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)
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.