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)
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.