Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 55C0001061	**(X3) Date Survey Completed** 07/17/2025
Name of Provider or Supplier Pacific Eye Institute	**Street Address, City, State** 555 N 13th Avenue, Upland, 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 the recertification survey conducted on July 14, 2025, through July17, 2025. Census: 8 Sample Size: 20 The following conditions were not met: Governing Body and Management Quality Assurance and Performance Improvement Laboratory Services Patient Right Infection Control Deficiencies were issued during this recertification survey.
Q0040	GOVERNING BODY AND MANAGEMENT CFR(s): 416.41 The ASC must have a governing body that assumes full legal responsibility for determining, implementing,and monitoring policies governing the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment,

	and develops and maintains a disaster preparedness plan. This CONDITION is not met as evidenced by: Based on interview and record review, the facility Governing Body (GB-administrative team of members responsible to the overall working of the facility) failed to evaluate or oversee the contracted services and to perform competency skills evaluation for three of three registry (contracted personnel) staffs (Registered Nurse (RN) 1, RN 3, and Surgical technician (ST 1)), when the facility was unable to provide documented evidence to show the three-registry staffs competency skill evaluation (Refer to Q0041). The cumulative effects of this systemic problem resulted in the facilitys inability to ensure safety for patients from unidentified staff skills and knowledge to perform job function which could jeopardize patients health and safety.
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 record review, the facility failed to perform competency skills evaluation for three of three registry (contracted personnel) staff (Registered Nurse (RN) 1, RN 3, and Surgical Technician (ST 1)), when the facility was unable to provide documented evidence to show the three-registry staffs competency skill evaluation. This failure had the potential to increase the safety risks for patients from unidentified and unqualified staff with lack of skills and knowledge to perform job function which could jeopardize patients health and safety. Findings: During an interview on July 16, 2025, at 10:00 AM, with RN 1, RN 1 stated, she is contracted with an outside registry company to work in this facility. RN 1 further stated, she did not need to have to complete skill evaluation when she started to work in the facility. During a concurrent record review and interview on July 16, 2025, at 4:30 PM, with the Director of Nursing (DON), the facility's employee Competency skills Checklist,

	undated, were reviewed. The DON verified and confirmed, RN1, RN 3, and ST 1s files were missing skill evaluation record. A follow-up interview on July 16, 2025, at 4:45 PM, with the DON, the DON stated, he was unable to provide any documented evidence to show RN1, RN 3, and ST 1 competency checklist evaluation. The DON confirmed that registry staff did not need to complete a competency checklist before starting to work in the facility. The DON further stated, the facility does not have a policy and procedure (P&P) regarding evaluating staff competency. A follow-up interview on July 16, 2025, at 4:55 PM, with the DON, the DON stated competency skills checklist will help to verify skills and knowledge of staff to verify that the staff can do the assigned job. The DON further stated that this practice puts patients at risk of complications from surgery, infections and delayed recognition and treatment of complications.
Q0080	QUALITY ASSESSMENT AND PERFORMANCE CFR(s): 416.43 The ASC must develop, implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure an effective and ongoing Quality Assurance Performance Improvement (QAPIa data driven and proactive approach to quality improvement) for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when: 1. The facility failed to monitor, collect data, and analyze performance to improve patients care (Refer to Q0081). 2. The facility failed to monitor, collect data and analyze the process of checking and restocking supplies (Refer to Q0082). 3. The GB did not have an oversight of the facilitys personnel qualification, did not maintain or evaluate for the effectiveness of the QAPI program, and did not ensure the infection control policy reflects the current required regulation (Refer to Q0084). The accumulative effects of these systemic problems resulted in the facilitys inability

	to ensure the provision of quality health care and nursing services in a safe environment.
Q0081	PROGRAM SCOPE; PROGRAM ACTIVITIES CFR(s): 416.43(a), 416.43(c)(1) (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility did not ensure an effective and ongoing Quality Assurance Performance Improvement (QAPIa data driven and proactive approach to quality improvement) for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when the facility failed to monitor, collecting data, and analyze the facility performance to improve patients care. This failure had resulted in the missed opportunities to identify any potential issues of the facilitys performance and to create any changes to improve patients health outcomes and had the potential to cause a preventable adverse patient outcome that could negatively affect patients health and safety. Findings: During an interview on July 17, 2025, at 9:18 AM, with the Director of Nursing (DON), the DON verified and stated, he was unable to find the QAPI meeting minute (a summary of issues related to the facilitys operation discussed during the QAPI meeting) from January 1, 2024, through July 17, 2025. The DON further stated, he is overseeing the QAPI program. During an interview on July 17, 2025, at 9:41 AM, with the DON, Senior Manager (SM), and On-Site Facility Manager (OFM), the survey team brought up issues identified during survey including lack of staff immunization and evaluation, and

	unqualified surgical technician. The DON verified and confirmed, the employee files did not contain the immunization status and evaluation. The SM verified and confirmed, Ambulatory Surgical Center Liaison Staff 1(ASCLS 1- a person who works in the front desk) did not have a qualification or training on file to be working as Surgical Technician (ST-a person who performs the duties and responsibilities of operating room technician). The DON and SM stated the facility was unaware of ASCLS 1s missing training or qualification but has been working as ST. A follow-up interview on July 17, 2025, at 9:42 AM, with the DON, SM, and OFM, the survey team inquired about the missing QAPI meeting minutes, the DON and SM confirmed and stated that the facility did not have any documented evidence that the QAPI program utilized any quality indicators to work on any improvement projects or focus on any issue areas. The DON also acknowledged that the facility did not have a well-defined laboratory service plan and was not able to provide any tracking of missing lab or specimen (sample of patients blood or tissue from procedure) collection. During an interview on July 17, 2025, at 10:06 AM, with the DON and Senior Vice President (SVP), the SVP acknowledged that the facility did not have an effective process for measure, analyze, and track quality indicators. The SVP further stated that the facility is responsible for an effective QAPI plan. The DON and SVP confirmed that the QAPI team did not have clear communication with the Governing Body (the administrative team member for Ambulatory Surgical center) regarding the indicators for tracking and improving patient care. During a concurrent interview and record review on July 17, 2025, at 10:20 AM, with the DON and SVP, the facilitys policy and procedure(P&P) tilted Quality Assurance Performance Improvement Plan (QAPI), [undated], was reviewed. The P&P indicated, Quality improvement at the surgery center includes the following components: Performance improvement ..Performance improvement is dynamic and ongoing, based on the premise that quality is dynamic in nature..Quality Assurance is retrospective in nature, reviewing specific indicators to identify problem areas which might include the following: to objectively and systematically monitor and evaluate the quality and appropriateness of patient care on an ongoing basis in order to assure that we have met quality standards The SVP stated that the policy was not followed as the QAPI failed to track the facilitys performance and review problem prone areas.
Q0082	PROGRAM DATA; PROGRAM ACTIVITIES CFR(s): 416.43(b), 416.43(c)(2), 416.43(c)(3) (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure

that improvements are sustained over time. (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.

This STANDARD is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure an effective and ongoing Quality Assurance Performance Improvement (QAPIa data driven and proactive approach to quality improvement) program for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when the facility failed to monitor, collecting data and analyze the process of checking and restocking of supplies.

This failure had resulted in the missed opportunities to identify issues of unsafe care from the beyond the use date (expired supplies) which had the potential to cause a preventable adverse patient outcome that could negatively affect patients health and safety.

Findings:

During a concurrent observation and interview on July 14, 2025, at 3:50 PM, with the Director of Nursing (DON), in Operating Room (OR 1), the following expired supplies were found:

Three Endotracheal Tube (a flexible plastic tube inserted into windpipe through the mouth or nose) Oral (mouth)/Nasal (nose), with an expiration date of June 28, 2025 (16 days expired).

One Constellation Vison System (a specialized surgical machine used in eye operations, specifically for both the front and back of the eye), 25 Gauge (GAsize of equipment) Chandelier (refers to light use during eye surgery) with an expiration date of May 31, 2025 (44 days expired).

One 25 GA Actua Forceps End Grip (a special instrument used for eye procedure) with an expiration date of May 1, 2025 (75 days expired).

One Lubricating Jelly (water based sterile gel used to reduce friction during medical procedure) with an expiration date of July 7, 2025 (7 days expired).

	The DON confirmed that expired medical supplies should not be available in the patient care area and should have been removed. During an interview on July 17, 2025, at 9:41 AM, with the DON, Senior Manager (SM), and On-Site Facility Manager (OFM), the survey team brought up issues regarding expired supplies. The DON verified and confirmed that the facility was not tracking for expired supplies and medications. The DON stated that the facility did not have a person in charge of supplies and there was no tracking log of supplies. During a concurrent interview and record review on July 17, 2025, at 9:45 AM, with the DON SM and OFM, the facilitys policy and procedure(P&P) titled, Quality Assurance Performance Improvement Plan (QAPI), [undated], was reviewed. The P&P indicated, Quality Assurance is retrospective in nature, reviewing specific indicators to identify problem areas which might include the following: to objectively and systematically monitor and evaluate the quality and appropriateness of patient care on an ongoing basis in order to assure that we have met quality standards. To show evidence of problem resolution by way of tracking and follow up. To identify problems requiring action by the QAPI committee and referring such problems for further investigation and actions The DON stated that the facility has no responsible person or a log for tracking the supplies. The SM stated that the facilitys QAPI was not meeting on a periodic basis as required, so there were missing documents.
Q0084	GOVERNING BODY RESPONSIBILITIES CFR(s): 416.43(e) The governing body must ensure that the QAPI program- (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. This STANDARD is not met as evidenced by: Based on interview and record review, the facilitys Governing Body (GB-administrative team of members responsible to the overall working of the facility) did not ensure the Quality Assurance Performance Improvement (QAPI-a data driven and proactive approach to quality improvement) program evaluated the facilitys quality of care and safety expectation for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025,when the GB did not have an oversight on the facilitys personnel qualification, did not maintain or evaluate for the effectiveness of the QAPI

program, and did not ensure the infection control policy reflects the current required regulation.

These failures have the potential to cause failure in delivery of care from unqualified personnel and inability to focus on the facilitys performance issues from lacking communication between the GB and QAPI team, and no acceptable guideline for infection control practices such as utilizing protective equipment, and isolation precaution (measures to prevent spread of infection) which could interfere with patients medical care and jeopardize the health and safety of patients.

Findings:

During a review of the facilitys Employee Roster, undated, the Employee Roster indicated, Ambulatory Surgical Center Liaison Staff 1 (ASCLS 1- a person who works in the front desk) was listed under surgical technician (ST- a person who is qualified to do assist in Operation Room).

During a concurrent interview and record review on July 16, 2025, at 10:00 AM with the Director of Human Resource (DHR), Employee File, dated August 17, 2020, was reviewed. The Employee File, indicated, ASCLS 1 was hired to the facility on August 17, 2020, with the job title as ASCLS. The DHR stated that ASCLS 1 has the duties and responsibilities of a liaison staff, and she is not qualified as ST.

During a concurrent interview and record review on July 17, 2025, at 8:30 AM, with the Senior Manager (SM), the facilitys online portal of hiring, undated, was reviewed. The online portal of hiring indicated that ASCLS 1 was hired for the position of ASC liaison on August 17, 2020. The SM acknowledged that ASCLS1 was not hired for the position of ST. The SM stated, she was unable to provide any documented evidence of training to show that ASCLS 1 is qualified to practice as ST. The SM further stated, ASCLS 1 is out of the facility this week and not available for interview.

During an interview on July 17, 2025, at 10:15 AM, with the Director of Nursing (DON) and Senior Vice President (SVP), the survey team brought up issues identified during survey including unqualified surgical technician, the missing GB and QAPI meeting minutes, and the policy and procedure (P&P) lacking utilizing guideline from national recognized infection control program. The DON and SVP confirmed that the QAPI team did not have clear communication with the GB regarding the indicators for tracking and improving patient care.

A follow up interview on July 17, 2025, at 10:20 AM, with the DON and SVP, the

	DON confirmed that ASCLS 1 was working as ST, and the facility management was unaware about the lack of training document and certification as ST for ASCLS 1. The SVP acknowledged that he was also unaware about ASCLS1s qualification. During a concurrent interview and record review on July 17, 2025, at 10:25 AM, with the DON and SVP, the facilitys document titled, bylaws, [undated], was reviewed. The bylaws indicated, Purpose: The purpose of the Governing Body is to oversee and determine, implement and monitor policies governing the ASCs total operation 2) functional roles and responsibilities: The governing body shall be responsible for the following specific functions and responsibilities: Policies and procedures: Establish the ASCs policies and ensure that those policies are implemented The SVP stated that GB is responsible for overseeing the facilitys operations and following the bylaws. During a concurrent interview and record review on July 17, 2025, at 10:45 AM, with the DON and SVP, the facilitys P&P titled, Infection Control Program, undated, was reviewed. The P&P did not indicate any nationally recognized infection control guidelines or plan to prevent control, investigate infections and communicable diseases. The SVP stated that the policy should be looked at and should be revised since it needs to reflect the current regulations that require the facility to follow nationally recognized infection control guidelines.
Q0109	EMERGENCY EQUIPMENT CFR(s): 416.44(d) (d) Standard: Emergency equipment. The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC's operating room. The equipment must meet the following requirements: (1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure emergency supplies were immediately available for use during emergency situations for 1292 of 1292 patients from June 1, 2025, through July 17, 2025, when one (1) medicine for use during emergency resuscitations (an emergency treatment done when patients breathing or heartbeat has stopped) was missing and not readily available in the crash cart (a wheeled container carrying medicine and equipment for use in emergency) in the facility for the two (2) operating rooms (ORlocation where surgical procedures are performed) and one (1) post anesthesia recovery unit (PACU- area where patients are monitored after surgery or procedures). This failure had the potential to deprive patients of the required lifesaving medicine in

	the event of medical emergency, which could potentially result in patient harm. Findings: During a concurrent observation and record review on July 14, 2025, at 2:30 PM, with Registered Nurse (RN 1), the facility had only one crash cart which is located in the PACU. The crash cart had the facilitys document titled, Monthly Crash Cart Checklist, dated June 2, 2025, indicated, Aminophylline (medication used to prevent and treat wheezing, shortness of breath and difficulty in breathing) 500 milligrams (mg-unit dosing medication) with quantity of zero and expired in June 2025. A follow-up interview on July 14, 2025, at 2:40 PM, with RN 1, RN 1 verified and confirmed that one intravenous (IV-into the vein) Aminophylline has been missing since June 1, 2025 (43 days missing). During a concurrent interview and record review on July 14, 2025, at 3:15 PM, with the Director of Nursing (DON), the facilitys policy and procedure (P&P) titled, Emergency Medications/Crash Cart, dated October 2019 was reviewed. The P&P indicated, POLICY: Emergency drugs and supplies, for use in medical emergencies only, shall be immediately available in the Ambulatory Surgical Center. The DON confirmed and stated that the Aminophylline medication was removed from the crash cart due to the expiration of the medication and supply issues. The DON further stated that the facility did not follow the P&P by not ensuring emergency medication is readily available for use. The DON added, this failure could have resulted in patient harm with lacking medication to use during medical emergency. A follow-up interview on July 17, 2025, at 9:42 AM, with the On-Site Facility Manager (OFSM), the OFSM stated that she was aware of Aminophylline missing from the crash cart and did not ensure the missing medication is replaced in the emergency cart.
Q0200	LABORATORY AND RADIOLOGIC SERVICES CFR(s): 416.49 This CONDITION is not met as evidenced by: Based on interview and record review, the facility failed to have the laboratory contracted services for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when the facility was unable to provide a contractual agreement or a well-defined laboratory service plan (Refer to Q0201).

	The cumulative effects of this systemic problem resulted in the facility's inability to ensure the provision of quality health care and laboratory services to the patients received care from this healthcare facility.
Q0201	LABORATORY SERVICES CFR(s): 416.49(a) If the ASC performs laboratory services, it must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with the requirements of Part 493 of this chapter. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to have a well-defined plan for laboratory services for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when the facility was unable to provide a well-defined plan of laboratory services and follow-up of tests or specimen (sample of patients blood or tissue from procedure) tracking. This failure had the potential to negatively affect 9749 patients from January 1, 2024, through July 17, 2025, who underwent surgery and needed laboratory services, which could jeopardize the diagnostic and treatment plan for patients without proper outline of laboratory services and specimen tracking. Findings: During an interview on July 16, 2025, at 7:45 AM, with the Director of Nursing (DON), the DON stated that the facility contracted outside laboratory service companies to perform the facilitys laboratory tests. During a review of the facilitys document titled, patient log, dated January 1, 2024, through July 17, 2025, the patient log indicated there were total of 9749 patients received services from the facility. During an interview on July 16, 2025, at 3:30 PM, with the DON, the DON stated, he was unable to provide any contracted laboratory services agreement forms or well-defined plan for the contracted company. The DON further stated that the facility did

	not have any assigned person to oversee the tracking of tests or specimens to ensure it was properly processed and reported. The DON verified and confirmed that the facility does not have a tracking log for the specimens. During an interview on July 17, 2025, at 9:18 AM, with the DON, the DON stated, he was unable to find any policy and procedure for contracted agreement with the laboratory, list of services provide, obtaining specimen, tracking of specimen, and/or missing of specimen.
Q0219	PATIENT RIGHTS CFR(s): 416.50 Condition for Coverage - Patient Rights The ASC must inform the patient or the patient's representative or surrogate of the patient's rights and must protect and promote the exercise of these rights, as set forth in this section. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to protect and promote patients rights for 1934 of 1934 patients receiving care from May 1, 2025, through July 17, 2025, when: 1. The written notice of patients rights was not displayed in the area to be easily noticed by patients, patients representative or surrogate (Refer to Q0220). 2. Expired supplies were observed in the Operating Room (OR) area and were readily available for patient use (Refer to Q0232). The cumulative effect of these failures resulted in the facilitys inability to protect the patients rights to receive care in a safe setting with, beyond the use date (expired) supplies, which could potentially cause harm and injuries to patients.
Q0220	NOTICE - POSTING CFR(s): 416.50 ... The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable.

	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to promote patients rights for 1934 of 1934 patients receiving care from May 1, 2025, through July 17, 2025, when the written notice of patients rights was not displayed in the area likely to be noticed by patients, patients representative or surrogate while waiting for treatment. This failure had the potential to violate patients rights. Findings: During a concurrent observation and interview on July 14, 2025, at 2:10 PM, with the Surgical Coordinator (SCO), there was no posting of the written notice of patients rights observed in the waiting area. The SCO verified and confirmed that we do not have patients rights information notice on display. During an interview on July 14, 2025, at 2:45 PM, with the Director of Nursing (DON). The DON verified and confirmed that there is no display of notice for patients rights in any of the patients areas. The DON stated that there was a notice of patients rights in waiting area/reception prior ... but it was taken down at the time of renovation, it should have been posted back but did not. The DON was unable to provide the facilitys policy and procedure regarding displaying notice for patients rights
Q0232	SAFETY CFR(s): 416.50(f)(2) [The patient has the right to -] (2) Receive care in a safe setting This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care was provided in a safe environment for 1934 of 1934 patients receiving care from May 1, 2025, through July 17, 2025, when expired medical supplies were found in the Operating Room (OR) area and were readily available for patient use. This failure had the potential to cause unsafe care provided to patients with beyond the use date (expired) supplies were found which could potentially cause harm and injuries to patients. Findings:

	During a concurrent observation and interview on July 14, 2025, at 3:50 PM, with the Director of Nursing (DON), in OR 1, the following expired supplies were found: Three Endotracheal Tube (a flexible plastic tube inserted into windpipe through the mouth or nose) Oral (mouth)/Nasal (nose), with an expiration date of June 28, 2025 (16 days expired). One Constellation Vison System (a specialized surgical machine used in eye operations, specifically for both the front and back of the eye), 25 Gauge (GAsize of equipment) Chandelier (refers to light use during eye surgery) with an expiration date of May 31, 2025 (44 days expired). One 25 GA Actua Forceps End Grip (a special instrument used for eye procedure) with an expiration date of May 1, 2025 (75 days expired). One Lubricating Jelly (water based sterile gel used to reduce friction during medical procedure) with an expiration date of July 7, 2025 (7 days expired). The DON confirmed that expired medical supplies should not be available in the patient care area and should have been removed. During a concurrent record review and interview on July 15, 2025, at 10:50 AM, with the DON, the facilitys policy and procedure (P&P) titled, Unusable and Outdated Drugs, dated October 2019, was reviewed, The P&P indicated PROCEDURE. All ASC [Ambulatory Surgery Center] medication and sterile supplies will be checked monthly for expiration date and will be removed from stock use when item is past expiration dateThe DON stated the P&P was not followed and expired supplies should have been removed as expired medical supplies can cause harm to patients.
Q0240	INFECTION CONTROL CFR(s): 416.51 416.51 Conditions for Coverage Infection control. The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases.

	This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an appropriate infection control program for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when: 1. The facilitys policy and procedure (P&P) titled, "Infection Control Program," did not indicate using or following of any national recognized infection control guidelines (Refer to Q0242). 2. Expired supplies were observed in the Operating Room (OR) area and were readily available for patient use (Refer to Q0245). 3. The facility was unable to provide documented evidence of vaccination record for 12 of 12 sampled employees (Director of Nursing (DON), Medical Doctor (MD 1, MD2, MD 3, MD 4), OR Registered Nurse (ORRN), RN 1, RN2, OR Technician (ORT), Instrument Technician (IT), Licensed Vocational Nurse (LVN 2), and Ambulatory Surgical Center Liaison Staff (ASCLS 1) (Refer to Q0245). The cumulative effects of these failures resulted in the facilitys inability to provide an effective infection control program, potentially resulting in lack of infection identification, lack of staff training, lack of infection reporting and infection surveillance leading to increased patients infection risk and delays in healing.
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 interview and record review, the facility failed to maintain an ongoing program that is designed to prevent and control infection for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when the facilitys policy and procedure (P&P) titled, "Infection Control Program," did not indicate using or following of any national recognized infection control guidelines. This failure had the potential to cause the increased in risk of healthcare associated infections (HAIs) from lacking appropriate infection prevention control strategies

	such as utilizing protective equipment, and isolation precaution (measures to prevent spread of infection) which could cause longer hospital stays, and negatively affect patients' health and safety. Findings: During an interview on July 16, 2025, at 4:00 PM, with the Director of Nursing (DON), the DON confirmed that he is also acting as Infection Preventionist (IP) and overseeing infection control program. During a concurrent record review and interview on July 16, 2025, at 4:15 PM, with the DON, the facilitys P&P titled, Infection Control Program, undated, was reviewed. The P&P did not indicate any recognized national infection control guidelines or plan to prevent control, investigate infections and communicable diseases. The DON verified and stated, he was unable to provide any documented evidence that the facility followed any recognized national infection control guidelines. The DON further stated that nationally recognized guidelines are important to follow, as with the guidelines there are infection prevention and control strategies that include hand hygiene, protective equipment, staff and patient education, that reduces the risk of patients acquiring HAIs. During a concurrent interview and record review on July 17, 2025, at 10:45 AM, with the DON and Senior Vice President (SVP), the facilitys policy and procedure (P& P) titled, Infection Control Program, undated, was reviewed. The P&P did not indicate any nationally recognized infection control guidelines or plan to prevent control, investigate infections and communicable diseases. The SVP stated that the policy should be looked at and should be revised since it needs to reflect the current regulations that require the facility to follow nationally recognized infection control guidelines
Q0245	INFECTION CONTROL PROGRAM CFR(s): 416.51(b)(3) 416.51(b) Standard: Infection control program. The program is] (3) Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an ongoing infection control program for 9749 of 9749 patients receiving care from January 1, 2024, through July 17, 2025, when:

1. Expired supplies were observed in the Operating Room (OR) area and were readily available for patient use.

2. The facility was unable to provide documented evidence of vaccination record for 12 of 12 sampled employees (Director of Nursing (DON), Medical Doctor (MD 1, MD2, MD 3, MD 4), OR Registered Nurse (ORRN), RN 1, RN2, OR Technician (ORT), Instrument Technician (IT), Licensed Vocational Nurse (LVN 2), and Ambulatory Surgical Center Liaison Staff (ASCLS 1).

These failures had the potential to result in cross-contamination (the transfer of harmful bacteria) causing a preventable bloodstream infection which can negatively affect patients health, prolonged hospitalization, lead up to actual harm, or possible death.

Findings:

1. During a concurrent observation and interview on July 14, 2025, at 3:50 PM, with the Director of Nursing (DON), in OR 1, the following expired supplies were found:

Three Endotracheal Tube (a flexible plastic tube inserted into windpipe through the mouth or nose) Oral (mouth)/Nasal (nose), with an expiration date of June 28, 2025 (16 days expired).

One Constellation Vison System (a specialized surgical machine used in eye operations, specifically for both the front and back of the eye), 25 Gauge (GAsize of equipment) Chandelier (refers to light use during eye surgery) with an expiration date of May 31, 2025 (44 days expired).

One 25 GA Actua Forceps End Grip (a special instrument used for eye procedure) with an expiration date of May 1, 2025 (75 days expired).

One Lubricating Jelly (water based sterile gel used to reduce friction during medical procedure) with an expiration date of July 7, 2025 (7 days expired).

The DON confirmed that expired medical supplies should not be available in the

patient care area and should have been removed.

During a concurrent record review and interview on July 15, 2025, at 10:50 AM, with the DON, the facilitys policy and procedure (P&P) titled, Unusable and Outdated Drugs, dated October 2019, was reviewed, The P&P indicated PROCEDURE. All ASC [Ambulatory Surgery Center] medication and sterile supplies will be checked monthly for expiration date and will be removed from stock use when item is past expiration date The DON stated the P&P was not followed and expired medical supplies should have been removed as using expired medical supplies can lead to decreased effectiveness of treatments. The DON further stated, expired items would increase risk of infections from losing their sterile (free from infection) condition, may lose potency, and potentially leading to ineffective treatment.

2. During a concurrent record review and interview on July 16, 2025, at 2:10 PM, with the Regional Director of Human Resources (RDHR), the employee files were reviewed. The employee files were missing immunization record for DON, MD 1, MD 2, MD 3, MD 4, ORRN, RN 1, RN 2, ORT, IT, LVN 2, and ASCLS 1. The RDHR verified and stated that she was unable to provide any immunization records for all 12 sample employees.

During an interview on July 16, 2025, at 4:00 PM, with the DON, the DON confirmed that he is also acting as IP and overseeing infection control program. The DON confirmed and verified the missing vaccination documents of the 12 sample employees.

During a concurrent record review and interview on July 16, 2025, at 4:15 PM, with the DON, the facilitys policy and procedure (P&P) titled Infection Control Program, undated, was reviewed. The P&P indicated, . Section 1.1.1 Infection Prevention Plan, Employee Health: Employee Health will be monitored on an ongoing basis. The infection Prevention Nurse will annually review the data on exposures and develop risk reduction interventions (hepatitis B and Influenza Vaccines, tuberculosis skin testing). The physical exams and screening plans require the full cooperation and participation of all employees and directors, who must be aware of their role in the prevention of ASC-acquired infection The DON verified and confirmed that the policy was not being followed. The DON stated that employees working in the facility without up-to-date immunization would pose a high risk of infection due to cross-contamination from staff to vulnerable patients from invasive procedures with open wounds.