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)
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.