Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001061	07/17/2025
Name of Provider or Supplier	**Street Address, City, State**	
Pacific Eye Institute	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)
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.