storing supplies and on the other side contained case carts (large rolling carts that contain items needed for surgical cases) and additional storage racks. This failure had the potential to put all 62 surgical patients at risk for complications related to restricted or difficult airway access. Findings: During a concurrent observation and interview on 5/6/26 at 10:17 a.m. with the Operating Room Manager (ORM) in the hallway located behind ORs, the ORM confirmed 5 active ORs opened into the hallway which was lined on one side with large metal racks containing supplies and on the other side [where the OR doors were located] was lined with additional storage racks and case carts and this created very little space to maneuver any type of equipment or walk through. The ORM further confirmed there were two VLs being stored in the back corner of the hallway and if they were needed emergently in any of the ORs, staff would not be able to roll the VLs down the hallway as there was not enough space. The ORM stated the VLs were used for difficult airway intubation (a healthcare professional inserts a tube into the windpipe to open the airway and facilitate breathing) by the anesthesiologist and are considered an emergency piece of equipment that should be available for immediate use if necessary. The ORM further stated storing the VLs in the hallway was a patient safety issue and they should be moved to a more appropriate location so they could be retrieved quickly. During a review of the facilitys policy and procedure (P&P) titled, General Safety Rules Policy, dated 12/8/25, the P&P indicated, All workforce members are expected to maintain general awareness of their work areaadhere to general safety practicesreport environmental conditions that may present a safety hazardGeneral Areas and Hallwaysgive right of way to wheeled equipmentkeep equipment in hallways stored on one sidekeep all storage areas neat and hazard freeMitigation Measuresmaintain hallways free from obstacles.

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, interviews, and policy review the Ambulatory Surgery Center (ASC) failed to ensure safe medication administration was provided for one of 62 surgical patients (Patient 1) when Anesthesiologist (ANES) 1 administered intravenous (IV-a small, flexible plastic tube inserted into the vein) medications to Patient 1 during their surgical procedure without following safe injection practices.

This failure had the potential for Patient 1 to experience post operative complications and negative surgical outcomes related to infection and the spread of communicable disease.

Findings:

During a review of the ASCs document titled, OR Master Daily Schedule, dated 5/5 /26, the document indicated Patient 1 was a 76-year-old female scheduled for Lateral Tarsal Strip with Debulk Both Eyes-Bilateral (procedure for both lower eyelid fat removal and tightening).

During an observation on 5/5/26 at 10:56 a.m. in operating room (OR) 1, ANES 1 performed the following when he administered IV medication to Patient 1 during her surgical procedure:

Did not perform hand hygiene (HH - washing hands with soap and water or using a hand sanitizing gel to prevent the spread of germs) before he put on his gloves.Did not disinfect the rubber top of the medication vial with alcohol prior to drawing up a clear IV medication into a small syringe with needle attached.Did not wipe the hub (hub-an entry port contained on IV tubing used to administer medications; a high-risk point for bacterial contamination, often responsible for infections) of the IV with alcohol prior to administering the clear medication.Placed the empty small syringe with needle attached on top of the anesthesia cart (cart that contains additional medications for anesthesia providers)Did not wipe the hub of the IV with alcohol prior to administering propofol (a sedative-hypnotic agent used to induce and maintain general anesthesia/unconsciousness) contained in a large syringe that had no needle or protective cap on the end.Did not perform HH after he removed his gloves.Placed the large syringe with the remaining propofol on the small counter portion of the anesthesia machine without covering the end of the syringe leaving it exposed.During this observation ANES 1 confirmed the small syringe contained a powerful opioid analgesic/pain reliever and the large syringe contained propofol.

During an observation on 5/5/26 at 11:19 a.m. in OR 1, ANES 1 performed the following when he administered IV medication to Patient 1 during her surgical procedure:

Did not perform HH before he put on his gloves.Picked up the empty small syringe /needle used to draw up previous medication from the top of the anesthesia cart to

draw up medication from a new vial.Did not disinfect the rubber top of the medication vial with alcohol prior to drawing up the clear IV medication into the syringe.Did not wipe the hub of the IV with alcohol prior to administering the medication.Placed the small empty syringe with needle attached on top of the anesthesia cart.Did not perform HH after he removed his gloves.During an observation on 5/5/26 at 11:27 a. m. in OR 1, ANES 1 performed the following when he administered IV medication to Patient 1 during her surgical procedure:

Did not perform HH before he put on his gloves.Picked up the empty small syringe /needle used to draw up previous medications from the top of the anesthesia cart to draw up medication from a new vial.Did not disinfect the rubber top of the medication vial with alcohol prior to drawing up the IV medication into the syringe.Did not wipe the hub of the IV with alcohol prior to administering the medication.Placed the small empty syringe with needle attached on top of the anesthesia cart.Did not perform HH after he removed his gloves.During an observation on 5/5/26 at 11:31 a.m. in OR 1, ANES 1 performed the following when he administered IV medication to Patient 1 during her surgical procedure:

Did not perform HH before he put on his gloves.Picked up the same large syringe with no protective cap that contained propofol from the small counter portion of the anesthesia machine.Did not wipe the hub of the IV with alcohol prior to administering the propofol.Did not perform HH after he removed his gloves.Placed the large syringe with the remaining white medication on the small counter portion of the anesthesia machine without covering the end of the syringe leaving it exposed.During an interview on 5/6/26 at 2:11 p.m. with the Infection Preventionist (IP), the IP stated safe medication practices included wiping the top of each medication vial with alcohol prior to drawing up the medication and always wiping the hub of the IV before giving the medication. The IP stated the ASC follows the One Needle, One Syringe, Only One Time standard which means every new vial of medication should be drawn up with a new needle and syringe. The IP stated if gloves are worn during medication administration HH should be performed before and after glove use and gloves are not a substitute for HH. The IP further stated everyone at the ASC is expected to follow all policies and procedures (P&P) regarding safe injection practices and by not doing so it put all patients at risk for infection and is considered substandard quality of care.

During a review of the ASCs P&P titled, Standard Transmission Based Precautions and Managing Transmissible Diseases, dated 12/11/24, the P&P indicated, Safe Injection PracticesUse aseptic technique [a set of specific medical and laboratory practice such as handwashing, wearing gloves, and using sterile equipment, designed to prevent the transfer of harmful germs and minimize contamination during procedures] when preparing and administering medicationscleanse the diaphragms [rubber top] of medication vials with 70% alcohol before inserting a device into the vialDo not reuse a syringe or a needle to enter a medication vial or solution. One Needle, One Syringe, Only One Time (CDC One and Only Campaign).

During a review of the ASCs P&P titled, [facility name] Hand Hygiene Policy, dated 3/21/24, the P&P indicated, Indications for hand hygienebefore and after having direct contact with patientsafter contact with used patient equipment and the patients environmentbefore a clean sterile or clean task [administering IV medications] Before donning [putting on] and after doffing [taking off] gloves.

During a review of a document published by the American Society of

	Anesthesiologists titled, Statement on Recommendations for Safe Injection Practices, dated 10/26/22, the document indicated, Safe injection practices are designed to prevent transmission of infectious diseases to patientsUse aseptic technique, including hand hygieneduring medication preparation to avoid cross-contamination of medications and sterile injection equipmentUse a new, sterile syringe and needle /cannula each time a medication or fluid container [medication vial or bag] is accessedPrior to access, wipe the medication vial [rubber top] or ampule neck or access port with 70% isopropyl alcohol and let dryUse aseptic technique when accessing injection ports [hub located on IV] to avoid introducing microorganisms which can result catheter [IV] associated blood stream infectionsDisinfect closed lumen needleless access ports [hub located on IV] by scrubbing with a 70% isopropyl alcohol swab for at least 5 seconds followed by drying. During a review of a document published by The Journal of Infection Control Hospital Epidemiology titled, Infection prevention in the operating room anesthesia work area, dated 10/19/18, the document indicated, Recommendation: To reduce the risk of bacterial contamination of the syringe and syringe contentsanesthesia providers cap needleless syringes that will be used to administer multiple doses of a drug [propofol] to the same patient after each administered dose. Needleless syringes should be capped with a sterile cap that completely covers the Luer connector [part of syringe that connects to IV tubing] on the syringe. Rationale: Bacterial contamination of medication syringes can occur during anesthesia practice, most commonly with skin microorganismsLow provider hand hygiene, lack of injection port disinfection, and contact with nonsterile equipment may increase the risk of intraoperative contamination of syringe contents when used to administer multiple doses of medication to the same patientcapping medication syringes will reduce the risk of inadvertent contamination of the syringe and contents from the hands or work space of the anesthesia provider.
Q0233	SAFETY - ABUSE/HARASSMENT CFR(s): 416.50(f)(3) [The patient has the right to -] (3) Be free from all forms of abuse or harassment This STANDARD is not met as evidenced by: Based on interview and record review, one of six staff members did not have documented evidence of required new hire and annual training on assault/abuse reporting obligations. This deficient practice had the potential for staff not having current knowledge and skills to recognize possible signs and symptoms of abuse. Findings: During a concurrent interview and record review on 5/06/26 at 2:00 P.M., with the Human Resources Business Partner (HRBP), Surgical Technician's (ST) employee file was reviewed. HRBP confirmed ST was a fulltime employee, hired on 10/09/20, and did not complete their new hire abuse training and subsequent annual abuse training.

	During an interview with the Administrator (ADM) on 5/06/26 at 2:45 P.M., the ADM stated that the ST was never assigned to complete abuse training upon hire. ADM acknowledged it is an expectation that all healthcare employees complete abuse training at time of hire and annually. During a follow-up interview with the HRBP on 5/07/26 at 8:15 A.M., the HRBP stated it is the expectation that all hired healthcare employees completed abuse training during new employee orientation and annually. During a review of the facility's policy and procedure (P&P) titled, "Assault-Abuse Reporting Policy," dated 4/12/26 the P&P indicated, State law requires health practitioners to provide oral and written reports to local authorities when instances of abuse, neglect and assault to children, elders, and dependent adults is suspected. The law also requires employers of health practitioners to obtain a signed statement attesting to the employees' understanding of their assault/abuse reporting obligations. The Surgery Center will comply with such laws.
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 policy review the Ambulatory Surgery Center (ASC) failed to ensure an effective infection prevention program was followed when: 1. One Medical Doctor (MD 1), one Anesthesiologist (ANES 1), and one Surgical Technologist (ST) did not perform hand hygiene (HH -washing hands with soap and water or using a hand sanitizing gel to prevent the spread of germs) while providing patient care to one of 62 sampled patients (Patient 1). 2. MD 1 did not disinfect a stethoscope (an instrument used for listening to internal body sounds, primarily to assess the heart, lungs, and intestines) used for an exam on Patient 1 before or after use. 3. ANES 1 was present in the operating room (OR) 1 during Patient 1s surgical procedure without proper surgical attire. 4. ANES 1 handled his personal cellular device multiple times during a surgical procedure in OR 1 and did not perform HH either before or after use. These failures had the potential for Patient 1 to experience negative surgical outcomes related to infection and the spread of communicable disease. Findings: During a review of the ASCs document titled, OR Master Daily Schedule, dated 5/5

/26, the document indicated Patient 1 was a 76-year-old female scheduled for Lateral Tarsal Strip with Debulk Both Eyes-Bilateral (procedure for both lower eyelid fat removal and tightening).

1. During an observation on 5/5/26 at 9:39 a.m. in Patient 1s preoperative room. MD 1 entered the room without performing HH. During a bedside examination, MD 1 touched multiple areas of Patient 1's face around both eyes. MD 1 did not have gloves on and failed to wash his hands or use an alcohol-based hand sanitizer (ABHS) before or after the examination. It was further observed MD 1 did not perform HH upon leaving Patient 1s preoperative room.

During an observation on 5/5/26 at 9:49 a.m. in Patient 1s preoperative room, MD 1 entered the room with a stethoscope and performed a physical exam on Patient 1 with bare hands. MD 1 failed to wash his hands or use ABHS before or after the examination.

During an observation on 5/5/26 at 10:37 a.m. in OR 1, ANES 1 put on gloves and performed placement of an airway device (device used to maintain an open airway while the patient is asleep during anesthesia) for Patient 1 and then removed his gloves. ANES 1 did not perform HH either before or after glove use or at any time before or after providing direct patient care to Patient 1.

During an observation on 5/5/26 at 10:40 a.m. in OR 1, MD 1, with bare hands, injected local medication (a type of medicine that causes a temporary loss of feeling or pain) to Patient 1s outer eye areas without performing HH either before or after the injection.

During an observation on 5/5/26 at 10:56 a.m., 11:05 a.m., 11:19 a.m., 11:27 a.m., and 11:31 a.m., in OR 1, ANES 1 put on gloves, drew up and administered intravenous (IV-a small, flexible plastic tube inserted into the vein) medication to Patient 1 and then removed his gloves. ANES 1 did not perform HH either before or after glove use or at any time before or after providing direct patient care to Patient 1.

During an observation on 5/5/26 at 11:08 a.m. in OR 1, the ST removed her sterile gown and gloves and placed them in the garbage bag without performing HH immediately after or before leaving the OR.

During an observation on 5/5/26 at 11:21 a.m. in OR 1, ANES 1 put on gloves, accessed a bag of IV fluid with sterile tubing and connected the bag to Patient 1s main IV tubing and then removed his gloves. ANES 1 did not perform HH either before or after glove use or at any time before or after providing direct patient care to Patient 1.

During an observation on 5/5/26 at 11:57 a.m. in OR 1, MD 1 removed his sterile gown and gloves and placed them in the garbage bag without performing HH immediately after, before using the computer located on the counter in the OR, or before leaving the OR.

During an observation on 5/5/26 at 12:04 p.m. in OR 1, ANES 1 put on gloves to transport Patient 1 to the recovery room, gave report to the recovery room nurse, removed his gloves and did not perform HH.

2. During an observation on 5/5/26 at 9:49 a.m. in Patient 1s preoperative room, MD 1 did not disinfect a stethoscope prior to being used to perform a physical exam on

Patient 1. MD 1 then walked into an empty adjacent preoperative room and did not disinfect the stethoscope prior to hanging it on a hook located on the wall.

3. During a concurrent observation and interview on 5/5/26 at 11 a.m. with the Operating Room Registered Nurse (ORRN) in OR 1, the ORRN confirmed ANES 1 was not wearing his beard cover properly and large sections of hair were showing on both sides of his face. ORRN 1 further confirmed ANES 1s scrub jacket was hanging on the back of his chair and his bare arms exposed.

4. During an observation on 5/5/26 at 11:17 a.m. in OR 1, ANES 1, with bare hands, removed his personal cell phone out of the back pocket of his scrub pants, used the device, and returned it to his pocket. ANES 1 did not perform HH either before or after using his cellular device.

During an observation on 5/5/26 at 11:21 a.m. in OR 1, while providing care for Patient 1 ANES 1 took his personal cell phone out of the back pocket of his scrub pants, used the device, and placed it on the small counter area of the anesthesia machine. ANES 1 did not perform HH either before or after he used his cellular device.

During an observation on 5/5/26 at 11:36 a.m. in OR 1, while providing care for Patient 1 ANES 1 took his personal cell phone from the small counter area of the anesthesia machine, used the device, and returned it to his back pocket. ANES 1 did not perform HH either before or after he used his cellular device.

During an observation on 5/5/26 at 11:46 a.m. in OR 1, while providing care for Patient 1 ANES 1 took his personal cell phone from his back pocket, used the device, and returned it to his back pocket. ANES 1 did not perform HH either before or after he used his cellular device.

During an interview on 5/6/26 at 2:11 p.m. with the Infection Preventionist (IP), the IP stated it was imperative that proper HH was performed before or immediately upon entering and after exiting a patients room, before and after glove use, before and after providing any direct patient care such as a physical exam or medication administration, and after handling high touch items such as a cell phone. The IP further stated gloves should be worn when physically touching a patient but wearing gloves is not a substitute for proper HH either with ABHS or soap and water and hands should be sanitized before and after wearing gloves. The IP stated proper disinfection before and after use of equipment such as a stethoscope, which was used on multiple patients, is very important to prevent the spread of germs from one patient to another. The IP stated proper surgical attire which included beard covers and scrub jackets are a very important part of infection control because they limit hair and skin shedding in the OR during surgical procedures. The IP further stated cell phones are a known source of germs and their use in patient care areas, especially the OR, should be limited and when used appropriate disinfection and HH should be performed. The IP stated the expectation was that everyone who worked at the ASC, including physicians and anesthesiologists were to adhere to all infection control policies and procedures (P&P) and by not doing so it affected the quality of care to all patients and put them at risk for surgical complications and infection.

During a review of the ASCs P&P titled, SSCD [facility name] Hand Hygiene Policy, dated 3/21/24, the P&P indicated, Purposeto remove dirt, organic material, and/or transient microorganisms from the hands in order to reduce the risk of

	transmission within the health care environmentIndications for hand hygienebefore and after having direct contact with patientsafter contact with used patient equipment and the patients environmentbefore a clean sterile or clean taskBefore donning [putting on] and after doffing [taking off] gloves. During a review of the ASCs P&P titled, Standard Transmission Based Precautions and Managing Transmissible Diseases, dated 12/11/24, the P&P indicated, Safe Injection PracticesUse aseptic technique [a set of specific medical and laboratory practice such as handwashing, wearing gloves, and using sterile equipment, designed to prevent the transfer of harmful germs and minimize contamination during procedures] when preparing and administering medicationsReusable equipmentNon-invasive patient care equipment [stethoscope] should be disinfectedbetween each patient use. During a review of the ASCs P&P titled, Dress Code and Work Practices in the Clinical Setting, dated 4/9/24, the P&P indicated, All individuals who enter the semi-restricted and restricted areas of the facility [operating room and designated surrounding area] will wearsurgical attireintended for use only within the operating roomMembers of the non-scrubbed perioperative team [anesthesiologists] should wearsingle use long-sleeved warm up jacket snapped closed with cuffs to the wrist to contain shedding skin squames (dead, flakey skin cells) from bare armsMale personnel must cover beards and hair completely. During a review of the ASCs P&P titled, Cellular Phone Usage Policy, dated 10 /30/24, the P&P indicated, Cell phone usage guidelinesPhysicians and anesthesia providersuse should be avoided in patient care areas and during times of performing a procedure/surgeryCell phone handling and cleaningCell phonesshould be cleaned and disinfectedbefore being brought into the ORPersonnel should perform hand hygiene frequently when handling these devices.