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Statement of Deficiencies
Citation Summary Sheet

For: METROPOLITAN SURGICAL ASSOCIATES (10263 / NJ31C0001006)

Survey Event: DJT711, Exit Date 11/02/2016

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
State	3B6I	9.00	00	0000	INITIAL COMMENTS	
State	3B6I	9.00	00	1885	PT CARE POL & SVCS: MED HISTORY & PHYS EXAM	
State	3B6I	9.00	00	2166	NURSING SVCS: RESPONSIBILITIES OF LIC NSG PER	
State	3B6I	9.00	00	2285	PHARMACEUTICAL SVCS: POLICIES & PROCEDURES	
State	3B6I	9.00	00	4098	INFEC PREV & CONTROL: POL & PROCEDURES	
State	3B6I	9.00	00	4112	INFEC PREV & CONTROL: POL & PROCEDURES	
State	3B6I	9.00	00	4154	Infec Prev & Control: Infec Prev Measures	
State	3B6I	9.00	00	4183	INFEC PREV & CONTROL: INFEC PREV MEASURES	
State	3B6I	9.00	00	4190	INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS	
State	3B6I	9.00	00	4215	INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS	
State	3B6I	9.00	00	4797	HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SERV	
State	J93T	02.08	00	1170	PAIN MGMT PROCDURS: PAIN ASSESSMENT PROCDURS	

Americans United for Life

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10263	A. BUILDING: _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS A State Re-licensure survey was conducted on 11/1 & 11/2/16 which resulted in deficiencies. Abbreviation Key: AAMI=Association for the Advancement of Medical Instrumentation AORN= Association of periOperative Registered Nurses CDC=Centers for Disease Control and Prevention CI=Chemical Indicator/Integrator HICPAC=Hospital Infection Control Practices Advisory Committee IDSA=Infectious Disease Society of America IFUs=Instructions for Use OPA=Ortho-Phthalaldehyde OR=Operating Room OSHA=Occupational Safety and Health Administration PPE=Personal Protective Equipment SHEA=Society of Healthcare Epidemiology of America TOP=Termination of Pregnancy	A 000		
A1885	8:43A-6.4(a) PT CARE POL & SVCS: MED HISTORY & PHYS EXAM The facility shall specify in its policies and procedures the circumstances under which the patient's medical history will be obtained, the contents of the medical history, and the frequency of updating. The contents shall include at least past surgical procedures and medical/health conditions, allergies, adverse reactions to drugs, and current medications.	A1885		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A1885	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, it was determined that the facility failed to ensure that a complete medical history is obtained prior to a procedure in accordance with its Medical Staff Rules and Regulation. Findings include: Reference: Facility Medical Staff Rules and Regulation states, "... VII. Medical Records ... 2. Under no circumstances may an operation be performed until the patient's history, physical examination ... are recorded on the medical record." 1. The medical records of Patients #2 - #20 lacked a complete medical history performed by the physicians prior to a procedure. The medical records have a Patient Information sheet that includes the patient's medical history, past surgery/hospitalization, allergies, medications, etc. which is completed and signed by the patient. As per Staff #7, this form is reviewed and utilized for additional notes by the physicians as a medical history prior to the procedure.	A1885		
A2166	8:43A-8.4(a) NURSING SVCS: RESPONSIBILITIES OF LIC NSG PER Licensed nursing personnel shall provide nursing care to patients in accordance with the State of New Jersey Nursing Practice Act, N.J.S.A. 45:11-23 et seq., as interpreted by the New Jersey State Board of Nursing, and written job descriptions. Services provided shall be	A2166		

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A2166	Continued From page 2 documented in the patient's medical record. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that nursing personnel did not provide nursing care in accordance with a recognized standard of practice and its policy. Findings include: Reference #1: The Nursing Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse RN is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference #2: Facility policy "Perioperative Pain Management at MMA" states, "... To make the patient's recovery after surgery and anesthesia more comfortable, the PACU nurse is advised to do a pain assessment based on a scale of 0-10, 0- no pain, 10, pain is absolutely unbearable ..." 1. The medical record of Patient #7 revealed that the patient underwent a procedure on 10/8/16. The PACU (post anesthesia care unit) Post Operative Admission sheet indicated that at 4:30 PM, the patient met discharge criteria. One indicator of the Discharge Criteria is "Pain score <	A2166		

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A2166	Continued From page 3 (less) 3." There was no evidence in the medical record that the patient's pain was assessed throughout the PACU stay and prior to discharge. 2. The medical record of Patient #6 revealed that the patient underwent a procedure on 10/25/16. The PACU Post Operative Admission sheet indicated that at 12:15 PM the patient met discharge criteria. One indicator of the Discharge Criteria is "Pain score < (less) 3." There was no evidence in the medical record that the patient's pain was assessed in PACU and prior to discharge. 3. The medical record of Patient #2 revealed that the patient underwent a procedure on 12/30/15. Post procedure there was no evidence that the patient's pain was assessed prior to the patient's transfer. 3. The medical record of Patient #5 indicated in the Patient's Information Medical History sheet that the patient was allergic to Dapro and Ibuprofen. The Post Operative Orders dated 10/14/16 contained an order for "Ibuprofen 800 mg (milligram) po (by mouth) prn (as needed) cramping x1." Although the patient did not require any medication for cramping post operatively, there was no evidence that nursing staff consulted with the physician for clarification or discontinuation of the order. 4. The medical record of Patient #7 indicated on 10/22/16 that post-operatively, the patient was maintained on Lactated Ringers at 125 ml (milliliter) per hour. There was no evidence in the Post Operative Orders of an intravenous fluid order. 5. The medical record of Patients #4 indicated	A2166		

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A2166	Continued From page 4 that post-operatively on 8/3/16, the patient was maintained on Lactated Ringers at 125 ml per hour with 20 units of Pitocin. There was no evidence in the Post-Operative Orders of an intravenous fluid order. 6. The medical records of Patients #2, #3, #4, #5 indicated that these patients were transferred post operatively to a hospital for evaluation. The medical records failed to include a transfer order. 7. The above was confirmed by Staff #2 and Staff #7.	A2166		
A2285	8:43A-9.3(b)(5) PHARMACEUTICAL SVCS: POLICIES & PROCEDURES The facility's policies and procedures for the administration, control, and storage of medications shall include, but not be limited to, policies and procedures for the purchase, storage, safeguarding, accountability, use, and disposition of drugs, in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and the Controlled Dangerous Substances Acts and amendments thereto. Pharmaceutical services provided through written agreement shall be provided by a pharmacy licensed by the New Jersey State Board of Pharmacy. An individual patient may choose to obtain medications from a pharmacy which is not located in New Jersey. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview	A2285		

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A2285	Continued From page 5 conducted on 11/2/16, it was determined that the facility failed to ensure the implementation of acceptable standards of practice for medication preparation. Findings include: Reference: Institute for Safe Medication Practices (ISMP) Safe Practice guidelines for Adult IV Push Medications, Appendix A, states, " 3.5 Do NOT withdraw IV push medications from commercially available, cartridge-type syringes into another syringe for administration." 1. Carpuject prefilled syringe cartridges of Labetalol were found in the anesthesia cart of Operating Room #4. 2. Upon interview, Staff # 4 stated that the facility withdraws the medication using a syringe and did not use carpuject holding devices. 3. These findings were confirmed by Staff #2.	A2285		
A4098	8:43A-14.2(b)(4) INFEC PREV & CONTROL: POL & PROCEDURES The infection control committee, with assistance from each service in the facility, shall develop, implement, and review, every three years or more frequently as necessary, written policies and procedures regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following: Infection control practices, including universal precautions, in accordance with the Occupational Safety and Health Administration (OSHA) rule 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne Pathogens, incorporated herein by	A4098		

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A4098	Continued From page 6 reference. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview conducted on 11/1/16, it was determined that the facility failed to ensure compliance to OSHA regulations. Findings include: Reference: OSHA (Occupational Safety and Health Administration) 29 CFR part 1910.1030(d)(3)(ii) states, "Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgement, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future." 1. During a tour outside OR #2, in the presence of Staff #2, Staff #9 was observed exiting OR #2 at 12:10 PM, carrying a container of soiled instruments without the benefit of protective gloves.	A4098		

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A4098	Continued From page 7 a. The container was observed to contain a biohazard warning label. 2. The facility failed to ensure implementation of PPE use in compliance to OSHA regulations. 3. This finding was confirmed by Staff #2.	A4098		
A4112	8:43A-14.2(b)(6) INFEC PREV & CONTROL: POL & PROCEDURES The infection control committee, with assistance from each service in the facility, shall develop, implement, and review, every three years or more frequently as necessary, written policies and procedures regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following: Aseptic technique, employee health in accordance with N.J.A.C 8:43A-3.7, and staff training in regard to infection control. This REQUIREMENT is not met as evidenced by: Based on document review, observation and interview, it was determined that the facility failed to ensure aseptic techniques are implemented in accordance with its policy. Findings include: Reference: Facility policy titled Safe Medication Administration Guidelines states, "... [bullet] Use	A4112		

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A4112	Continued From page 8 aseptic technique to avoid contamination of sterile injection equipment... [bullet] Multi-dose vials will be used as single dose vials at all times. They will be punctured once and discarded after single use... [bullet] Always use a new sterile syringe and needle to draw up medications... [bullet] Do not re-use needles, syringes or cannulae... [bullet] Swab all vials with an alcohol pad prior to drawing up medication even single use vials." 1. During an observation of Patient #1 on 11/1/16, Staff #4 re-used the same needle and syringe used previously to administer propofol, to draw up an additional dose of propofol. 2. Staff #4 did not disinfect the rubber septum with alcohol prior to piercing the vial. 3. Staff #1 and Staff #7 confirmed the above findings.	A4112		
A4154	8:43A-14.3(a) Infec Prev & Control: Infec Prev Measures Infection prevention activities shall be based on the Centers for Disease Control and Prevention Guidelines, and Hospital Infection Control Practices Advisory Committee (that is, HICPAC) recommendations.	A4154		

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A4154	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies and procedures, review of nationally recognized guidelines, and staff interview, it was determined that the facility failed to disinfect intravenous ports according to established CDC guidelines. Findings include: Reference #: CDC, Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011, pg. 55 states, " ... Appropriate disinfectants must be used to prevent transmission of microbes through connectors [357]. Some studies have shown that disinfection of the devices with chlorhexidine/alcohol solutions appears to be most effective in reducing colonization [195, 196]. ... . " 1. On 11/1/16, Staff #1 indicated that the facility follows CDC guidelines for its infection control practices. 2. During an observation of Patient #1 on 11/1/16, Staff #4 administered IV medication numerous times to Patient #1 without first disinfecting his/her IV port with alcohol. 3. Staff #1 and Staff #7 confirmed the above findings.	A4154		
A4183	8:43A-14.3(a)(5) INFEC PREV & CONTROL: INFEC PREV MEASURES	A4183		

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A4183	Continued From page 10 Infection prevention activities shall be based on Centers for Disease Control and Prevention Guidelines, and Hospital Infection Control Practices Advisory Committee (that is, HICPAC) recommendations. An exception to the adoption of the following guideline shall be allowed providing that there is a sound infection control rationale based upon scientific research or epidemiologic data. The following published guideline is incorporated herein by reference, as amended and supplemented: Guideline for Hand Hygiene in Health-Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16), published by the Coordinating Center for Health Information and Service, available at http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf and at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review conducted on 11/1/16, it was determined that the facility failed to ensure a safe and sanitary environment for the provision of surgical services by adhering to hand hygiene procedures in accordance with CDC-HICPAC guidelines and its own policy.	A4183		

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A4183	Continued From page 11 Findings include: Reference #1: Facility policy and procedure titled, "Hand Hygiene Policy and Procedure" states, "... A. Indications for Handwashing ...3. Handwashing may also be used for routinely decontaminating hands in the following clinical situations: ... After removing gloves ... B. Indications for Handrubbing ... After removing gloves ..." Reference #2: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee[HICPAC] and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the CDC (Centers for Disease Control and Prevention) Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16) page 32 states, " Recommendations: 1. Indications for Handwashing and Hand antisepsis ... C. Decontaminate hands before having direct contact with patients. ... E. Decontaminate hands before inserting...peripheral vascular catheters, or other invasive devices... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with ... a patient's nonintact skin ... I. Decontaminate hands after contact with inanimate objects...in the immediate vicinity of the patient. J. Decontaminate hands after removing gloves."	A4183		

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A4183	Continued From page 12 1. During a tour of OR #2 at 12:20 PM, in the presence of Staff #2, Staff #8 was observed removing his/her soiled gloves and touching his/her mask and eyeglasses without first sanitizing his/her hands. a. This finding was confirmed by Staff #2 and Staff #8. 2. During a tour of the SPD area, in the presence of Staff #2, Staff #3 was observed removing his/her soiled gloves and opening a door, without first sanitizing his/her hands. a. The above finding were confirmed by Staff #2 and Staff #3. 3. The facility failed to ensure a safe and sanitary environment by implementing hand hygiene in accordance with CDC-HICPAC guidelines and its own Infection Control policy. 4. On 11/1/16 in Operating Room (OR) #2 during a procedure, Staff #8 donned and doffed his/her gloves multiple times without hand sanitizing between glove changes. a. With gloved hands, Staff #8 pushed discarded wrappers down inside a trash can. (i) While still wearing the same gloves, Staff #8 began opening and closing cabinet doors in search of supplies. b. At 12:46 PM, Staff #8 doffed his/her gloves and left the OR to retrieve supplies. (i) When Staff #8 returned to the OR, he/she did	A4183		

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A4183	Continued From page 13 not hand sanitize prior to donning gloves. Reference #3: AORN, Guidelines for Perioperative Practice, 2016 Edition pg. 30 states, " ... Chipped fingernail polish should be removed prior to entry into the restricted area of the perioperative environment. Fingernail polish that is chipped may harbor pathogens in large numbers ... Chipped fingernail polish should be removed to prevent possible contamination of the environment or the patient... Artificial fingernails should not be worn by health care personnel in the perioperative environment. Any fingernail enhancement or resin bonding product is considered artificial. Fingernail extensions or tips, gels and acrylic overlays, resin wraps, or acrylic fingernails constitute types of artificial fingernails. ... . " 1. The following observations were made on 11/1/16 in the PACU area: a. Staff #15 confirmed that he/she was wearing gel nails. b. Staff #14 was wearing nail polish that was visibly chipped on both hands. c. Staff #10 was wearing nail polish that was visibly chipped on both hands. 2. Staff #1 and Staff #7 confirmed the above findings.	A4183		
A4190	8:43A-14.4(a)(1) INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS Methods for processing reusable medical devices shall conform with the following or revised or later	A4190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10263	A. BUILDING: _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4190	Continued From page 14 editions, if in effect, incorpated herein by reference: The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Good Hospital Practice: Steam Sterilization and Sterility Assurance," ST 46. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview conducted on 11/1/16, it was determined that the facility failed to ensure its Instrument Reprocessing adheres to AAMI ST 79 guidelines. (ST 79 replaces and supercedes ST 46 by consolidating ST 46 with 4 other AAMI standards [ST33, ST37, ST42, and ST35] approved 7/10/2009.) Findings include: Reference #1: AAMI Sterilization in Health Care Facilities, 2014 edition, ST 79 section 10.5.2.2.2 Internal chemical indicators states, "An internal CI should be used within each package, tray, or rigid sterilization container system to be sterilized." 1. During a tour of the SPD area located in the basement, in the presence of Staff #3 and Staff #11, a sterile instrument tray labeled "D&C set" was opened and inspected. The tray was observed to lack an internal CI (chemical indicator/integrator) within the package.	A4190		

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A4190	Continued From page 15 2. The facility failed to ensure compliance with AAMI ST79 guidelines. 3. This finding was confirmed by Staff #3. Reference #2: AAMI Sterilization in Health Care Facilities, 2014 edition, ST 79, section 3.3.6.5 Temperature states, "... The decontamination area should have a temperature controlled between 16 degrees C [Celsius] and 18 degrees C (60 degrees F [Fahrenheit] and 65 degrees F). ... bacteria thrive at high temperatures; cool temperatures in the decontamination area might help minimize bioburden." 1. During a review of SPD Temperature and Relative Humidity logs, the "Decontamination Area Documentation of Temperature and Humidity" logs evidenced daily temperatures above 65 degrees F from 9/1/16 through 10/29/16. a. The log indicated that the facility's acceptable temperature range in the Decontamination Area is between "60 degrees F and 65 degrees F." 2. The facility failed to ensure temperature control is implemented in the Decontamination Area, in accordance with AAMI guidelines and its own policy. 3. These findings were confirmed by Staff #2.	A4190		
A4215	8:43A-14.4(g) INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS The manufacturer's instructions for cleaning, testing, disassembly, and sterilization of equipment shall be readily available and followed	A4215		

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A4215	Continued From page 16 by employees. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer's instructions for use (IFUs) conducted on 11/1/16, it was determined that the facility failed to ensure that manufacturer's IFUs are followed. Findings include: Reference #1: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2014 edition states in ST 79 section 7.2.2 Manufacturers' written IFU [Instructions for Use], "The written IFU of the device manufacturer should always be followed." Reference #2: Shimadzu Ultrasonic Vaginal Probe manufacturer's IFU states, "High Level Disinfection ... Disinfect the probe after each use. ... (3) Dipping: Use disinfectant, listed in Table 1. Disinfectant procedure should be executed in accordance with disinfectant manufacture's (sic) instructions. ... Table 1 Recommended Solution: Active ingredient: Glutaraldehyde ... Solution: Cidex ... Manufacturer: Johnson & Johnson" 1. During observation of a high-level disinfection procedure at 1:05 PM, Staff #3 was observed using Cidex OPA (Ortho-Phthalaldehyde) solution to clean and disinfect a Shimadzu Ultrasonic	A4215		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A4215	Continued From page 17 Vaginal Probe. a. Cidex OPA solution is a different disinfectant from Cidex glutaraldehyde solution. b. Cidex OPA is not listed by the manufacturer as a recommended product for disinfecting the Shimadzu probes. 2. The facility failed to ensure adherence to the manufacturer's IFUs. 3. This finding was confirmed by Staff #3.	A4215		
A4797	8:43A-17.4(a)(15) HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SERV The following environmental condition shall be met: All equipment and environmental surfaces shall be kept clean to sight and touch. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review conducted on 11/1/16, it was determined that the facility failed to ensure a safe and sanitary environment for the provision of surgical services by adhering to the nationally recognized guidelines it has selected for its Infection Control program. Findings include:	A4797		

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A4797	Continued From page 18 Reference: AORN Guidelines For Perioperative Practice, 2016 edition states on pages 12-13, " Recommendation III. A clean environment should be reestablished after the patient is transferred from the area. ... III.C.5. The floors and walls of operating and procedure rooms should be cleaned and disinfected after each surgical or invasive procedure if soiled or potentially soiled." 1. During the entrance conference, Staff #1 and Staff #2 stated that the facility follows AAMI, AORN, CDC, and OSHA guidelines for its Infection Control program. The facility performs termination of pregnancy (TOP) procedures only. 2. During observation of room turnover cleaning in OR #2, in the presence of Staff #2, Staff #10 was observed mopping the floors without moving the table to clean the floor underneath. a. The floors can be potentially soiled with blood and bodily fluids due to the type of procedures it performs. 3. The facility failed to ensure that the floors were cleaned and disinfected between patients. 4. This finding was confirmed by Staff #2 and Staff #10.	A4797		
H1170	8:43E-6.4(b) PAIN MGMT PROCDURS: PAIN ASSESSMENT PROCDURS Assessment of a patient's/resident's pain shall occur, at a minimum, upon admission, on the day of a planned discharge, and when warranted by changes in a patient's/resident's condition, self-reporting of pain and/or evidence of	H1170		

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H1170	Continued From page 19 behavioral cues indicative of the presence of pain. In the case of individuals receiving home health care services, assessment shall coincide with a visit by staff of the home health service agency and assessment on the day of discharge is not required if the individual has been admitted to an inpatient or residential health care facility and discharge from the home health service agency takes place after the admission. This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure that pain assessment is conducted upon admission and upon discharge. Findings include: 1. Medical Records #2- #20 lacked evidence that pain was assessed upon admission. 2. Medical Records #2, #3 and #5 through #21 lacked evidence that pain was assessed post procedure. 3. The above was confirmed by Staff #2.	H1170		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 10263 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 4/24/2018 Y3

NAME OF FACILITY METROPOLITAN SURGICAL ASSOCIATES	STREET ADDRESS, CITY, STATE, ZIP CODE 40 ENGLE STREET ENGLEWOOD, NJ 07631

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	**DATE** Y5	**ITEM** Y4	**DATE** Y5	**ITEM** Y4	**DATE** Y5
ID Prefix H1170 Reg. # 8:43E-6.4(b) LSC	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 11/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

EVENT ID: DJT712

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
10263 Y1	A. Building B. Wing Y2	4/24/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1885	Correction	ID Prefix A2166	Correction	ID Prefix A2285	Correction
Reg. # 8:43A-6.4(a)	Completed	Reg. # 8:43A-8.4(a)	Completed	Reg. # 8:43A-9.3(b)(5)	Completed
LSC	04/24/2018	LSC	04/24/2018	LSC	04/24/2018
ID Prefix A4098	Correction	ID Prefix A4112	Correction	ID Prefix A4154	Correction
Reg. # 8:43A-14.2(b)(4)	Completed	Reg. # 8:43A-14.2(b)(6)	Completed	Reg. # 8:43A-14.3(a)	Completed
LSC	04/24/2018	LSC	04/24/2018	LSC	04/24/2018
ID Prefix A4183	Correction	ID Prefix A4190	Correction	ID Prefix A4215	Correction
Reg. # 8:43A-14.3(a)(5)	Completed	Reg. # 8:43A-14.4(a)(1)	Completed	Reg. # 8:43A-14.4(g)	Completed
LSC	04/24/2018	LSC	04/24/2018	LSC	04/24/2018
ID Prefix A4797	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:43A-17.4(a)(15)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/24/2018	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
11/2/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

METROPOLITAN SURGICAL ASSOCIATES

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Email: metmedical@aol.com

February 28, 2016

VIA FACSIMILE# (609) 943-3013
Department of Health and Senior Services
State of New Jersey
Attn: Crescenza Zizza, RN
PO Box 367
Trenton, NJ 08625

RE: Metropolitan Surgical Associates

Dear Ms. Zizza

Enclosed please find a copy of our completed Plan of Correction (PoC) in response to the Statement of Deficiency from the New Jersey Department of Health and Senior Services. Kindly confirm receipt and acceptance upon receiving this document.

We greatly appreciate your time and professional courtesy with regards to this matter. Should you have any additional question please do not hesitate to contact me directly.

Very Truly Yours,

Administrator

Americans United for Life

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10263	A. BUILDING: _____ B. WING _____	11/02/2016

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A 000	8:43A INITIAL COMMENTS A State Re-licensure survey was conducted on 11/1 & 11/2/16 which resulted in deficiencies. Abbreviation Key: AAMI=Association for the Advancement of Medical Instrumentation AORN= Association of periOperative Registered Nurses CDC=Centers for Disease Control and Prevention CI=Chemical Indicator/Integrator HICPAC=Hospital Infection Control Practices Advisory Committee IDSA=Infectious Disease Society of America IFUs=Instructions for Use OPA=Ortho-Phthalaldehyde OR=Operating Room OSHA=Occupational Safety and Health Administration PPE=Personal Protective Equipment SHEA=Society of Healthcare Epidemiology of America TOP=Termination of Pregnancy	A 000		
A1885	8:43A-6.4(a) PT CARE POL & SVCS: MED HISTORY & PHYS EXAM The facility shall specify in its policies and procedures the circumstances under which the patient's medical history will be obtained, the contents of the medical history, and the frequency of updating. The contents shall include at least past surgical procedures and medical/health conditions, allergies, adverse reactions to drugs, and current medications.	A1885		

TITLE

(X6) DATE

A1885

1. The medical chart will include a complete medical history and physical examination, performed, signed and dated by the patient's attending physician prior to any procedure performed at the ASC.

2. Revision of the medical chart provides a systemic change that will ensure that that this deficient practice does not recur.

3. The ASC will monitor this POC by auditing patient charts to assure ongoing compliance. This will be performed by the DON or a DON designee on a monthly basis and will become part of the Facility's ongoing chart review process. The goal is complete compliance with the POC and findings of the monitoring process will be reported to the QAC.

4. This corrective action was completed on Jan 11, 2017, following the identification of the deficiency by the Site Survey Team on Nov 2, 2016.

A2166 Reference 1 and 2/ 1,2,3

1. The medical chart will now provide written documentation of patients' pain assessment by the nursing staff.

2. The PACU portion of the medical chart was amended to provide a systemic correction to this deficiency and thus provide a written record of patients' pain assessment.

3. Compliance of this corrective action will be monitored via the chart review process. The DON will, as part of the monthly chart auditing process, check to assess that the medical chart is complete in this regard. This monitoring will be ongoing, with the goal of achieving complete compliance to this plan of correction. Identified deficiencies will be addressed by the DON to the nursing staff and reported to the Quality Assurance Committee.

4. The POC was fully implemented as of Nov 17, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 3

1. Nursing staff has been reminded that merely not dispensing medication that may share hypersensitivity concerns with a patient's known allergy is insufficient and that potential interactions must be positively identified and clarified with the potential prescribing physician.

2. The medical chart has been revised to facilitate systemic correction of this deficiency. It has been amended to contain a template for the listing of allergies directly over the prescribing orders template so that potential drug interactions are easier to note. This revision will help assure the efficient comparison of documented allergies to the prescribing orders for every patient by the responsible RN and the resolution of any identified concerns with the prescribing physician. This systemic correction will ensure against recurrence of this deficiency.

3. Monitoring of this POC will occur via chart review. The DON will, as part of the monthly chart auditing process, check to assess that there no prescribed orders which are thought to have potential adverse reactions with patients' known allergens. This monitoring will be ongoing with the goal of achieving complete compliance to this plan of correction. Identified deficiencies will be addressed by the DON to the medical and nursing staff, as well as, reported to the Quality Assurance Committee.

4. This POC was fully implemented as of February 1, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 4, 5

1. Upon transfer from the OR to the PACU, the attending physician must perform a medication reconciliation to avoid errors of duplication or omission. All medicine and intravenous fluid orders must be reviewed and rewritten upon transfer of the patient between the two care areas.

2. The medical chart has been modified to assure systemic compliance with this corrective action. The order templates have been amended to facilitate comparison and prescribing of medications and intravenous fluids between the OR and PACU. The identified deficiency and the POC were reviewed in separate attendance mandated meetings of the nursing and physician staff.

3. Monitoring to assure against recurrences of this deficiency will occur by incorporating assessment of adherence to this POC into the monthly chart auditing process that is conducted by the DON, or a DON designee. The DON is tasked with reporting compliance and / or identified deficiencies to this corrective action to the QAC.

4 This POC was fully implemented as of Jan 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 6

1. Physicians transferring a patient from the Facility to the hospital will enter such an order into the patient's medical record.

2. Identification of this deficiency and the corrective action was reviewed at an attendance mandated quality assurance meeting of the medical staff. Awareness by the physician staff to document a transfer order, along with, an awareness by the nursing staff of such a requirement, will assure ongoing and systemic compliance.

3. The DON will review chart of all patients entered into the Transfer Log to assess for ongoing compliance to the POC. The monitoring of this corrective action will be ongoing with the goal of complete compliance. Deficiencies will be brought to the QAC for follow up.

4. This POC was fully implemented as of Nov 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2285

1. The ASC strives to maintain compliance with all applicable regulatory requirements, including those relating to the purchase, storage, administration and disposition of pharmaceuticals.

Medications from cartridge-like syringes will not be withdrawn into a second syringe for administration.

2. The Facility has purchased an adequate supply of Carpujet Injectors and a memo has been issued by the DON in conjunction with the ASC's Pharmacy Consultant informing the medical staff of this deficiency and its correction. The memo also delineated the location of the injectors. These systemic changes will assure that the observed deficiency does not recur.

3. The DON will monitor for compliance of this corrective action via assessment polling during staff meetings, as well as, via observation of daily routines. Any deviations will be corrected if and when they are identified. The goal is complete adherence to the corrective action and observations of continued deficiencies in this matter will be reported to the Pharmacy Consultant and QAC for further attention.

4. This POC was fully implemented as of Nov 12, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A4098

1. Personnel will wear appropriate personal protective equipment. The ASC provides easily accessible and appropriate personal protective equipment, such as, gloves, gowns, masks and eye protection to its staff.

2. Systemic compliance will be achieved by an in-service reviewing universal precaution standards and OSHA's blood borne pathogens guidelines as delineated under CFR 1910.1030. The important role of consistent and appropriate PPE use to staff safety and infection / exposure control will be reviewed.

3. On daily basis during hours of operation the ICO will observe staff for sustained compliance to these guidelines. This monitoring is ongoing with the aim of complete compliance to these standards. The ICO will report to the QAC if lapses to these employee safety guidelines.

4. The POC will be fully implemented by March 7, 2017.

OK. ACM. 3/7/17

A4112, A4154

1. The ASC's Safe Medication Administration Guidelines policy incorporates the CDC's recommendations as delineated in Safe Practices for Medical Injections, as well as, Guidelines for the Prevention of Intravascular Catheter Related Infections. An in-service of the medical staff was held on Feb 23, 2017 to review this policy, the recommendations on which it is based and its importance to infection control.

The need to wipe IV injector ports and vials with 70% alcohol and that single dose vials entered more than once for the same patient must be done with new needle and syringe will be discussed in particular and note made of the Survey Team's identification of deficiencies in this regard.

2. An emphasis on the use of alcohol swaps to wipe vials prior to accessing and the need for a new needle and syringe when re-accessing vials will be incorporated into the ASC's continuing education program and addressed, at least annually, during reviews of the Facility's Safe Medication Administration Guidelines.

3. The ICO will inform the QAC that the in-service has occurred and will on a continuous basis monitor for adherence to the Facility's standards and provide immediate remediation to any observed deficiency. The goal for this corrective action is complete adherence to the Facility's guidelines in this matter.

4. The POC was implemented on Feb 24, 2017.

not accepted 3/6/17 RW

A4183 Reference 1, 2

1. During the course of its inspections, the Site Survey Team identified several instances of incomplete adherence to both the ASC's and CDC-HICPAC policies and standards in regards to infection control and hand hygiene by at least two of its staff members. The ASC will hold in-services mandatory to the medical, SPD and cleaning staffs and chaired by the Infection Control Officer. The meetings' purpose will be to review the cited findings, review the ASC's policies regarding hand hygiene and infection control, as well as, role-play scenarios so that staff can better understand the real life applications of these standards.

2. Continued periodic meetings of the above staff addressing these infection control concerns will serve to address these concerns in a systemic fashion.

3. The Infection Control Officer will notify the QAC upon the successful completion of the in-services. The ICO, or a designee, will one month later and monthly, thereafter, conduct random observations of the members of these departments to assess the effectiveness of the POC, assure compliance with the relevant ASC policies and provide corrective guidance. If during the course of this monitoring, systemic deficiencies are encountered, the Infection Control Officer will report to the QAC so that further remediate steps are taken.

Ok. Acm. 3/7/17

4. The POC shall be fully implemented by Mar 7, 2017.

Not accepted 3/6/17 RW

A4183 Reference 3

1. The ASC, to improve its adherence to professionally acceptable standards regarding the achievement of optimal sanitary environments included in its in-service on hand hygiene a review of AORN's Guidelines of Perioperative Practice as they relate to nail grooming and restrictions to various nail enhancement products.

2. In addition to the in-service of applicable members of the Facility staff; review of these guidelines during orientation of new employees will provide systemic assurance of continued vigilance.

3. The observational monitoring of the ASC's relevant staff by the ICO, or a designee, will provide a mechanism to confirm the POC has been successfully implemented and will be complied with in the future. The monitoring will be daily and ongoing, with complete compliance as a goal.

4. This POC was fully implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A4190 Reference 1

1. ASC policies regarding the reprocessing of its reusable instruments follow ANSI/AAMI guidelines; this includes, the placement of a chemical indicator strip in each pack that is to undergo sterilization. The corrective action was to provide an in-service to members of the Sterilization and Processing staff; not only, in regards to the deviation from policy regarding the placement of a CI in each pack, but also, as to its purpose and its import to the infection control mechanisms in place at the ASC.

2. Systemic compliance should be ensured by the universal adherence to this standard. All sterile packages should have CI.

3. The in-service will occur on Feb 28, 2017. The frequency of randomly inspected sterile packs will also be increased starting on Feb 28, 2017 to once a week to ensure sustained adherence to referenced standards and to the effectiveness of the corrective action. Following an eight-week period, the Certified Sterile Processing and Distribution Technician will report to the QAC the results of the intensified compliance monitoring. The goal will be complete conformity to the standard that there should be a CI in every sterile pack.

4. The plan of correction will formally begin with the in-service on Feb 28, 2017. The results of the increased surveillance will be reported to the QAC in eight weeks' time.

Not Ok. Acm. 3/7/17

A4190 Reference 2

1. The ASC policy regarding temperature controlled Decontamination area is drafted to reflect the guideline set forth in the AAMI Sterilization in Health care Facilities, 2014 Edition. An in-service will be completed by the Sterilization Consultant with the all Sterile Processing Technician (SPT) and the Certified Sterile Processing and Distribution Lead Technician (CSPDT) to review new temperature recording procedures and safeguards.

2. The Sterilization Consultant shall perform an in-service that will include specific instructions that during the time the sterilization equipment is running in the Decontamination area, the cooling units shall be adjusted accordingly to accommodate for the slight potential increase in room temperature.

3. The Sterile Processing Technician (SPT)) shall be responsible for keeping a daily temperature log for the Decontamination area. In the event that the temperature is out of acceptable range the SPT shall immediately notify the CSPDT who shall immediately turn on cooling units until the Decontamination area temperature is within acceptable range. Additionally the CSPDT shall make monthly reviews of the daily temperature log to make sure all readings have either been within range or

Not Ok. Acm. 3/7/17

immediately addressed and recorded. If any deviation from this protocol has occurred the CSPDT shall notify the Sterilization Consultant for another in-service.

4. The Medical Director in conjunction with the Sterilization Consultant shall be responsible for ensuring that the plan of correction is properly implemented no later than March 15, 2017.

A4215

1. The ASC recognizes that device manufacturers, in accordance with FDA and AAMI guidelines, have validated steps necessary for the proper processing of their devices and that Instructions For Use are an integral part of the correct preparation of equipment for safe patient use. During the survey an IFU was provided for a Shimadzu ultrasound vaginal probe. The staff member providing this was unaware that this ultrasound machine had long been replaced. All of the Facility's ultrasound machines are GE models and have been since July 2015. Staff members who would have been a position to know this did not recognize what had occurred. The Facility uses and follows the correct IFU's for the processing of its equipment.

2. Following the recognition of this finding, the corrective action will be to review the catalogue of medical equipment to remove outdated manuals. The ASC, will going forward, review its catalogue of medical equipment to ensure that it remains current. This corrective action should provide systemic assurance that such an error does not recur.

3. By Mar 3, 2017 the DON and the Assistant Medical Director will assure that only Operator Manuals and IFU's of current equipment is maintained and report this to the QAC. This monitoring will continue on a biannual basis. This should assure that such an error does not arise in the future

4. The POC will be completed by Mar 3, 2017.

Ok.
ACM.
3/7/17

A4797

1. The OR's are to be properly prepared prior to reuse. The reestablishment of a clean sanitary environment includes the cleaning of the floor under the OR table after every case regardless whether is obvious soiling.

2. Review of the Facility Cleaning Manual to assure delineation of this step and a review of this corrective action with the cleaning staff by the Infection Control Officer will assure a systemic correction.

3. The Infection Control Officer, will on a daily and ongoing basis, observe for compliance to this corrective action. The goal is for complete adherence to this standard. Shortcomings will be brought to the attention of the cleaning staff and reported to the QAC.

4. This POC was fully implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Ok.
ACM.
3/7/17

H1170

1. There will be documentation of the assessment of patients' pain levels upon admission to Facility during preoperative holding and a final documentation of assessment just prior to discharge from the Facility.

2. The medical chart will amended to provide space for this assessment. An in-service on this corrective action will be held for the nursing staff. This POC provides for systemic correction to this observed deficiency.

3. This POC will monitored for effectiveness by auditing patient charts to assure ongoing compliance to the corrective action. This will be performed by the DON, or a DON designee, on a monthly basis and will become part of the Facility's ongoing chart review process. The goal is complete compliance with the POC and findings of the monitoring process will be reported to the QAC.

4. The POC will be implemented by Mar 15, 2017.

Americans United for Life

Metropolitan Surg. Assoc

State POC Add#1 Revd 4/12/17

A1885

1. The medical chart will include a complete medical history and physical examination, performed, signed and dated by the patient's attending physician prior to any procedure performed at the ASC.

2. Revision of the medical chart provides a systemic change that will ensure that that this deficient practice does not recur.

3. The ASC will monitor this POC by auditing ten (10) patient charts per month to assure ongoing compliance. This will be performed by the DON or a DON designee on a monthly basis and will become part of the Facility's ongoing chart review process. The goal is complete compliance with the POC and findings of the monitoring process will be reported to the QAC.

DC 4/13/17

4. A mandatory in-service occurred on Jan 10, 2107 informing the physician staff of the need for this corrective action. This corrective action was completed on Jan 11, 2017, following the identification of the deficiency by the Site Survey Team on Nov 2, 2016.

A2166 Reference 1 and 2/ 1,2,3

1. The medical chart will now provide written documentation of patients' pain assessment by the nursing staff.

2. The PACU portion of the medical chart was amended to provide a systemic record of this assessment and an in-service was held with the nursing staff to inform them of this change.

error

3. Compliance of this corrective action will be monitored via the chart review process. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance were noted. Following this, ongoing compliance became part of the monthly chart auditing process. Identified deficiencies will be addressed by the DON to the nursing staff and reported to the Quality Assurance Committee. The QAC will report implementation of this corrective action to the Governing Body.

DC 4/13/17

4. The POC was fully implemented as of Nov 17, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 3

1. Nursing staff has been reminded, during an in-service on February 22, 2017, that merely not dispensing medication that may share hypersensitivity concerns with a patient's known allergy is insufficient and that potential interactions must be positively identified and clarified with the potential prescribing physician.

2. The medical chart has been revised to facilitate systemic correction of this deficiency. It has been amended to contain a template for the listing of allergies directly over the prescribing orders template so that potential drug interactions are easier to note. This revision will help assure the efficient comparison of documented allergies to the prescribing orders for every patient by the responsible RN

and the resolution of any identified concerns with the prescribing physician. This systemic correction will ensure against recurrence of this deficiency.

3. Monitoring of this POC will occur via chart review. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. The DON will, as part of the monthly chart auditing process, check to assess that there no prescribed orders which are thought to have potential adverse reactions with patients' known allergens. This monitoring will be ongoing with the goal of achieving complete compliance to this plan of correction. Identified deficiencies will be addressed by the DON to the medical and nursing staff, as well as, reported to the Quality Assurance Committee. The QAC will report implementation and compliance with corrective action to the Governing Body.

4. This POC was implemented as of February 1, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 4, 5

1. Upon transfer from the OR to the PACU, the attending physician must perform a medication reconciliation to avoid errors of duplication or omission. All medicine and intravenous fluid orders must be reviewed and rewritten upon transfer of the patient between the two care areas.

2. The medical chart has been modified to assure systemic compliance with this corrective action. The order templates have been amended to facilitate comparison and prescribing of medications and intravenous fluids between the OR and PACU. The identified deficiency and the POC were reviewed in separate attendance mandated meetings of the nursing and physician staff. The in-service meetings were held on January 11 and January 17, 2017.

3. Monitoring to assure against recurrences of this deficiency will occur by incorporating assessment of adherence to this POC into the monthly chart auditing process that is conducted by the DON, or a DON designee. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. The DON is tasked with reporting compliance and / or identified deficiencies to this corrective action to the QAC. The QAC will report implementation and compliance with corrective action to the Governing Body. The Governing Body will be responsible for ensuring full compliance with all rules and regulations.

4 This POC was implemented as of Jan 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 6

1. Physicians transferring a patient from the Facility to the hospital will enter such an order into the patient's medical record.

2. Identification of this deficiency and the corrective action was reviewed at an attendance mandated quality assurance meeting of the medical staff, held on January 17, 2017. Awareness by the physician staff to document a transfer order, along with, an awareness by the nursing staff of such a requirement, will assure ongoing and systemic compliance.

3. The DON will review the charts of all patients entered into the Transfer Log to assess for ongoing compliance to the POC. The monitoring of this corrective action will be ongoing with the goal of complete compliance. Deficiencies will be brought to the QAC for follow up.

4. This POC was implemented as of Nov 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

OK 4/13/17

A2285

1. The ASC strives to maintain compliance with all applicable regulatory requirements, including those relating to the purchase, storage, administration and disposition of pharmaceuticals.

Medications from cartridge-like syringes will not be withdrawn into a second syringe for administration.

2. The Facility has purchased an adequate supply of Carpujet Injectors and a memo has been issued by the DON in conjunction with the ASC's Pharmacy Consultant informing the medical staff of this deficiency and its correction. The memo also delineated the location of the injectors. These systemic changes will assure that the observed deficiency does not recur.

3. The DON will monitor for compliance of this corrective action via assessment polling during staff meetings, as well as, via observation of daily routines. Any deviations will be corrected if and when they are identified. The goal is complete adherence to the corrective action and observations of continued deficiencies in this matter will be reported to the Pharmacy Consultant and QAC for further attention.

4. This POC was fully implemented as of Nov 12, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

OK CCC 4/25/17

A4098

1. Personnel will wear appropriate personal protective equipment. The ASC provides easily accessible and appropriate personal protective equipment, such as, gloves, gowns, masks and eye protection to its staff.

2. Systemic compliance will be achieved by an in-service reviewing universal precaution standards and OSHA's blood borne pathogens guidelines as delineated under CFR 1910.1030. The important role of consistent and appropriate PPE use to staff safety and infection / exposure control will be reviewed.

3. The Infection Control Officer will initially monitor all personnel on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO, or an appointed designee, shall also be responsible for providing immediate

remediation if non-compliance is later observed by conducting a mandatory in-service with non-complying personnel and shall report non-compliance to the QAC.

4. The in-service was completed on March 7, 2017.

A4112, A4154

1. The ASC's Safe Medication Administration Guidelines policy incorporates the CDC's recommendations as delineated in Safe Practices for Medical Injections, as well as, Guidelines for the Prevention of Intravascular Catheter Related Infections. An in-service of the Physician and Nursing staff was held on Feb 23, 2017 to review this policy, the recommendations on which it is based and its importance to infection control.

The need to wipe IV injector ports and vials with 70% alcohol and that single dose vials entered more than once for the same patient must be done with new needle and syringe will be discussed in particular and note made of the Survey Team's identification of deficiencies in this regard.

OK
RW
4/13/17

2. An emphasis on the use of alcohol swaps to wipe vials prior to accessing and the need for a new needle and syringe when re-accessing vials will be incorporated into the ASC's continuing education program and addressed, at least annually, during reviews of the Facility's Safe Medication Administration Guidelines.

3. The ICO will inform the QAC that the in-service has occurred and will monitor for adherence to the Facility's standards and provide immediate remediation to any observed deficiency. The goal for this corrective action is complete adherence to the Facility's guidelines in this matter. The Infection Control Officer will initially monitor the Physician and Nursing staff on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO and the AMD will be responsible for implementation of this corrective action and report its implementation and compliance to the QAC.

4. The POC was implemented on Feb 24, 2017.

A4183 Reference 1, 2

1. During the course of its inspections, the Site Survey Team identified several instances of incomplete adherence to both the ASC's and CDC-HICPAC policies and standards in regards to infection control and hand hygiene by at least two of its staff members. The ASC held a mandatory in-service on February 21, 2017 for the medical, SPD and cleaning staffs and chaired by the Infection Control Officer. The meetings' purpose will be to review the cited findings, review the ASC's policies regarding hand hygiene and infection control, as well as, role-play scenarios so that staff can better understand the real life applications of these standards.

2. Continued periodic meetings of the above staff addressing these infection control concerns will serve to address these concerns in a systemic fashion.

3. Monitoring by the Infection Control Officer or designee will include random observations of one employee from each department (medical, SPD and cleaning staffs) per week for a period of one month until 100% compliant with the relevant ASC policies. Corrective guidance will be provided during the course of this monitoring as needed and if systemic deficiencies are encountered, the Infection Control Officer will report to the QAC so that further remediate steps are taken.

4. The POC was completed on February 21, 2017.

OK
RW
4/13/17

A4183 Reference 3

1. The ASC, to improve its adherence to professionally acceptable standards regarding the achievement of optimal sanitary environments held an in-service, on February 21, 2017, on hand hygiene and a review of AORN's Guidelines of Perioperative Practice, as they relate to nail grooming and restrictions to various nail enhancement products.

2. In addition to the in-service of applicable members of the Facility staff; review of these guidelines during orientation of new employees will provide systemic assurance of continued vigilance.

3. The observational monitoring of the ASC's relevant staff by the ICO, or a designee, will provide a mechanism to confirm the POC has been successfully implemented and will be complied with in the future. Initially, monitoring will be on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds.

4. This POC was completed on February 21, 2017.

OK
RW
4/13/17

A4190 Reference 1

1. ASC policies regarding the reprocessing of its reusable instruments follow ANSI/AAMI guidelines; this includes, the placement of a chemical indicator strip in each pack that is to undergo sterilization. The corrective action was to provide an in-service to members of the Sterilization and Processing staff; not only, in regards to the deviation from policy regarding the placement of a CI in each pack, but also, as to its purpose and its import to the infection control mechanisms in place at the ASC.

2. Systemic compliance should be ensured by the universal adherence to this standard. All sterile packages should have CI.

3. The in-service was held on Feb 28, 2017. The frequency of randomly inspected sterile packs was also increased on Feb 28, 2017 to once a week to ensure sustained adherence to referenced standards and to the effectiveness of the corrective action. Following an eight-week period, during which two of each type of sterile packs will be inspected weekly, the Certified Sterile Processing and Distribution Technician will report to the QAC the results of the intensified compliance monitoring. The goal will be complete conformity to the standard that there should be a CI in every sterile pack. If compliance to this standard is met inspections will return to the Facility's standard frequency.

4. The plan of correction began with the in-service on Feb 28, 2017. The results of the increased surveillance will be reported to the QAC in eight weeks' time.

OK.
Acm.
4/17/17

A4190 Reference 2

1. The ASC policy regarding temperature controlled Decontamination area is drafted to reflect the guideline set forth in the AAMI Sterilization in Health care Facilities, 2014 Edition. An in-service was completed on January 16, 2017 by the Sterilization Consultant with the all Sterile Processing Technician (SPT) and the Certified Sterile Processing and Distribution Lead Technician (CSPDT) to review new temperature recording procedures and safeguards.

2. The Sterilization Consultant shall perform an in-service that will include specific instructions that during the time the sterilization equipment is running in the Decontamination area, the cooling units shall be adjusted accordingly to accommodate for the slight potential increase in room temperature.

3. The Sterile Processing Technician (SPT)) shall be responsible for keeping a daily temperature log for the Decontamination area. In the event that the temperature is out of acceptable range the SPT shall immediately notify the CSPDT who shall immediately turn on cooling units until the Decontamination area temperature is within acceptable range. Additionally the CSPDT shall make monthly reviews of the daily temperature log to make sure all readings have either been within range or immediately addressed and recorded. If any deviation from this protocol has occurred the CSPDT shall notify the Sterilization Consultant for another in-service. In the event that the SPT has to notify the CSPDT of three (3) or more temperature variations within one (1) calendar month, the CSPDT shall immediately bring it to the attention of the Governing Body and the Governing Body will immediately act accordingly to bring in an independent specialist to fix whatever is causing the variations so as to resolve the issue.

4. The Medical Director in conjunction with the Sterilization Consultant shall be responsible for ensuring that the plan of correction is properly implemented.

Ok. fcm. 4/17/17

A4215

1. The ASC recognizes that device manufacturers, in accordance with FDA and AAMI guidelines, have validated steps necessary for the proper processing of their devices and that Instructions For Use are an integral part of the correct preparation of equipment for safe patient use. During the survey an IFU was provided for a Shimadzu ultrasound vaginal probe. The staff member providing this was unaware that this ultrasound machine had long been replaced. All of the Facility's ultrasound machines are GE models and have been since July 2015. Staff members who would have been in a position to know this did not recognize what had occurred. The Facility uses and follows the correct IFU's for the processing of its equipment.

2. Following the recognition of this finding, the corrective action will be to review the catalogue of medical equipment to remove outdated manuals. The ASC, will going forward, review its catalogue of medical equipment to ensure that it remains current. This corrective action should provide systemic assurance that such an error does not recur.

3. By Mar 3, 2017 the DON and the Assistant Medical Director will assure that only Operator Manuals and IFU's of current equipment is maintained and report this to the QAC. This monitoring will continue on a biannual basis. This should assure that such an error does not arise in the future

4. The POC will be completed by Mar 3, 2017.

A4797

1. The OR's are to be properly prepared prior to reuse. The reestablishment of a clean sanitary environment includes the cleaning of the floor under the OR table after every case regardless whether is obvious soiling.

2. An in-service to review the Facility Cleaning Manual to assure delineation of this step and a review of this corrective action with the cleaning staff by the Infection Control Officer was held on November 15, 2016 to assure systemic correction.

3. The Infection Control Officer observed the staff and the ORs for compliance on a daily basis for a two-week period to assure complete compliance; continued compliance, is assured via the monthly Infection Control rounds. Shortcomings will be brought to the attention of the cleaning staff for correction and reported to the QAC.

4. This POC was implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

H1170

1. There will be documentation of the assessment of patients' pain levels upon admission to Facility during preoperative holding and a final documentation of assessment just prior to discharge from the Facility.

2. The medical chart will be amended to provide space for this assessment. An in-service on this corrective action will be held for the nursing staff. This POC provides for systemic correction to this observed deficiency. Nov 15, 2016 Asp WSA

3. This POC will monitor for effectiveness by auditing patient charts to assure ongoing compliance to the corrective action. This will be performed by the DON, or a DON designee, on a monthly basis and will become part of the Facility's ongoing chart review process. The goal is complete compliance with the POC and findings of the monitoring process will be reported to the QAC.

4. The POC will be implemented by Mar 15, 2017.

ok 4/13/17

Americans United for Life

Metropolitan Surg Assoc - State add # 2 rec'd 5/3/17

A1885

1. The medical chart will include a complete medical history and physical examination, performed, signed and dated by the patient's attending physician prior to any procedure performed at the ASC.

2. Revision of the medical chart provides a systemic change that will ensure that that this deficient practice does not recur.

3. The ASC will monitor this POC by auditing ten (10) patient charts per month to assure ongoing compliance. This will be performed by the DON or a DON designee on a monthly basis and will become part of the Facility's ongoing chart review process. The goal is complete compliance with the POC and findings of the monitoring process will be reported to the QAC.

OK 5/11/17 8

4. A mandatory in-service occurred on Jan 10, 2107 (2017) informing the physician staff of the need for this corrective action. This corrective action was completed on Jan 11, 2017, following the identification of the deficiency by the Site Survey Team on Nov 2, 2016.

A2166 Reference 1 and 2/ 1,2,3

1. The medical chart will now provide written documentation of patients' pain assessment by the nursing staff.

2. The PACU portion of the medical chart was amended to provide a systemic record of this assessment and an in-service was held with the nursing staff to inform them of this change. on 11/15/16 SM

3. Compliance of this corrective action will be monitored via the chart review process. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance were noted. Following this, ongoing compliance became part of the monthly chart auditing process. Identified deficiencies will be addressed by the DON to the nursing staff and reported to the Quality Assurance Committee. The QAC will report implementation of this corrective action to the Governing Body.

not OK 5/11/17 8

4. The POC was fully implemented as of Nov 17, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 3

1. Nursing staff has been reminded, during an in-service on February 22, 2017, that merely not dispensing medication that may share hypersensitivity concerns with a patient's known allergy is insufficient and that potential interactions must be positively identified and clarified with the potential prescribing physician.

2. The medical chart has been revised to facilitate systemic correction of this deficiency. It has been amended to contain a template for the listing of allergies directly over the prescribing orders template so that potential drug interactions are easier to note. This revision will help assure the efficient comparison of documented allergies to the prescribing orders for every patient by the responsible RN

and the resolution of any identified concerns with the prescribing physician. This systemic correction will ensure against recurrence of this deficiency.

3. Monitoring of this POC will occur via chart review. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. The DON will, as part of the monthly chart auditing process, check to assess that there no prescribed orders which are thought to have potential adverse reactions with patients' known allergens. This monitoring will be ongoing with the goal of achieving complete compliance to this plan of correction. Identified deficiencies will be addressed by the DON to the medical and nursing staff, as well as, reported to the Quality Assurance Committee. The QAC will report implementation and compliance with corrective action to the Governing Body.

4. This POC was implemented as of February 1, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 4, 5

1. Upon transfer from the OR to the PACU, the attending physician must perform a medication reconciliation to avoid errors of duplication or omission. All medicine and intravenous fluid orders must be reviewed and rewritten upon transfer of the patient between the two care areas.

2. The medical chart has been modified to assure systemic compliance with this corrective action. The order templates have been amended to facilitate comparison and prescribing of medications and intravenous fluids between the OR and PACU. The identified deficiency and the POC were reviewed in separate attendance mandated meetings of the nursing and physician staff. The in-service meetings were held on January 11 and January 17, 2017.

ok

3. Monitoring to assure against recurrences of this deficiency will occur by incorporating assessment of adherence to this POC into the monthly chart auditing process that is conducted by the DON, or a DON designee. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. The DON is tasked with reporting compliance and / or identified deficiencies to this corrective action to the QAC. The QAC will report implementation and compliance with corrective action to the Governing Body. The Governing Body will be responsible for ensuring full compliance with all rules and regulations.

4 This POC was implemented as of Jan 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2166 Reference 2/ 6

1. Physicians transferring a patient from the Facility to the hospital will enter such an order into the patient's medical record.

2. Identification of this deficiency and the corrective action was reviewed at an attendance mandated quality assurance meeting of the medical staff, held on January 17, 2017. Awareness by the physician staff to document a transfer order, along with, an awareness by the nursing staff of such a requirement, will assure ongoing and systemic compliance.

3. The DON will review the charts of all patients entered into the Transfer Log to assess for ongoing compliance to the POC. The monitoring of this corrective action will be ongoing with the goal of complete compliance. Deficiencies will be brought to the QAC for follow up.

4. This POC was implemented as of Nov 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A2285

1. The ASC strives to maintain compliance with all applicable regulatory requirements, including those relating to the purchase, storage, administration and disposition of pharmaceuticals.

Medications from cartridge-like syringes will not be withdrawn into a second syringe for administration.

2. The Facility has purchased an adequate supply of Carpujet Injectors and a memo has been issued by the DON in conjunction with the ASC's Pharmacy Consultant informing the medical staff of this deficiency and its correction. The memo also delineated the location of the injectors. These systemic changes will assure that the observed deficiency does not recur.

3. The DON will monitor for compliance of this corrective action via assessment polling during staff meetings, as well as, via observation of daily routines. Any deviations will be corrected if and when they are identified. The goal is complete adherence to the corrective action and observations of continued deficiencies in this matter will be reported to the Pharmacy Consultant and QAC for further attention.

4. This POC was fully implemented as of Nov 12, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

A4098

1. Personnel will wear appropriate personal protective equipment. The ASC provides easily accessible and appropriate personal protective equipment, such as, gloves, gowns, masks and eye protection to its staff.

2. Systemic compliance will be achieved by an in-service reviewing universal precaution standards and OSHA's blood borne pathogens guidelines as delineated under CFR 1910.1030. The important role of consistent and appropriate PPE use to staff safety and infection / exposure control will be reviewed.

3. The Infection Control Officer will initially monitor all personnel on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO, or an appointed designee, shall also be responsible for providing immediate

remediation if non-compliance is later observed by conducting a mandatory in-service with non-complying personnel and shall report non-compliance to the QAC.

4. The in-service was completed on March 7, 2017.

A4112

1. The ASC's Safe Medication Administration Guidelines policy incorporates the CDC's recommendations as delineated in Safe Practices for Medical Injections, as well as, Guidelines for the Prevention of Intravascular Catheter Related Infections. An in-service of the Physician and Nursing staff was held on Feb 23, 2017 to review this policy, the recommendations on which it is based and its importance to infection control.

The need to wipe IV injector ports and vials with 70% alcohol and that single dose vials entered more than once for the same patient must be done with new needle and syringe was discussed in particular and note made of the Survey Team's identification of deficiencies in this regard.

2. An emphasis on the use of alcohol swaps to wipe vials prior to accessing and the need for a new needle and syringe when re-accessing vials will be incorporated into the ASC's continuing education program and addressed, at least annually, during reviews of the Facility's Safe Medication Administration Guidelines.

3. The ICO will inform the QAC that the in-service has occurred and will monitor for adherence to the Facility's standards and provide immediate remediation to any observed deficiency. The goal for this corrective action is complete adherence to the Facility's guidelines in this matter. The Infection Control Officer will initially monitor the Physician and Nursing staff on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO and the AMD will be responsible for implementation of this corrective action and report its implementation and compliance to the QAC.

4. The POC was implemented on Feb 24, 2017.

A4154

1. The Facility's infection prevention guidelines are based on the CDC's Safe Practices for Medical Injections, as well as, Guidelines for the Prevention of Intravascular Catheter Related Infections. As part of the corrective action, an in-service of the Physician and Nursing staff was held on Feb 23, 2017 to review these guidelines. The in service emphasized the need to wipe IV injector ports and vials with 70% alcohol, as an infection control technique.

2. The use of alcohol swaps to wipe vials prior to accessing, have incorporated into the ASC's continuing education program and will be addressed during reviews of the Facility's Safe Medication Administration Guidelines.

3. The ICO will inform the QAC that the in-service has occurred and will monitor for adherence to the Facility's standards and provide immediate remediation to any observed deficiency. The goal for this corrective action is complete adherence to the Facility's guidelines in this matter. The Infection Control Officer will initially monitor the Physician and Nursing staff on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO and the AMD will be responsible for implementation of this corrective action and report its implementation and compliance to the QAC.

4. The POC was implemented on Feb 24, 2017.

A4183 Reference 1, 2

1. During the course of its inspections, the Site Survey Team identified several instances of incomplete adherence to both the ASC's and CDC-HICPAC policies and standards in regards to infection control and hand hygiene by at least two of its staff members. The ASC held a mandatory in-service on February 21, 2017 for the medical, SPD and cleaning staffs and chaired by the Infection Control Officer. The meetings' purpose will be to review the cited findings, review the ASC's policies regarding hand hygiene and infection control, as well as, role-play scenarios so that staff can better understand the real life applications of these standards.

2. Continued periodic meetings of the above staff addressing these infection control concerns will serve to address these concerns in a systemic fashion.

3. Monitoring by the Infection Control Officer or designee will include random observations of one employee from each department (medical, SPD and cleaning staffs) per week for a period of one month until 100% compliant with the relevant ASC policies. Corrective guidance will be provided during the course of this monitoring as needed and if systemic deficiencies are encountered, the Infection Control Officer will report to the QAC so that further remediate steps are taken.

4. The POC was completed on February 21, 2017.

A4183 Reference 3

1. The ASC, to improve its adherence to professionally acceptable standards regarding the achievement of optimal sanitary environments held an in-service, on February 21, 2017, on hand hygiene and a review of AORN's Guidelines of Perioperative Practice, as they relate to nail grooming and restrictions to various nail enhancement products.

2. In addition to the in-service of applicable members of the Facility staff; review of these guidelines during orientation of new employees will provide systemic assurance of continued vigilance.

3. The observational monitoring of the ASC's relevant staff by the ICO, or a designee, will provide a mechanism to confirm the POC has been successfully implemented and will be complied with in the

future. Initially, monitoring will be on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds.

4. This POC was completed on February 21, 2017.

A4190 Reference 1

1. ASC policies regarding the reprocessing of its reusable instruments follow ANSI/AAMI guidelines; this includes, the placement of a chemical indicator strip in each pack that is to undergo sterilization. The corrective action was to provide an in-service to members of the Sterilization and Processing staff; not only, in regards to the deviation from policy regarding the placement of a CI in each pack, but also, as to its purpose and its import to the infection control mechanisms in place at the ASC.

2. Systemic compliance should be ensured by the universal adherence to this standard. All sterile packages should have CI.

3. The in-service was held on Feb 28, 2017. The frequency of randomly inspected sterile packs was also increased on Feb 28, 2017 to once a week to ensure sustained adherence to referenced standards and to the effectiveness of the corrective action. Following an eight-week period, during which two of each type of sterile packs will be inspected weekly, the Certified Sterile Processing and Distribution Technician will report to the QAC the results of the intensified compliance monitoring. The goal will be complete conformity to the standard that there should be a CI in every sterile pack. If compliance to this standard is met inspections will return to the Facility's standard frequency.

4. The plan of correction began with the in-service on Feb 28, 2017. The results of the increased surveillance will be reported to the QAC in eight weeks' time.

A4190 Reference 2

1. The ASC policy regarding temperature controlled Decontamination area is drafted to reflect the guideline set forth in the AAMI Sterilization in Health care Facilities, 2014 Edition. An in-service was completed on January 16, 2017 by the Sterilization Consultant with the all Sterile Processing Technician (SPT) and the Certified Sterile Processing and Distribution Lead Technician (CSPDT) to review new temperature recording procedures and safeguards.

2. The Sterilization Consultant shall perform an in-service that will include specific instructions that during the time the sterilization equipment is running in the Decontamination area, the cooling units shall be adjusted accordingly to accommodate for the slight potential increase in room temperature.

3. The Sterile Processing Technician (SPT)) shall be responsible for keeping a daily temperature log for the Decontamination area. In the event that the temperature is out of acceptable range the SPT shall immediately notify the CSPDT who shall immediately turn on cooling units until the Decontamination area temperature is within acceptable range. Additionally the CSPDT shall make monthly reviews of the daily temperature log to make sure all readings have either been within range or immediately addressed and recorded. If any deviation from this protocol has occurred the CSPDT shall

notify the Sterilization Consultant for another in-service. In the event that the SPT has to notify the CSPDT of three (3) or more temperature variations within one (1) calendar month, the CSPDT shall immediately bring it to the attention of the Governing Body and the Governing Body will immediately act accordingly to bring in an independent specialist to fix whatever is causing the variations so as to resolve the issue.

4. The Medical Director in conjunction with the Sterilization Consultant shall be responsible for ensuring that the plan of correction is properly implemented.

A4215

1. The ASC recognizes that device manufacturers, in accordance with FDA and AAMI guidelines, have validated steps necessary for the proper processing of their devices and that Instructions For Use are an integral part of the correct preparation of equipment for safe patient use. During the survey an IFU was provided for a Shimadzu ultrasound vaginal probe. The staff member providing this was unaware that this ultrasound machine had long been replaced. All of the Facility's ultrasound machines are GE models and have been since July 2015. Staff members who would have been in a position to know this did not recognize what had occurred. The Facility uses and follows the correct IFU's for the processing of its equipment.

2. Following the recognition of this finding, the corrective action will be to review the catalogue of medical equipment to remove outdated manuals. The ASC, will going forward, review its catalogue of medical equipment to ensure that it remains current. This corrective action should provide systemic assurance that such an error does not recur.

3. By Mar 3, 2017 the DON and the Assistant Medical Director will assure that only Operator Manuals and IFU's of current equipment is maintained and report this to the QAC. This monitoring will continue on a biannual basis. This should assure that such an error does not arise in the future

4. The POC will be completed by Mar 3, 2017.

A4797

1. The OR's are to be properly prepared prior to reuse. The reestablishment of a clean sanitary environment includes the cleaning of the floor under the OR table after every case regardless whether is obvious soiling.

2. An in-service to review the Facility Cleaning Manual to assure delineation of this step and a review of this corrective action with the cleaning staff by the Infection Control Officer was held on November 15, 2016 to assure systemic correction.

3. The Infection Control Officer observed the staff and the ORs for compliance on a daily basis for a two-week period to assure complete compliance; continued compliance, is assured via the monthly Infection Control rounds. Shortcomings will be brought to the attention of the cleaning staff for correction and reported to the QAC.

4. This POC was implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

H1170

1. There will be documentation of the assessment of patients' pain levels upon admission to Facility during preoperative holding and a final documentation of assessment just prior to discharge from the Facility.

2. The medical chart will be amended to provide space for this assessment. An in-service on this corrective action will be held for the nursing staff. This POC provides for systemic correction to this observed deficiency.

as per SM OK 2/16/18
11/15/16 on service was held.

nor OK 5/1/17

3. This POC will monitor for effectiveness by auditing patient charts to assure ongoing compliance to the corrective action. This will be performed by the DON, or a DON designee, on a monthly basis and will become part of the Facility's ongoing chart review process. The goal is complete compliance with the POC and findings of the monitoring process will be reported to the QAC.

4. The POC will be implemented by Mar 15, 2017.

Americans United for Life

Metropolitan Surg Assoc -

POC added #3

State

State Plan of Correction Addendum

A2166- Reference 2

The PACU portion of the medical chart was amended to provide a systemic record of this assessment and an in-service with the nursing staff was held on November 15, 2016, to inform them of this change.

OK
3/16/18
S

H1170-Reference2

The medical chart will be amended to provide space for this assessment. An in-service on this corrective action was held for the nursing staff on November 15, 2016. This POC provides for systemic correction to this observed deficiency.

Americans United for Life

PRINTED: 05/29/2018

Statement of Deficiencies
Citation Summary Sheet

For: METROPOLITAN SURGICAL ASSOCIATES (31C0001006 / NJ31C0001006)

Survey Event: LCSL11, Exit Date 11/02/2016

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	FQ08	08.02	00	0000	INITIAL COMMENTS	
Federal	FQ08	08.02	00	0040	GOVERNING BODY AND MANAGEMENT	
Federal	FQ08	08.02	00	0100	ENVIRONMENT	
Federal	FQ08	08.02	00	0104	SAFETY FROM FIRE	
Federal	FQ08	08.02	00	0141	ORGANIZATION AND STAFFING	
Federal	FQ08	08.02	00	0181	ADMINISTRATION OF DRUGS	
Federal	FQ08	08.02	00	0223	NOTICE - PHYSICIAN OWNERSHIP	
Federal	FQ08	08.02	00	0224	ADVANCED DIRECTIVES	
Federal	FQ08	08.02	00	0240	INFECTION CONTROL	
Federal	FQ08	08.02	00	0241	SANITARY ENVIRONMENT	
Federal	FQ08	08.02	00	0242	INFECTION CONTROL PROGRAM	
Federal	FQ08	08.02	00	0261	ADMISSION ASSESSMENT	
Federal	FQ08	08.02	00	9999	FINAL OBSERVATIONS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS A Federal Re-certification survey was conducted on 11/1 and 11/2/16. An Immediate Jeopardy regarding the use of an Oxygen Concentrator in an Operating Room intended for individual use in the home, was identified. The following Conditions for Coverage are out of compliance: 42 CFR 416.41 Governing Body and Management 42 CFR 416.44 Environment 42 CFR 416.51 Infection Control Medical Records Reviewed: 20 Staff Files Reviewed/Interviews: 15 Abbreviation Key: AAMI=Association for the Advancement of Medical Instrumentation AORN= Association of periOperative Registered Nurses CDC=Centers for Disease Control and Prevention CI=Chemical Indicator/Integrator HICPAC=Hospital Infection Control Practices Advisory Committee IDSA=Infectious Disease Society of America IFUs=Instructions for Use OPA=Ortho-Phthalaldehyde OR=Operating Room OSHA=Occupational Safety and Health	Q 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 000	Continued From page 1 Administration PPE=Personal Protective Equipment SHEA=Society of Healthcare Epidemiology of America TOP=Termination of Pregnancy	Q 000		
Q 040	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 document review, staff interview, and observation, it was determined that the Governing Body failed to demonstrate it is effective in carrying out the responsibility of the operation and management of the Ambulatory Surgical Center (ASC). The Governing Body failed to provide necessary oversight and leadership as evidenced by the lack of compliance with the following Condition of Participation: Environment and Infection Control.	Q 040		
Q 100	ENVIRONMENT CFR(s): 416.44 The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of	Q 100		

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Q 100	Continued From page 2 patients. This CONDITION is not met as evidenced by: Based on observation and staff interview on 11/2/16, it was determined that the facility failed to provide a safe environment to protect the health of patients, staff, and the public. Findings include: 1. The facility failed to comply with the requirements of the National Fire Protection Association's Life Safety Code, 2012 edition. (Cross refer to Tag Q 104).	Q 100		
Q 104	SAFETY FROM FIRE CFR(s): 416.44(b) (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to http://www.archives.gov/federalregister/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park,	Q 104		

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Q 104	Continued From page 3	Q 104		

Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

(2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.

(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.

(4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006.

(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if:

(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and

(iv) The dispensers are installed in accordance

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Q 104	Continued From page 4 with the following provisions: (A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m); (B) The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors (2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms (C) The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other; (D) Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet; (E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code; (F) The dispensers shall not be installed over or directly adjacent to an ignition source; (G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and (v) The dispensers are maintained in accordance with dispenser manufacturer guidelines. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to comply with	Q 104		

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Q 104	Continued From page 5 the requirements of the National Fire Protection Association's Life Safety Code, 2012 edition. Findings include: 1. The facility failed to ensure buildings of type III(200) that are two or more stories in height are sprinklered throughout by an approved supervised automatic sprinkler system. Cross Reference Tag K 0161. 2. The facility failed to ensure that exit enclosures provide a continue protected path of travel to an exit discharge. Cross Reference Tag K 0211. 3. The facility failed to ensure doors required to be self-closing are closed, unless held open by an approved hold-open device. Cross reference Tag K 0223. 4. The facility to ensure stairs used as a component of the means of egress are enclosed. Cross reference Tag K 0311.	Q 104		
Q 141	ORGANIZATION AND STAFFING CFR(s): 416.46(a) Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. This STANDARD is not met as evidenced by: Based on medical record review and interview, it was determined that nursing personnel did not	Q 141		

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Q 141	Continued From page 6 provide nursing care in accordance with a recognized standard of practice and its policy. Findings include: Reference #1: The Nursing Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse RN is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference #2: Facility policy "Perioperative Pain Management at MMA" states, "... To make the patient's recovery after surgery and anesthesia more comfortable, the PACU nurse is advised to do a pain assessment based on a scale of 0-10, 0- no pain, 10, pain is absolutely unbearable ..." 1. The medical record of Patient #7 revealed that the patient underwent a procedure on 10/8/16. The PACU (post anesthesia care unit) Post Operative Admission sheet indicated that at 4:30 PM, the patient met discharge criteria. One indicator of the Discharge Criteria is "Pain score < (less) 3." There was no evidence in the medical record that the patient's pain was assessed throughout the PACU stay and prior to discharge. 2. The medical record of Patient #6 revealed that the patient underwent a procedure on 10/25/16. The PACU Post Operative Admission sheet indicated that at 12:15 PM, the patient met discharge criteria. One indicator of the Discharge	Q 141		

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Q 141	Continued From page 7 Criteria is "Pain score < (less) 3." There was no evidence in the medical record that the patient's pain was assessed in PACU and prior to discharge. 3. The medical record of Patient #2 revealed that the patient underwent a procedure on 12/30/15. Post procedure there was no evidence that the patient's pain was assessed prior to the patient's transfer. 3. The medical record of Patient #5 indicated in the Patient's Information Medical History sheet that the patient was allergic to Dapro and Ibuprofen. The Post Operative Orders dated 10/14/16 contained an order for "Ibuprofen 800 mg (milligram) po (by mouth) prn (as needed) cramping x1." Although the patient did not require any medication for cramping post-operatively, there was no evidence that nursing staff consulted with the physician for clarification or discontinuation of the order. 4. The medical record of Patient #7 indicated on 10/22/16 that post-operatively the patient was maintained on Lactated Ringers at 125 ml (milliliter) per hour. There was no evidence in the Post Operative Orders of an intravenous fluid order. 5. The medical record of Patients #4 indicated that post-operatively on 8/3/16, the patient was maintained on Lactated Ringers at 125 ml per hour with 20 units of Pitocin. There was no evidence in the Post-Operative Orders of an intravenous fluid order. 6. The medical records of Patient #2, #3, #4, #5 indicated that these patients were transferred to a	Q 141		

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Q 141	Continued From page 8 hospital post-operatively for evaluation. The medical records failed to include a transfer order. 7. The above was confirmed by Staff #2 and Staff #7.	Q 141		
Q 181	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 and staff interview conducted on 11/2/16, it was determined that the facility failed to ensure the implementation of acceptable standards of practice for medication preparation. Findings include: Reference: Institute for Safe Medication Practices (ISMP) Safe Practice guidelines for Adult IV Push Medications, Appendix A, states, "3.5 Do NOT withdraw IV push medications from commercially available, cartridge-type syringes into another syringe for administration." 1. Carpuject prefilled syringe cartridges of Labetalol were found in the anesthesia cart of Operating Room #4. 2. Upon interview, Staff # 4 stated that the facility withdraws the medication using a syringe and did not use carpuject holding devices.	Q 181		

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Q 181	Continued From page 9 3. These findings were confirmed by Staff #2.	Q 181		
Q 223	NOTICE - PHYSICIAN OWNERSHIP CFR(s): 416.50(b) The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of information must be in writing. This STANDARD is not met as evidenced by: Based on review of 4 of 4 medical records and interview, it was determined that the facility failed to ensure that the patient is provided written information regarding the facility physician ownership prior to surgery. Findings include: 1. The medical records of Patient #6, #8, #10 and #12 lacked evidence that written information regarding the physicians ownership in the facility was provided to the patients. 2. The above was confirmed by Staff #1.	Q 223		
Q 224	ADVANCED DIRECTIVES CFR(s): 416.50(c)(1)(2)(3) The ASC must comply with the following requirements: (1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.	Q 224		

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Q 224	Continued From page 10 (2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by: Based on a review of 4 of 4 medical records, review of facility policy, and interview of administrative staff, it was determined that the facility failed to provide patients or, as appropriate the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives; failed to inform the patient, or as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care; and failed to document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. Findings include: 1. The medical records of Patients #6, #8, #10, and #12 failed to indicate that written information had been provided to the patient regarding the facility policies on advance directives including a description of applicable State health and safety laws, and if requested, official State advance directive forms. 2. The medical records of Patient #6, #8, and #12 lacked evidence of an advance directive inquiry at the time of admission. 3. Staff #1 confirmed the above findings.	Q 224		

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Q 240	INFECTION CONTROL CFR(s): 416.51 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, document review and staff interview conducted on 11/1/16 and 11/2/16, it was determined that the facility failed to have an adequate Infection Control program that seeks to minimize infections and communicable diseases. Findings include: 1. The facility failed to provide a functional and sanitary environment for provision of surgical services by adhering to professionally acceptable standards of practice. (Cross refer to Tag Q 0241). 2. The facility failed to implement and monitor compliance with the infection control policies, procedures and protocols of the facility's Infection Control Plan and the nationally recognized guidelines that it has selected for its Infection Control program. (Cross refer to Tag Q 0242).	Q 240		
Q 241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: A. Based on observation, review of facility	Q 241		

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Q 241	Continued From page 12	Q 241		

documentation, and staff interview, it was determined that the facility failed to ensure a functional and sanitary environment for the provision of surgical services.

Findings include:

1. On 11/2/16 at 10:50 AM, in the presence of Staff #1, a Platinum 5 HF model IRC5LX02 Oxygen Concentrator was being used in Operating Room #2 while procedures were being performed.

a. A review of the Manufacture's Operator Manual states, "Your oxygen concentrator is intended for individual use in the home." ... Select a location: You may select a room in your house ... The air intake of the unit should be located in a well ventilated area to avoid airborne pollutants and/or fumes. ..."

b. During interview, Staff #1 confirmed the oxygen concentrator was functioning during procedures on 11/2/16.

c. The Oxygen Concentrator was not utilized in accordance with Manufactures' Operator Manual.

This finding resulted in an Immediate Jeopardy which immediately curtailed this practice. The Immediate Jeopardy was removed on 11/2/16, day of survey, upon receipt of an acceptable plan of correction.

B. Based on observation, staff interview and facility policy review conducted on 11/1/16, it was determined that the facility failed to ensure a safe and sanitary environment for the provision of

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Q 241	Continued From page 13 surgical services by adhering to hand hygiene procedures in accordance with CDC-HICPAC guidelines and its own policy. Findings include: Reference #1: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee[HICPAC] and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the CDC (Centers for Disease Control and Prevention) Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16) page 32 states, " Recommendations: 1. Indications for Handwashing and Hand antisepsis ... C. Decontaminate hands before having direct contact with patients. ... E. Decontaminate hands before inserting...peripheral vascular catheters, or other invasive devices... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with ... a patient's nonintact skin ... I. Decontaminate hands after contact with inanimate objects...in the immediate vicinity of the patient. J. Decontaminate hands after removing gloves." Reference #2: Facility policy titled Hand Hygiene Policy and Procedure states, "... If hands are not visibly soiled, an alcohol-based hand rub may be used for routinely decontaminating hands in the	Q 241		

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following clinical situations: [bullet] Before having direct contact with patients... [bullet] After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient)... [bullet] When moving from a contaminated body site to a clean body site during patient care... [bullet] After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient... [bullet] After removing gloves... 1. Artificial fingernails or extenders may not be worn if duties include direct contact with patients... 3. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient. ... ."

1. During a tour of OR #2 at 12:20 PM, in the presence of Staff #2, Staff #8 was observed removing his/her soiled gloves and touching his/her mask and eyeglasses without first sanitizing his/her hands.

a. This finding was confirmed by Staff #2 and Staff #8.

2. During a tour of the SPD area, in the presence of Staff #2, Staff #3 was observed removing his/her soiled gloves and opening a door, without first sanitizing his/her hands.

a. This finding was confirmed by Staff #2 and Staff #3.

3. On 11/1/16 in Operating Room (OR) #2 during a procedure, Staff #8 donned and doffed his/her gloves multiple times without hand sanitizing between glove changes.

b. With gloved hands, Staff #8 pushed discarded

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Q 241	Continued From page 15 wrappers down inside a trash can. (i) While still wearing the same gloves, Staff #8 began opening and closing cabinet doors in search of supplies. c. At 12:46 PM, Staff #8 doffed his/her gloves and left the OR to retrieve supplies. (i) When Staff #8 returned to the OR, he/she did not hand sanitize prior to donning gloves. 4. The facility failed to ensure a safe and sanitary environment by implementing hand hygiene in accordance with CDC-HICPAC guidelines and its own Infection Control policy. C. Based on observation, staff interview and facility policy review conducted on 11/1/16, it was determined that the facility failed to ensure a safe and sanitary environment for the provision of surgical services by adhering to the nationally recognized guidelines it has selected for its Infection Control program. Findings include: 1. During the entrance conference, Staff #1 and Staff #2 stated that the facility follows AAMI, AORN, CDC, and OSHA guidelines for its Infection Control program. The facility performs termination of pregnancy (TOP) procedures only. Reference: AORN Guidelines For Perioperative Practice, 2016 edition states on pages 12-13, "Recommendation III. A clean environment should be reestablished after the patient is transferred from the area. ... III.C.5. The floors and walls of operating and procedure rooms	Q 241		

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Q 241	Continued From page 16 should be cleaned and disinfected after each surgical or invasive procedure if soiled or potentially soiled. " 1. During observation of room turnover cleaning in OR #2, in the presence of Staff #2, Staff #10 was observed mopping the floors without moving the table to clean the floor underneath. a. The floors can be potentially soiled with blood and bodily fluids due to the type of procedures it performs. 2. The facility failed to ensure that the floors are cleaned and disinfected between patients. 3. This finding was confirmed by Staff #2 and Staff #10.] D. Based on observation, review of facility policies and procedures, review of nationally recognized guidelines, and staff interview, it was determined that the facility failed to provide a sanitary environment by adhering to professionally acceptable standards of practice. Findings include: Reference #1: AORN, Guidelines for Perioperative Practice, 2016 Edition pg. 30 states, " ... Chipped fingernail polish should be removed prior to entry into the restricted area of the perioperative environment. Fingernail polish that is chipped may harbor pathogens in large numbers ... Chipped fingernail polish should be removed to prevent possible contamination of the environment or the patient... Artificial fingernails should not be worn by health care personnel in the perioperative environment. Any fingernail	Q 241		

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Q 241	Continued From page 17 enhancement or resin bonding product is considered artificial. Fingernail extensions or tips, gels and acrylic overlays, resin wraps, or acrylic fingernails constitute types of artificial fingernails. ... . " 1. The following was observed on 11/1/16 in the PACU area: a. Staff #15 confirmed that he/she was wearing gel nails. b. Staff #14 was wearing nail polish that was visibly chipped on both hands. c. Staff #10 was wearing nail polish that was visibly chipped on both hands. Reference #2: CDC, Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011, pg. 55 states, "... Appropriate disinfectants must be used to prevent transmission of microbes through connectors [357]. Some studies have shown that disinfection of the devices with chlorhexidine/alcohol solutions appears to be most effective in reducing colonization [195, 196]. ..." 1. During an observation of Patient #1 on 11/1/16, Staff #4 administered IV medication numerous times to Patient #1 without first disinfecting the IV port with alcohol. 2. Staff #1 and Staff #7 confirmed the above findings. Reference #3: Facility policy titled Safe Medication Administration Guidelines states, "... [bullet] Use aseptic technique to avoid	Q 241		

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Q 241	Continued From page 18 contamination of sterile injection equipment... [bullet] Multi-dose vials will be used as single dose vials at all times. They will be punctured once and discarded after single use... [bullet] Always use a new sterile syringe and needle to draw up medications... [bullet] Do not re-use needles, syringes or cannulae... [bullet] Swab all vials with an alcohol pad prior to drawing up medication even single use vials." 1. During an observation of Patient #1 on 11/1/16, Staff #4 re-used the same needle and syringe used previously to administer propofol, to draw up an additional dose of propofol. 2. Staff #4 did not disinfect the rubber septum with alcohol prior to piercing the vial. 3. Staff #1 and Staff #7 confirmed the above findings.	Q 241		
Q 242	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: A. Based on observation, staff interview, and review of manufacturer's instructions for use (IFUs) conducted on 11/1/16, it was determined that the facility failed to ensure that	Q 242		

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Q 242	Continued From page 19 manufacturer's IFUs are followed. Findings include: Reference #1: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2014 edition states in ST 79 section 7.2.2 Manufacturers' written IFU [Instructions for Use], "The written IFU of the device manufacturer should always be followed." Reference #2: Shimadzu Ultrasonic Vaginal Probe manufacturer's IFU states, "High Level Disinfection ... Disinfect the probe after each use. ... (3) Dipping: Use disinfectant, listed in Table 1. Disinfectant procedure should be executed in accordance with disinfectant manufacture's (sic) instructions. ... Table 1 Recommended Solution: Active ingredient: Glutaraldehyde ... Solution: Cidex ... Manufacturer: Johnson & Johnson" 1. During observation of a high-level disinfection procedure at 1:05 PM, Staff #3 was observed using Cidex OPA (Ortho-Phthalaldehyde) solution to clean and disinfect a Shimadzu Ultrasonic Vaginal Probe. a. Cidex OPA solution is a different disinfectant from Cidex glutaraldehyde solution. b. Cidex OPA is not listed by the manufacturer as a recommended product for disinfecting the Shimadzu probes. 2. The facility failed to ensure adherence to the manufacturer's IFUs. 3. This finding was confirmed by Staff #3.	Q 242		

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Q 242	Continued From page 20 B. Based on observation and staff interview conducted on 11/1/16, it was determined that the facility failed to ensure its Instrument Reprocessing adheres to AAMI ST 79 guidelines. AAMI is one of the nationally recognized guidelines the facility has selected for its Infection Control program. Findings include: Reference #1: AAMI Sterilization in Health Care Facilities, 2014 edition, ST 79 section 10.5.2.2.2 Internal chemical indicators states, "An internal CI should be used within each package, tray, or rigid sterilization container system to be sterilized." 1. During a tour of the SPD area located in the basement, in the presence of Staff #3 and Staff #11, a sterile instrument tray labeled "D&C set" was opened and inspected. The tray lacked an internal CI (chemical indicator/integrator) within the package. 2. The facility failed to ensure compliance with AAMI ST79 guidelines. 3. This finding was confirmed by Staff #3. Reference #2: AAMI Sterilization in Health Care Facilities, 2014 edition, ST 79, section 3.3.6.5 Temperature states, "... The decontamination area should have a temperature controlled between 16 degrees C [Celsius] and 18 degrees C (60 degrees F [Fahrenheit] and 65 degrees F). ... bacteria thrive at high temperatures; cool temperatures in the decontamination area might help minimize bioburden."	Q 242		

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Q 242	Continued From page 21 1. During a review of SPD Temperature and Relative Humidity logs, the "Decontamination Area Documentation of Temperature and Humidity" logs evidenced daily temperatures above 65 degrees F from 9/1/16 through 10/29/16. a. The log indicated that the facility's acceptable temperature range in the Decontamination Area is between "60 degrees F and 65 degrees F." 2. The facility failed to ensure temperature control in the Decontamination Area was in accordance with AAMI guidelines and its own policy. 3. These findings were confirmed by Staff #2. C. Based on observation and staff interview conducted on 11/1/16, it was determined that the facility failed to ensure perioperative practices that adhere to AORN guidelines. Findings include: Reference #1: AORN [Association of periOperative Registered Nurses] Clinical FAQs <https://www.aorn.org/clinicalfaqs/attire/> updated November 13, 2014 states, "Perioperative team members should wear scrub attire that covers the arms when opening sterile supplies. Wearing long-sleeved attire helps contain skin squames shed from bare arms. Opening sterile supplies onto the sterile field without wearing a long-sleeved jacket may allow skin squames from the perioperative team member's bare arms to drop onto the sterile field and may increase the patient's risk for an SSI."	Q 242		

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Q 242	Continued From page 22 Reference #2: AORN Guidelines For Perioperative Practice, 2016 edition states on page 100, "I.c. When in the restricted areas, all nonscrubbed personnel should completely cover their arms with a long-sleeved scrub top or jacket." 1. AORN is one of the nationally recognized guidelines the facility has selected for its Infection Control program. 2. During observation of room preparation for a procedure in OR #2, in the presence of Staff #2, Staff #8 was observed opening sterile surgical items onto the sterile field without wearing a long-sleeved attire. a. The lack of a long-sleeved attire allows skin squames that are shed from Staff #8's arms to drop onto the sterile field and potentially contaminate the field. 3. The facility failed to ensure all nonscrubbed personnel wear long-sleeved attire while in the restricted areas of the facility. 4. The facility failed to ensure the sterile integrity of surgical items on the sterile field were maintained. 5. These findings were confirmed by Staff #2 and Staff #8. D. Based on observation and staff interview conducted on 11/1/16, it was determined that the facility failed to ensure compliance to OSHA regulations. Findings include:	Q 242		

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Q 242	Continued From page 23 Reference: OSHA (Occupational Safety and Health Administration) 29 CFR part 1910.1030(d)(3)(ii) states, "Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgement, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future." 1. During a tour outside OR #2, in the presence of Staff #2, Staff #9 was observed exiting OR #2 at 12:10 PM, carrying a container of soiled instruments without the benefit of protective gloves. a. The container was observed to contain a biohazard warning label. 2. The facility failed to ensure implementation of PPE use in compliance to OSHA regulations. 3. This finding was confirmed by Staff #2.	Q 242		
Q 261	ADMISSION ASSESSMENT CFR(s): 416.52(a)(1) Not more than 30 days before the date of the scheduled surgery, each patient must have a	Q 261		

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METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 261	Continued From page 24 comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by: Based on document review and staff interview, it was determined that the facility failed to ensure that a complete medical history is obtained prior to a procedure. Findings include: Reference: Facility Medical Staff Rules and Regulation states, "... VII. Medical Records ... 2. Under no circumstances may an operation be performed until the patient's history, physical examination ... are recorded on the medical record." 1. The medical records of Patients #2 - #20 lacked a complete medical history performed by the physicians prior to a procedure. The medical records contain a Patient Information sheet that includes the patient's medical history, past surgery/hospitalization, allergies, medications, etc. which is completed and signed by the patient. As per Staff #7, this form is reviewed and utilized for additional notes by the physicians as a medical history prior to the procedure.	Q 261		
Q9999	FINAL OBSERVATIONS 11/2/16---Surveyors are on site today for a Federal Recertification survey and have identified an Immediate Jeopardy. The survey team	Q9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q9999	Continued From page 25 observed a Platinum 5 HF model IRC5LX02 Oxygen Concentrator being used in the Operating Room during a procedure. The instructions for use indicate the following: " Your oxygen concentrator is intended for individual use in the home " " Select a location: You may select a room in your house ... " " ... The air intake of the unit should be located in a well ventilated area to avoid airborne pollutants and/or fumes. " The unit takes air from the operating room, converts it to concentrated oxygen and administers O2 via nasal cannulas and also exhausts air though the side. The facility was made aware of the IJ and an immediate Plan of Correction was requested by the survey team. The Condition tag that this will be cited under is Physical Environment. 11/21/16-*An acceptable Plan of Correction has been received by the survey team and the IJ has been removed.	Q9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
31C0001006 Y1	A. Building B. Wing Y2	4/24/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Q0040	Correction	ID Prefix Q0100	Correction	ID Prefix Q0104	Correction
Reg. # 416.41	Completed	Reg. # 416.44	Completed	Reg. # 416.44(b)	Completed
LSC	04/24/2018	LSC	04/24/2018	LSC	04/24/2018
ID Prefix Q0141	Correction	ID Prefix Q0181	Correction	ID Prefix Q0223	Correction
Reg. # 416.46(a)	Completed	Reg. # 416.48(a)	Completed	Reg. # 416.50(b)	Completed
LSC	04/24/2018	LSC	04/24/2018	LSC	04/24/2018
ID Prefix Q0224	Correction	ID Prefix Q0240	Correction	ID Prefix Q0241	Correction
Reg. # 416.50(c)(1)(2)(3)	Completed	Reg. # 416.51	Completed	Reg. # 416.51(a)	Completed
LSC	04/24/2018	LSC	04/24/2018	LSC	04/24/2018
ID Prefix Q0242	Correction	ID Prefix Q0261	Correction	ID Prefix	Correction
Reg. # 416.51(b)	Completed	Reg. # 416.52(a)(1)	Completed	Reg. #	Completed
LSC	04/24/2018	LSC	04/24/2018	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

PRINTED: 05/29/2018

Statement of Deficiencies
Citation Summary Sheet

For: METROPOLITAN SURGICAL ASSOCIATES (31C0001006 / NJ31C0001006)

Survey Event: LCSL21, Exit Date 11/02/2016

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	K309	03.02	02	0000	INITIAL COMMENTS	
Federal	K309	03.02	02	0161	Building Construction Type and Height	
Federal	K309	03.02	02	0211	Means of Egress - General	
Federal	K309	03.02	02	0223	Doors with Self-Closing Devices	
Federal	K309	03.02	02	0311	Vertical Openings - Enclosure	

Americans United for Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING **02** B. WING _____	**11/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	**40 ENGLE STREET ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This was a Federal Recertification Survey. This facility is not in compliance with the National Fire Protection Association's 2012 Life Safety Code for this federal recertification survey only.	K 000		
K 161	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height Building construction type and stories meet Table 20.1.6.1 or Table 21.1.6.1, respectively. Construction Type 1 I (442), I (332), II (222), II (111), III (211), IV (2HH), non-sprinklered or sprinklered V (111) — Any number of stories 2 II (000), III (200), V (000) — One story non-sprinklered; Any number of stories sprinklered Any level below the level of exit discharge shall be separated by Type II (111), Type III (211), or Type V (111) construction unless both of the following are met: 1. Such levels are under the control of the ambulatory health care occupancy. 2. Hazardous spaces are protected per section 8.7. Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 20.3.5 or 21.3.5, respectively)	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING **02** B. WING _____	**11/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	**40 ENGLE STREET** **ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 1 Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. 20.1.6.1, 20.1.6.2, 21.1.6.1, 21.1.6.2 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure buildings of type III (200) that are two or more stories in height, are sprinklered throughout by an approved supervised automatic sprinkler system. Findings include: 1. On 11/2/16 at 1:30 PM, in the presence of Staff #1, the building was found to be three stories, constructed of masonry exterior walls with unprotected combustible interior floors and walls. a. The building was equipped with a supervised automatic sprinkler system in the Basement only. 2. Staff #1 confirmed this finding.	K 161		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING **02** B. WING _____	**11/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	**40 ENGLE STREET** **ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that exit enclosures provide a continue protected path of travel to an exit discharge. Findings include: Reference #1: National Fire Protection Association's Life Safety Code, 2012 edition, "101:7.2.2.5.1, All inside stairs serving as an exit or an exit component, shall be enclosed in accordance with 7.1.3.2." Reference #2: National Fire Protection Association's Life Safety Code, 2012 edition, "101:7.1.3.2.2, An exit enclosure shall provide a continuous protected path of travel to an exit discharge." 1. On 11/2/16 at 11:10 AM, in the presence of Staff #1, fifty percent (50%) of the required exit capacity for the Basement was up a staircase that was enclosed at the First Floor Level but discharged into the Pre/Post Operative Care Unit and was not a protected path to an Exit Discharge.	K 211		
K 223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors required to be self-closing are permitted to be held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment, entire	K 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING **02** B. WING _____	**11/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	**40 ENGLE STREET** **ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	Continued From page 3 facility, and all stair enclosure doors upon activation of: * Required manual fire alarm system, and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power 20.2.2.4, 20.2.2.5, 21.2.2.4, 21.2.2.5 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that doors required to be self-closing are closed, unless held open by an approved hold-open device. Findings include: 1. On 11/2/16 at 11:05 AM, in the presence of Staff #1, a manual folding door stop was attached to the basement door in the Pre/Post Operative Care Unit. This door stop was holding the door open at the time of this survey.	K 223		
K 311	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Unenclosed openings which do not serve as a required means of egress are permitted. 3. Exit access stairs may be unenclosed if they meet the following conditions: Two stories or less a. Building is protected throughout by a	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING **02** B. WING _____	**11/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	**40 ENGLE STREET** **ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 4 supervised sprinkler system per 9.7.1.1(1). b. Total travel distance to outside does not exceed 100 feet. Three stories or less a. Occupant load per story does not exceed 15 people. b. Building is sprinkler protected throughout per 9.7.1.1(1). c. Building contains an automatic smoke detection system per 9.6. d. Activation of the sprinkler system or smoke detection system notifies all occupants of the building. e. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 21.3.1, 39.3.1.1, 39.3.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility to ensure that stairs used as a component of the means of egress are enclosed. Findings include: 1. On 11/2/16 at 10:25 AM, in the presence of Staff #1, the required exit from the second floor was down a set of stairs which was open at the second floor to the Waiting Room.	K 311		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
31C0001006 Y1	A. Building 02 - METROPOLITAN MEDICAL ASSOCIATES B. Wing Y2	4/24/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	04/24/2018	LSC K0211	04/24/2018	LSC K0223	04/24/2018
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0311	04/24/2018	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
11/2/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

METROPOLITAN MEDICAL ASSOCIATES
40 Engle Street
Englewood, New Jersey 07631
Phone (201) 567-0522
Fax (201) 816-9863

IMMEDIATE REMOVAL PORTABLE O2 CONCENTRATORS

During the federal inspection, an immediate jeopardy violation was identified. The portable O2 concentrators were not being used in accordance with the manufacturer's guidelines. Effective immediately, the portable O2 concentrators that were located in OR2 and OR4 were permanently removed from the facility. All staff will be in-serviced and all necessary policies shall be revised. All ORs are now equipped with oxygen tanks.

Initially, rounds will be conducted by the IC Designee on a weekly basis for one (1) month to ensure that O2 concentrators will not be used. Thereafter, during monthly environmental rounds for the next three (3) months, IC Designee will ensure that O2 concentrators will not be used.

Date: November 2, 2016

Americans
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for Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS A Federal Re-certification survey was conducted on 11/1 and 11/2/16. An Immediate Jeopardy regarding the use of an Oxygen Concentrator in an Operating Room intended for individual use in the home, was identified. The following Conditions for Coverage are out of compliance: 42 CFR 416.41 Governing Body and Management 42 CFR 416.44 Environment 42 CFR 416.51 Infection Control Medical Records Reviewed: 20 Staff Files Reviewed/Interviews: 15 Abbreviation Key: AAMI=Association for the Advancement of Medical Instrumentation AORN= Association of periOperative Registered Nurses CDC=Centers for Disease Control and Prevention CI=Chemical Indicator/Integrator HICPAC=Hospital Infection Control Practices Advisory Committee IDSA=Infectious Disease Society of America IFUs=Instructions for Use OPA=Ortho-Phthalaldehyde OR=Operating Room OSHA=Occupational Safety and Health	Q 000		

TITLE (X6) DATE

excused from correcting providing it is determined that
mes, the findings stated above are disclosable 90 days
bove findings and plans of correction are disclosable 14
days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Q 104(1)/K161 NFPA 101 Building Construction Type and Height

1. The ASC shall ensure that it's building construction type and height is compliant with the National Fire Protection Association's 2012 Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to conduct a thorough analysis of the facility's exterior walls, and it's interior walls and floors. On February 20th, 2017 an initial inspection of the ASC revealed masonry exterior walls, and concrete interior walls and floors.

3. Axis Architectural Studio is currently in the process of determining the specific need of the building in order to comply with the National Fire Protection Association's 2012 Life Safety Code. Once all evaluation is complete the and corresponding architectural plans are completed and approved, the ASC will retain the services of the appropriate contracting company to make all necessary changes to ensure the ASC is in compliance with code.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun preparing a plan for the ASC to be in compliance with the National Fire Protection Association's 2012 Life Safety Code. All work shall be completed by September 1, 2017

Q104 (2)/ K211 Means of Egress – General

1. The ASC shall ensure that all inside stairs serving as an exit or an exit component shall be enclosed in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the staircase leading up from the basement to the Pre/Post Operative Care Unit so that it is a protected path to an Exit Discharge.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the basement into the Pre/Post Operative Care Unit. Once construction is complete, compliance shall be automatically and permanently maintained.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

Not Acceptable 3/6/17

Americans United for Life

Q104 (3) K223 NFPA 101 Doors with Self-Closing Devices

1. The ASC shall ensure that all self-closing doors are equipped with a release device that complies with the National Fire Protection Associate Life Safety Code.

2. The manual folding door stop that was attached to the basement door in the Pre/Post Operative Care unit has been removed.

3. A complete and thorough sweep will be conducted of the ASC to ensure that all manually folding doors equipped with a manual doorstop are inspected and that the manual doorstops are either removed or replaced with an approved hold-open device compliant with the National Fire Protection Associate Life Safety Code.

4. The ASC Fire Safety Coordinator shall conduct a final inspection of all self-closing doors and assure that all hold-open devices are in compliance with the National Fire Protection Association's Life Safety Code.

5. The manual doorstop on the cited door has been replaced as of February 28, 2017 and a full inspection by the ASC Fire Safety Coordinator shall be conducted no later that June 1, 2017.

Q104 (4) K311 Vertical Openings - Enclosures

1. The ASC shall ensure that all vertical openings shall be enclosed or protected in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the required exit from the second floor that was down a set of stairs, which was open at the second floor to the waiting room.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the second floor to the waiting room. Once construction is complete, compliance shall be automatically and permanently maintained.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

Americans United for Life

Q40 not addressed
Q 100

Q 141 Reference 1, 2 (1, 2, 3)

1. There is now on going documentation of patients' pain assessment by the nursing staff.

2. The PACU portion of the medical chart was amended to provide a systemic record of this assessment.

3. Compliance of this corrective action will be monitored via the chart review process. Identified deficiencies will be addressed by the Director of Nursing to the nursing staff and reported to the Quality Assurance Committee.

4. The DON and the Assistant Medical Director (AMD) were responsible for implementing this plan of correction.

5. The POC was implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 1, 2 (3)

1. Nursing staff has been reminded that merely not dispensing medication that may share hypersensitivity concerns with a patient's known allergy is insufficient and that potential interactions must be positively identified and clarified with the prescribing physician. The medical chart has also been revised to facilitate systemic correction of this deficiency. It has been amended to contain a template for the listing of allergies directly over the prescribing orders template so that potential drug interactions are easier to note.

2. Systemic correction of this deficiency will be assured by comparison of documented allergies to the prescribing orders for every patient by the responsible RN and resolution of any identified concerns with prescribing physician.

3. Monitoring to assure the effectiveness of this POC will occur via chart review. The DON will, as part of the monthly chart auditing process, check to assess that there no prescribed orders which are thought to have potential adverse reactions with patients' known allergens

4. The DON and the AMD were responsible for this corrective action.

5. This POC was fully implemented as of Jan 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 2 (4, 5)

1. Upon transfer from the OR to the PACU the attending physician must perform a medication reconciliation to avoid errors of duplication or omission. All medicine and intravenous fluid orders must be reviewed and rewritten upon transfer of the patient between the two care areas.

2. The medical chart has been modified to assure effective systemic compliance with this corrective action. The order templates have been amended to facilitate comparison and prescribing of

medications and intravenous fluids between the OR and PACU. The identified deficiency and the POC was reviewed in separate attendance mandated meetings of the nursing and physician staff.

3. Monitoring to assure compliance with this corrective action will be via chart review by the DON or a DON designee. The DON is tasked with reporting compliance and / or identified deficiencies to this POC to the QAC.

4. The DON and the AMD were responsible for this POC.

5. This POC was fully implemented as of January 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 2 (6)

1. Physicians transferring a patient from the Facility to the hospital will enter such an order in the patient's medical record.

2. Identification of this deficiency and the corrective action was reviewed at an attendance mandated quality assurance meeting of the medical staff. Awareness by the physician staff to document a transfer order, along with, awareness by the nursing staff of such a requirement, will assure ongoing and systemic compliance.

3. The DON will review the charts of patients entered into the Transfer Log to assess for ongoing compliance. Deficiencies will be brought to the QAC for follow up.

4. The DON and the AMD were responsible for this corrective action.

5. This POC was fully implemented as of February 1, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

OK
3/27/17

Q181

1. Medications from cartridge-like syringes will not be withdrawn into a second syringe for administration.

2. The Facility has purchased an adequate supply of Carpujet Injectors and a memo has been issued by the DON and the ASC's Pharmacy Consultant informing the medical staff of this deficiency and its correction. The memo also delineated the location of the injectors.

3. The DON will monitor for compliance of this corrective action via assessment polling during staff meetings, as well as, via observation of daily routines. Any deviations will be corrected if and when they are identified. Repeated observations of continued deficiencies in this matter will be reported to the Pharmacy Consultant and QAC for further attention.

4. The DON and Pharmacy Consultant were responsible for this POC.

5. This POC was fully implemented as of Nov 12, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

OK
CC/C
3/27/17

Q223

1. The ASC will now provide written disclosure of physician ownership prior to care at the facility. This disclosure information is provided to patients via the Internet directly on ASC's website. This information is both viewable and printable online. Patients contacting the ASC via telephone are instructed to visit the website to view patient disclosure information. Finally in the event a patient does not have access to a computer, patients are instructed that upon request and prior to receiving any treatment, the ASC receptionist shall provide a written copy of this information.

2. The universal availability and active provisioning of this information prior to any rendering of services by the Facility and its staff will assure continuous systemic correction of this deficiency.

3. Written documentation of the provision of this information prior to the initiation of care will be documented in the counseling portion of the patients' medical record. Monitoring of this corrective action will thus become part of the chart audit process conducted by the DON or designee.

4. The Facility Administrator is responsible for this POC and its implementation.

5. The POC will be fully implemented by April 1, 2017 and reported as such to the QAC.

Q224

1. Following the identified deficiency, the Facility has updated its methods of assuring patients and their designated representatives are adequately provided with written information regarding their ability to make informed decisions in respect to their care, as well as, their ability to institute Advance Directives prior to the initiation of care at this ASC. The Facility will update its online information to include facts, questions and answers regarding advance directives, as well as, provide directing links to information, documents and resources provided by this State's Dept. of Health.

All patients scheduling appointments are to be queried regarding their desire to be furnished with written information relating to patient rights and advance directives. Such requested information will be provided prior to the initiation of care at the Facility and provided by the method most convenient to the patient; either, on line, via e-mail, fax or directly at the ASC.

Finally, the patient's medical record will be revised to better document provision of information with regards to patients' rights and advance directives. The patient record will have written confirmation that the information was offered. Furthermore, the history portion of the medical chart will be amended to provide documentation of whether an advance directive exists.

2. The above corrective action provides systemic correction of the identified deficiency and will be applicable to all patients of this ASC.

3. Once the POC is implemented the Facility Administrator will assess the completeness and functioning of the on line corrective actions and the DON will add assessment of the completion of the advance directive section of the medical record to the chart review process. Both will report their findings to the QAC.

Americans United for Life

4. The Facility Administrator and the ASC's Information Technology Consultant will be responsible for implementing these planned corrections.

5. The POC is scheduled to fully in place by Mar 31, 2017.

Q240/Q241

The Facility aims to diligently adhere to professionally acceptable standards and provide the most sanitary environment possible to its staff and in its provision of patient care and surgical services. The following POC objective is help assure its policies and procedures are in accordance with nationally recognized guidelines and that its quality assurance mechanisms adequately monitor compliance, as well as, identify and correct deficiencies on timely and ongoing basis. The observed deficiencies are addressed below.

OK. ACM. 3/7/17

Q241 A

1. The use of an oxygen concentrator in a manner not consistent with the Manufacturer's Operator Manual was immediately ceased and by immediately removing the equipment the corrective action assured that this deficiency would not recur. Equipment at the ASC will be used in a manner consistent with the Manufacturer's Operator Manual.

2. A meeting of the QAC was held on Nov 4, 2017, Members of the Committee were informed of the Site Survey Team's finding by the AMD. Following this, and at the request of the QAC, the MD and the DON reviewed a catalogue of the ASC's available medical equipment to ensure that no other was being utilized outside its manufacturer's described parameters.

Acceptable 3/6/17

3. To assure systemic compliance going forward, the QAC has charged the MD with assuring equipment purchased in the future will be utilized in a manner consistent with the Manufacturer's Operating Manual.

4. The AMD and the Infection Control Officer were responsible for this corrective action.

5. This POC was fully implemented as of Nov 8, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q241 B

1. During the course of its inspection, the Site Survey Team identified several instances of incomplete adherence to both the ASC's and CDC-HICPAC policies and standards with regards to infection control and hand hygiene by at least two of its staff members. The ASC will hold in-services mandatory to the medical, SPD and cleaning staffs and chaired by the Infection Control Officer. The meetings' purpose will be to review the cited findings, review the ASC's policies regarding hand hygiene and infection control, as well as, role-play scenarios so that staff can better understand the real life applications of these standards.

OK. ACM. 3/7/17

2. Continued periodic meetings of the above staff addressing these infection control concerns will serve to address these concerns in a systemic fashion.

3. The Infection Control Officer or a designee will one month later and monthly, thereafter, conduct random observations of the members of these departments to assess the effectiveness of the POC, assure compliance with the relevant ASC policies and provide corrective guidance. If during the course of this monitoring, systemic deficiencies are encountered, the Infection Control Officer will report to the QAC so that further remediate steps are taken.

4. The Infection Control Officer and the AMD were responsible for the implementation of this POC.

5. The POC is shall be implemented by March 7, 2017.

Ok. Acm 3/7/17

Not accepted 3/6/17 fw

Q241 C

1. The OR's are to be adequately prepared prior to reuse. The reestablishment of a clean environment includes the cleaning of the floor under the OR table after every case regardless whether is obvious soiling.

2. Review of the Facility Cleaning Manual to assure delineation of this step and a review of this corrective action with the cleaning staff by the Infection Control Officer will assure a systemic correction.

3. The Infection Control Officer will observe for compliance on an ongoing basis. Shortcomings will be brought to the attention of the cleaning staff and reported to the QAC.

4. The ICO and the AMD were responsible for this POC.

5. This POC was fully implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

NOT Ok. Acm. 3/7/17

Q241 D Reference #1

1. The ASC, to improve its adherence to professionally acceptable standards regarding the achievement of an optimal sanitary environment will provide an in-service on hand hygiene and review AORN's Guidelines of Perioperative Practice as they relate to nail grooming and restrictions to various nail enhancement products.

2. In addition to the in-service of applicable members of the Facility staff, review of these guidelines during orientation of new employees will provide systemic assurance of continued vigilance.

3. The observational monitoring of the ASC's relevant staff will provide a mechanism to confirm the POC has been successfully implemented and will be complied with in the future.

4. The implementation of this POC was tasked to the Infection Control Officer.

5. This POC was fully implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q241 D Reference #2, 3

1. The ASC's Safe Medication Administration Guidelines policy incorporates the CDC's recommendations as delineated in Safe Practices for Medical Injections, as well as, Guidelines for the Prevention of Intravascular Catheter Related Infections. An in-service of the medical staff was held on Feb 23, 2017 to review this policy, the recommendations on which it is based and its importance to infection control.

not OK RW 3/6/17

The need to wipe IV injector ports with 70% alcohol and that single dose vials entered more than once for the same patient must be done with new needle and syringe will be discussed in particular. Note will be made of the Survey Team's identification of deficiencies in this regard.

2. Review of the Facility's Safe Medication Administration Guidelines will be incorporated into the ASC's continuing education program and reviewed on at least an annual basis.

3. The ICO, or an appointed designee, will monitor for compliance to these guidelines and provide immediate remediation to observed deficiencies.

4. The ICO and the AMD will be responsible for implementation of this corrective action.

5. The POC was implemented by Feb 24, 2017.

Q242 A

1. The ASC recognizes that device manufacturers, in accordance with FDA and AAMI guidelines, have validated steps necessary for the proper processing of their devices and that Instructions For Use are an integral part of the correct preparation of equipment for safe patient use. During the survey an IFU was provided for a Shimadzu ultrasound vaginal probe. The staff member providing this was unaware that this ultrasound machine had long been replaced. As of July 2015, all of the Facility's ultrasound machines have been GE models. Staff members who would have been in a position to know this did not recognize what had occurred. The Facility uses and follows the correct IFU's for the processing of its equipment.

OK. Acm. 3/7/17

2. Following the recognition of this finding, the POC will be to review the catalogue of medical equipment and to remove outdated manuals.

3. On a biannual basis the AMD will review this catalogue to assure it remains current.

4. The AMD is responsible for the implementation of this POC.

5. The POC will be completed by Mar 3, 2017.

Q242 B Reference 1

1. ASC policies regarding the reprocessing of its reusable Instruments follow ANSI/AAMI guidelines; this includes the placement of a chemical indicator strip in each pack that is to undergo sterilization. The corrective action was to provide an in-service to members of the Sterilization and Processing staff.

OK. Acm. 3/7/17

not only with regards to the deviation from policy regarding the placement of a CI in each pack, but also, as to its purpose and its importance to the infection control mechanisms in place at the ASC.

2. Systemic compliance should be ensured by the universal adherence to this standard. All sterile packages should have CI.

3. Monitoring for compliance to this POC will be accomplished by increasing the number of randomly checked sterile packs, as well as, the frequency of this action to once a week for a period of 8 weeks. The Certified Sterile Processing and Distribution Technician will then report to the QAC the effectiveness of this corrective action.

4. The ICO, the AMD and the CSPDT were responsible for this POC.

5. The in-service will occur on Feb 28, 2017. The results of the increased surveillance will be in 8 weeks' time.

NOT Ok
AEM.
3/7/17

Q 242 B Reference 2

1. The ASC policy regarding temperature controlled Decontamination area is drafted to reflect the guideline set forth in the AAMI Sterilization in Health care Facilities, 2014 Edition. An in-service will be completed by the Sterilization Consultant with the all Sterile Processing Technician (SPT) and the Certified Sterile Processing and Distribution Lead Technician (CSPDT) to review new temperature recording procedures and safeguards.

2. The Sterilization Consultant shall perform an in-service that will include specific instructions that during the time the sterilization equipment is running in the Decontamination area, the cooling units shall be adjusted accordingly to accommodate for the slight potential increase in room temperature.

NOT OK.
AEM.
3/7/17

3. The SPT shall be responsible for keeping a daily temperature log for the Decontamination area. In the event that the temperature is out of acceptable range the SPT shall immediately notify the CSPDT who shall immediately turn on cooling units until the Decontamination area temperature is within acceptable range. Additionally the CSPDT shall make monthly reviews of the daily temperature log to make sure all readings have either been within range or immediately addressed and recorded. If any deviation from this protocol has occurred the CSPDT shall notify the Sterilization Consultant for another in-service.

4. The Medical Director in conjunction with the Sterilization Consultant shall be responsible for ensuring this Plan of correction is properly implemented by the SPT and CSPDT.

5. This plan of correction shall be completed no later than March 15, 2017.

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Q242 C

1. The ASC recognizes that the integrity of the sterile field is paramount to infection control and patient safety. Non-scrubbed personal will wear long sleeved attire while in restricted areas of the ASC.

2. To ensure a systemic correction of this deficiency the ASC purchased long sleeved scrubs for personnel working in restricted areas, this is in addition to the long sleeve gowns that are available to the relevant staff. A mandatory in-service for the relevant staff will be held to review the referenced AORN guidelines. The ASC will also revise its own policy to clearly reflect this standard.

3. The ICO, or an appointed designee, will be charged with observing for compliance on daily basis and for providing immediate remediation if non-compliance is observed. Failure to adhere to this policy will be reported to the QAC.

4. The AMD is responsible for the implementation of this POC.

5. Compliance to these standards was initiated following identification of the deficiency by the Survey Team on Nov 2, 2016. The POC will be fully implemented by Mar 6, 2017.

Ok.
ACM.
3/7/17

Q242 D

1. Personnel will wear appropriate personal protective equipment. The ASC provides easily accessible and appropriate personal protective equipment, such as, gloves, gowns, masks and eye protection to its staff.

2. Systemic compliance will be achieved by an in-service reviewing universal precaution standards and OSHA's blood borne pathogens guidelines as delineated under CFR 1910.1030. The important role of consistent and appropriate PPE use to staff safety and infection / exposure control will be reviewed.

3. The ICO will monitor staff for sustained compliance to these guidelines.

4. The AMD and ICO are responsible for instituting this POC.

5. The POC will have been fully implemented by March 7, 2017.

Not OK.
ACM.
3/7/17

Q261

1. The medical chart will include a complete medical history and physical examination, performed, signed and dated by the patient's attending physician prior to any procedure performed at the ASC.

2. The medical chart was revised to reflect this POC and assure a systemic change. A mandatory in-service occurred on Jan 10, 2107 informing the physician staff of the need for this corrective action.

3. Monitoring of this POC will be monthly and on going via the chart audit process performed by the DON. Lack of compliance will be reported to the QAC.

4. The AMD was responsible for this POC.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING 02 - METROPOLITAN MEDICAL ASSOCIATES B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This was a Federal Recertification Survey. This facility is not in compliance with the National Fire Protection Association's 2012 Life Safety Code for this federal recertification survey only.	K 000		
K 161	NFPA 101 Building Construction Type and Height Building Construction Type and Height Building construction type and stories meet Table 20.1.6.1 or Table 21.1.6.1, respectively. Construction Type 1 I (442), I (332), II (222), II (111), III (211), IV (2HH), V (111) Any number of stories non-sprinklered or sprinklered 2 II (000), III (200), V (000) One story non-sprinklered Any number of stories sprinklered Any level below the level of exit discharge shall be separated by Type II (111), Type III (211), or Type V (111) construction unless both of the following are met: 1. Such levels are under the control of the ambulatory health care occupancy. 2. Hazardous spaces are protected per section 8.7. Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 20.3.5 or 21.3.5, respectively) Give a brief description, in REMARKS, of the	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Susan Mantell — AD Administrator — 12/6/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

5. This corrective action was completed on Jan 11, 2017, following the identification of the deficiency by the Site Survey Team on Nov 2, 2016.

K161 NFPA 101 Building Construction Type and Height

1. The ASC shall ensure that it's building construction type and height is compliant with the National Fire Protection Association's 2012 Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to conduct a thorough analysis of the building's the facility's exterior walls, and it's interior walls and floors. On February 20th, 2017 an initial inspection of the ASC revealed masonry exterior walls, and concrete interior walls and floors.

3. Axis Architectural Studio is currently in the process of determining the specific need of the building in order to comply with the National Fire Protection Association's 2012 Life Safety Code. Once all evaluation is complete the and corresponding architectural plans are completed and approved, the ASC will retain the services of the appropriate contracting company to makes all necessary changes to ensure the ASC is in compliance with code.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun preparing a plan for the ASC to be in compliance with the National Fire Protection Association's 2012 Life Safety Code. All work shall be completed by September 1, 2017

K211 Means of Egress – General

1. The ASC shall ensure that all inside stairs serving as an exit or an exit component shall be enclosed in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the staircase leading up from the basement to the Pre/Post Operative Care Unit so that it is a protected path to an Exit Discharge.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the basement into the Pre/Post Operative Care Unit. Once construction is complete, compliance shall be automatically and permanently maintained.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

Accepted 3/6/17

K223 NFPA 101 Doors with Self-Closing Devices

1. The ASC shall ensure that all self-closing doors are equipped with a release device that complies with the National Fire Protection Associate Life Safety Code.

2. The manual folding door stop that was attached to the basement door in the Pre/Post Operative Care unit has been replaced with a release device that is in compliance with the National Fire Protection Associate Life Safety Code.

3. A complete and thorough sweep will be conducted of the ASC to ensure that all manually folding doors equipped with a manual doorstop are inspected and the manual doorstops are either removed or replaced with an approved hold-open device compliant with the National Fire Protection Associate Life Safety Code.

4. The ASC Fire Safety Coordinator shall conduct a final inspection of all self-closing doors and assure that all hold-open devices are in compliance with the National Fire Protection Association's Life Safety Code.

5. The manual doorstop on the cited door has been replaced as of February 24, 2017 and a full inspection by the ASC Fire Safety Coordinator shall be conducted no later that June 1, 2017.

K311 Vertical Openings - Enclosures

1. The ASC shall ensure that all vertical openings shall be enclosed or protected in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the required exit from the second floor that was down a set of stairs, which was open at the second floor to the waiting room.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the second floor to the waiting room. Once construction is complete, compliance shall be automatically and permanently maintained.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

Americans United for Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS A Federal Re-certification survey was conducted on 11/1 and 11/2/16. An Immediate Jeopardy regarding the use of an Oxygen Concentrator in an Operating Room intended for individual use in the home, was identified. The following Conditions for Coverage are out of compliance: 42 CFR 416.41 Governing Body and Management 42 CFR 416.44 Environment 42 CFR 416.51 Infection Control Medical Records Reviewed: 20 Staff Files Reviewed/Interviews: 15 Abbreviation Key: AAMI=Association for the Advancement of Medical Instrumentation AORN= Association of periOperative Registered Nurses CDC=Centers for Disease Control and Prevention CI=Chemical Indicator/Integrator HICPAC=Hospital Infection Control Practices Advisory Committee IDSA=Infectious Disease Society of America IFUs=Instructions for Use OPA=Ortho-Phthalaldehyde OR=Operating Room OSHA=Occupational Safety and Health	Q 000		

TITLE (X6) DATE 2/2/17

...xcused from correcting providing it is determined that ...nes, the findings stated above are disclosable 90 days ...ve findings and plans of correction are disclosable 14 ...days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...program participation.

Metropolitan Surgical Assoc -

Federal Metropolitan added #1 Rcd 4/4/17

Q040 416.41 Governing Body and Management

1. The Governing Body held a meeting to review the specific findings for every deficiency as a result of the Federal Re-certification survey of the Facility on November 2, 2016. The Governing Body will effectively carry out the responsibilities of the Facility until all deficiencies are completely corrected and will ensure that the Facility remains complaint with all rules and regulation going forward.

2. As a direct result of the November 2, 2016 Federal Re-certification survey, the Governing Body has proactively decided to set short-term monthly meetings in order to review the findings of the survey and the proposed plan of correction. Monthly meetings will be held until all deficiencies are corrected and the plan of correction has been carried out.

3. The Governing Body has ultimate responsibility for assuring and monitoring that the Plan of Correction is implemented and that all deficiencies are corrected.

4. The Governing Body shall take all necessary actions to assure the Facility continues to provide quality healthcare in a safe environment.

OK 4/13/17

5. The Governing Body met on February 15, 2017 to initially review the specific deficiencies identified as a result of the November 2, 2016 Federal Re-certification survey. The Governing Body will continue to meet on a monthly basis, or as needed if greater frequency is required, until all deficiencies have been corrected and the final approved Plan of Correction is completed. Once completed, the Governing body will resume its normal scheduled meetings.

Q100 416.44 Environment

1. The Governing Body held a meeting to review the specific findings of the Federal Re-certification survey of the Facility on November 2, 2016. The Governing Body contracted with Axis Architectural Studios for assistance in evaluating the requirements for fully complying with the National Fire Protection Association's Life Safety Code, 2012 edition.

2. Axis Architectural Studios completed a full inspection of the ASC's structural facility to assure full compliance with the NFPA. The building will be brought up to all code requirements in order to ensure a safe and sanitary environment to protect the health and safety of patients.

OK 4/13/17

3. The Governing Body has ultimate responsibility for assuring and monitoring that the Plan of Correction is implemented and that all deficiencies are corrected.

4. The Governing Body shall take all necessary actions to assure that the ASC has a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients

5. The Governing Body met on February 15, 2017 to initially review the specific deficiencies identified as a result of the November 2, 2016 Federal Re-certification survey. The Governing Body will continue to monitor the progress of Axis Architectural Studios until all deficiencies are corrected and the final plan of correction is fully completed.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

Q104 (3) K223 NFPA 101 Doors with Self-Closing Devices

1. The ASC shall ensure that all self-closing doors are equipped with a release device that complies with the National Fire Protection Associate Life Safety Code.

2. The manual folding door stop that was attached to the basement door in the Pre/Post Operative Care unit has been removed.

3. A complete and thorough sweep will be conducted of the ASC to ensure that all manually folding doors equipped with a manual doorstop are inspected and that the manual doorstops are either removed or replaced with an approved hold-open device compliant with the National Fire Protection Associate Life Safety Code.

4. The ASC Fire Safety Coordinator shall conduct a final inspection of all self-closing doors and assure that all hold-open devices are in compliance with the National Fire Protection Association's Life Safety Code.

5. The manual doorstop on the cited door has been replaced as of February 28, 2017 and a full inspection by the ASC Fire Safety Coordinator shall be conducted no later that June 1, 2017.

Q104 (4) K311 Vertical Openings - Enclosures

1. The ASC shall ensure that all vertical openings shall be enclosed or protected in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the required exit from the second floor that was down a set of stairs, which was open at the second floor to the waiting room.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the second floor to the waiting room. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

Q 104(1)/K161 NFPA 101 Building Construction Type and Height

1. The ASC shall ensure that it's building construction type and height is compliant with the National Fire Protection Association's 2012 Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to conduct a thorough analysis of the facility's exterior walls, and it's interior walls and floors. On February 20th, 2017 an initial inspection of the ASC revealed masonry exterior walls, and concrete interior walls and floors.

3. Axis Architectural Studio is currently in the process of determining the specific need of the building in order to comply with the National Fire Protection Association's 2012 Life Safety Code. Once all evaluation is complete the and corresponding architectural plans are completed and approved, the ASC will retain the services of the appropriate contracting company to make all necessary changes to ensure the ASC is in compliance with code. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun preparing a plan for the ASC to be in compliance with the National Fire Protection Association's 2012 Life Safety Code. All work shall be completed by September 1, 2017

Q104 (2)/ K211 Means of Egress – General

1. The ASC shall ensure that all inside stairs serving as an exit or an exit component shall be enclosed in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the staircase leading up from the basement to the Pre/Post Operative Care Unit so that it is a protected path to an Exit Discharge.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the basement into the Pre/Post Operative Care Unit. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

Q 141 Reference 1, 2 (1, 2, 3)

1. There is now on going documentation of patients' pain assessment by the nursing staff.

2. The PACU portion of the medical chart was amended to provide a systemic record of this assessment and an in-service was held with the nursing staff to inform them of this change.

3. Compliance of this corrective action will be monitored via the chart review process. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. Identified deficiencies will be addressed by the Director of Nursing to the nursing staff and reported to the Quality Assurance Committee.

4. The DON and the Assistant Medical Director (AMD) were responsible for implementing this plan of correction. The QAC will report the POC and the results of the compliance monitoring to the Governing Body at its next meeting. The Governing Body will be responsible for ensuring full compliance with all rules and regulation.

5. The POC was implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 1, 2 (3)

1. Nursing staff has been reminded, during an in-service held on February 22, 2017, that merely not dispensing medication that may share hypersensitivity concerns with a patient's known allergy is insufficient and that potential interactions must be positively identified and clarified with the prescribing physician. The medical chart has also been revised to facilitate systemic correction of this deficiency. It has been amended to contain a template for the listing of allergies directly over the prescribing orders template so that potential drug interactions are easier to note.

2. Systemic correction of this deficiency will be assured by comparison of documented allergies to the prescribing orders for every patient by the responsible RN and resolution of any identified concerns with prescribing physician.

3. Monitoring to assure the effectiveness of this POC will occur via chart review. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. Any potential identified deficiencies will be addressed by the Director of Nursing to the nursing staff and reported to the Quality Assurance Committee.

4. The DON and the Assistant Medical Director (AMD) were responsible for implementing this plan of correction. The QAC will report the POC and the results of the compliance monitoring to the Governing Body at its next meeting. The Governing Body will be responsible for ensuring full compliance with all rules and regulation.

5. This POC was implemented as of February 22, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 2 (4, 5)

1. Upon transfer from the OR to the PACU the attending physician must perform a medication reconciliation to avoid errors of duplication or omission. All medicine and intravenous fluid orders must be reviewed and rewritten upon transfer of the patient between the two care areas.

2. The medical chart has been modified to assure effective systemic compliance with this corrective action. The order templates have been amended to facilitate comparison and prescribing of medications and intravenous fluids between the OR and PACU. The identified deficiency and the POC was reviewed in separate attendance mandated meetings of the nursing and physician staff. The in-service meetings were held on January 11 and January 17, 2017.

3. Monitoring to assure compliance with this corrective action will be via chart review by the DON or a DON designee. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. Any potential identified deficiencies will be addressed by the Director of Nursing to the nursing staff and reported to the Quality Assurance Committee.

4. The DON and the Assistant Medical Director (AMD) were responsible for implementing this plan of correction. The QAC will report the POC and the results of the compliance monitoring to the Governing Body at its next meeting. The Governing Body will be responsible for ensuring full compliance with all rules and regulation.

5. This POC was fully implemented as of January 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

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AJ

Q141 Reference 2 (6)

1. Physicians transferring a patient from the Facility to the hospital will enter such an order in the patient's medical record.

2. Identification of this deficiency and the corrective action was reviewed at an attendance mandated quality assurance meeting of the medical staff held on January 17, 2017. Awareness by the physician staff to document a transfer order, along with, awareness by the nursing staff of such a requirement, will assure ongoing and systemic compliance.

3. The DON will review the charts of patients entered into the Transfer Log to assess for ongoing compliance. Deficiencies will be brought to the QAC for follow up.

4. The DON and the AMD were responsible for this corrective action.

5. This POC was fully implemented as of February 1, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q181

1. Medications from cartridge-like syringes will not be withdrawn into a second syringe for administration.

2. The Facility has purchased an adequate supply of Carpujet Injectors and a memo has been issued by the DON and the ASC's Pharmacy Consultant informing the medical staff of this deficiency and its correction. The memo also delineated the location of the injectors.

3. The DON will monitor for compliance of this corrective action via assessment polling during staff meetings, as well as, via observation of daily routines. Any deviations will be corrected if and when they are identified. Repeated observations of continued deficiencies in this matter will be reported to the Pharmacy Consultant and QAC for further attention.

4. The DON and Pharmacy Consultant were responsible for this POC.

5. This POC was fully implemented as of Nov 12, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q223

1. The ASC will now provide written disclosure of physician ownership prior to care at the facility. This disclosure information is provided to patients via the Internet directly on ASC's website. This information is both viewable and printable online. Patients contacting the ASC via telephone are instructed to visit the website to view patient disclosure information. Additionally, upon arrival to the ASC and prior to receiving any treatment, all patients will be provided a written copy of this information by the receptionist as per the in-service completed on March 28, 2017.

2. The universal availability and active provisioning of this information prior to rendering of any services by the Facility and its staff will assure continuous systemic correction of this deficiency.

3. Counseling staff shall be responsible for documenting that patients have received written disclosure of physician ownership prior to the initiation of care. Compliance will be documented in the counseling portion of the patients' medical record. Following phone conference with the DOH on March 29, 2017 an intensive monitoring period shall include 10 random charts per week for compliance review by a DON designee. Monitoring will continue until four (4) successive weeks of 100% compliance. Following this, ongoing compliance will continue to be part of the standard chart review process.

4. The Facility Administrator is responsible for this POC and its implementation. Facility Administrator will report any variance from this proposed POC directly to the Governing Body.

5. The POC will be implemented by April 10, 2017 and reported as such to the QAC.

Q224

1. Following the identified deficiency, the Facility has updated its methods of assuring patients and their designated representatives are adequately provided with written information regarding their ability to make informed decisions in respect to their care, as well as, their ability to institute Advance Directives prior to the initiation of care at this ASC. The Facility will update its online information to

include facts, questions and answers regarding advance directives, as well as, provide directing links to information, documents and resources provided by this State's Dept. of Health.

All patients scheduling appointments are to be queried regarding their desire to be furnished with written information relating to patient rights and advance directives. Such requested information will be provided prior to the initiation of care at the Facility and provided by the method most convenient to the patient; either, on line, via e-mail, fax or directly at the ASC.

Finally, the patient's medical record will be revised to better document provision of information with regards to patients' rights and advance directives. The patient record will have written confirmation that the information was given. Furthermore, the history portion of the medical chart will be amended to provide documentation of whether an advance directive exists.

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2. The above corrective action provides systemic correction of the identified deficiency and will be applicable to all patients of this ASC.

3. Once the POC is implemented the Facility Administrator will assess the completeness and functioning of the on line corrective actions and the DON will add assessment of the completion of the advance directive section of the medical record to the chart review process. Both will report their findings to the QAC.

4. The Facility Administrator and the ASC's Information Technology Consultant will be responsible for implementing these planned corrections.

5. The POC is scheduled to be fully in place by Mar 31, 2017.

Q240/Q241

The Facility aims to diligently adhere to professionally acceptable standards and provide the most sanitary environment possible to its staff and in its provision of patient care and surgical services. The following POC objective is help assure its policies and procedures are in accordance with nationally recognized guidelines and that its quality assurance mechanisms adequately monitor compliance, as well as, identify and correct deficiencies on timely and ongoing basis. The observed deficiencies are addressed below.

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Q241 A

1. The use of an oxygen concentrator in a manner not consistent with the Manufacturer's Operator Manual was immediately ceased and by immediately removing the equipment the corrective action assured that this deficiency would not recur. Equipment at the ASC will be used in a manner consistent with the Manufacturer's Operator Manual.

2. A meeting of the QAC was held on Nov 4, 2017, Members of the Committee were informed of the Site Survey Team's finding by the AMD. Following this, and at the request of the QAC, the MD and the DON reviewed a catalogue of the ASC's available medical equipment to ensure that no other was being utilized outside its manufacturer's described parameters.

2017

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3. To assure systemic compliance going forward, the QAC has charged the MD with assuring that any medical equipment purchased in the future will be utilized in a manner consistent with the Manufacturer's Operating Manual. Quarterly environmental rounds will now include inspection of new medical equipment to assure that this standard is complied with.

4. The AMD and the Infection Control Officer were responsible for this corrective action.

5. This POC to immediately remove the oxygen concentrator from the ASC was fully implemented and accepted by the DOH on November 2, 2016. The next environmental rounds will include review of any new medical equipment to assure compliance

Q241 B

1. During the course of its inspection, the Site Survey Team identified several instances of incomplete adherence to both the ASC's and CDC-HICPAC policies and standards with regards to infection control and hand hygiene by at least two of its staff members. The ASC held a mandatory in-service on February 21, 2017 for the medical, SPD and cleaning staffs and chaired by the Infection Control Officer. The meeting's purpose was to review the cited findings, review the ASC's policies regarding hand hygiene and infection control, as well as, role-play scenarios so that staff can better understand the real life applications of these standards.

2. Continued periodic meetings of the above staff addressing these infection control concerns will serve to address these concerns in a systemic fashion.

3. Monitoring by the Infection Control Officer or designee will include random observations of one employee from each department (medical, SPD and cleaning staffs) per week for a period of one month until 100% compliant with the relevant ASC policies. Corrective guidance will be provided during the course of this monitoring as needed and if systemic deficiencies are encountered, the Infection Control Officer will report to the QAC so that further remediate steps are taken.

4. The Infection Control Officer and the AMD were responsible for the implementation of this POC.

5. The in-service was conducted on February 21, 2017 and monitoring will continue until full compliance has been reported to the QAC by the Infection Control Officer.

Q241 C

1. The OR's are to be adequately prepared prior to reuse. The reestablishment of a clean environment includes the cleaning of the floor under the OR table after every case regardless whether is obvious soiling.

2. An in-service to review of the Facility Cleaning Manual to assure delineation of this step and a review of this corrective action with the cleaning staff by the Infection Control Officer was held on November 15, 2016 to assure systemic correction.

3. The Infection Control Officer observed the staff and the ORs for compliance on a daily basis for a two-week period to assure complete compliance; continued compliance, is assured via the monthly

Infection Control rounds. Shortcomings will be brought to the attention of the cleaning staff for correction and reported to the QAC.

4. The ICO and the AMD were responsible for this POC.

5. This POC was implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q241 D Reference #1

1. The ASC, to improve its adherence to professionally acceptable standards regarding the achievement of an optimal sanitary environment held an in-service on February 21, 2017, on hand hygiene and review AORN's Guidelines of Perioperative Practice as they relate to nail grooming and restrictions to various nail enhancement products.

2. In addition to the in-service of applicable members of the Facility staff, review of these guidelines during orientation of new employees will provide systemic assurance of continued vigilance.

3. The observational monitoring of the ASC's relevant staff by the Infection Control Officer will initially be on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. This will provide a mechanism to confirm the POC has been successfully implemented and will be complied with in the future.

4. The implementation of this POC was tasked to the Infection Control Officer.

5. In-service was held on February 21, 2017

Q241 D Reference #2, 3

1. The ASC's Safe Medication Administration Guidelines policy incorporates the CDC's recommendations as delineated in Safe Practices for Medical Injections, as well as, Guidelines for the Prevention of Intravascular Catheter Related Infections. An in-service of the Physician and Nursing staff was held on Feb 23, 2017 to review this policy, the recommendations on which it is based and its importance to infection control.

The need to wipe IV injector ports with 70% alcohol and that single dose vials entered more than once for the same patient must be done with new needle and syringe will be discussed in particular. Note will be made of the Survey Team's identification of deficiencies in this regard.

2. Review of the Facility's Safe Medication Administration Guidelines will be incorporated into the ASC's continuing education program and reviewed on at least an annual basis.

3. The ICO, or an appointed designee, will monitor for compliance to these guidelines and provide immediate remediation to observed deficiencies. The Infection Control Officer will initially monitor the Physician and Nursing staff on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds.

4. The ICO and the AMD will be responsible for implementation of this corrective action and report its implementation and compliance to the QAC.

5. The POC was implemented on Feb 24, 2017.

Q242 A

1. The ASC recognizes that device manufacturers, in accordance with FDA and AAMI guidelines, have validated steps necessary for the proper processing of their devices and that Instructions For Use are an integral part of the correct preparation of equipment for safe patient use. During the survey an IFU was provided for a Shimadzu ultrasound vaginal probe. The staff member providing this was unaware that this ultrasound machine had long been replaced. As of July 2015, all of the Facility's ultrasound machines have been GE models. Staff members who would have been in a position to know this did not recognize what had occurred. The Facility uses and follows the correct IFU's for the processing of its equipment.

Ok. 3/7/17

2. Following the recognition of this finding, the POC will be to review the catalogue of medical equipment and to remove outdated manuals.

3. On a biannual basis the AMD will review this catalogue to assure it remains current.

4. The AMD is responsible for the implementation of this POC.

5. The POC will be completed by Mar 3, 2017.

Q242 B Reference 1

1. ASC policies regarding the reprocessing of its reusable instruments follow ANSI/AAMI guidelines; this includes the placement of a chemical indicator strip in each pack that is to undergo sterilization. The corrective action was to provide an in-service to members of the Sterilization and Processing staff, not only with regards to the deviation from policy regarding the placement of a CI in each pack, but also, as to its purpose and its importance to the infection control mechanisms in place at the ASC.

Ok. 4/17/17

2. Systemic compliance should be ensured by the universal adherence to this standard. All sterile packages should have CI.

3. Monitoring for compliance of this POC will be accomplished by randomly checking two of each type of sterile packs, once a week for a period of 8 continuous weeks. If complete compliance is noted, the Facility will return to its standard standard policy. The Certified Sterile Processing and Distribution Technician will then report to the QAC the effectiveness of this corrective action, or if deficiencies are noted and further remediate steps are needed.

4. The ICO, the AMD and the CSPDT were responsible for this POC.

5. The in-service was conducted on Feb 28, 2017.

Q 242 B Reference 2

1. The ASC policy regarding temperature controlled Decontamination area is drafted to reflect the guideline set forth in the AAMI Sterilization in Health care Facilities, 2014 Edition. An in-service was completed on March 15, 2017 to review new temperature recording procedures and safeguards by the Sterilization Consultant with the all Sterile Processing Technician (SPT), the Certified Sterile Processing and the Distribution Lead Technician (CSPDT).

2. The in-service by the Sterilization Consultant included specific instructions that during the time the sterilization equipment is running in the Decontamination area, the cooling units shall be adjusted accordingly to accommodate for the slight potential increase in room temperature.

3. The SPT shall be responsible for keeping a daily temperature log for the Decontamination area. In the event that the temperature is out of acceptable range the SPT shall immediately notify the CSPDT who shall immediately turn on cooling units until the Decontamination area temperature is within acceptable range. Additionally the CSPDT shall make monthly reviews of the daily temperature log to make sure all readings have either been within range or immediately addressed and recorded. If any deviation from this protocol has occurred the CSPDT shall notify the Sterilization Consultant for another in-service. In the event that the SPT has to notify the CSPDT of three (3) or more temperature variations within one (1) calendar month, the CSPDT shall immediately bring it to the attention of the Governing Body and the Governing Body will immediately act accordingly to bring in an independent specialist to fix whatever is causing the variations so as to resolve the issue

Ok. Acm. 4/17/17

4. The Medical Director in conjunction with the Sterilization Consultant shall be responsible for ensuring this Plan of correction is properly implemented by the SPT and CSPDT.

5. This plan of correction was completed on January 16, 2017 following the identification of this deficiency buy the Site Survey Team on November 2, 2016.

Q242 C

1. The ASC recognizes that the integrity of the sterile field is paramount to infection control and patient safety. Non-scrubbed personal will wear long sleeved attire while in restricted areas of the ASC.

2. To ensure a systemic correction of this deficiency the ASC purchased long sleeved scrubs for personnel working in restricted areas, this is in addition to the long sleeve gowns that are available to the relevant staff. A mandatory in-service for the relevant staff will be held to review the referenced AORN guidelines. The ASC will also revise its own policy to clearly reflect this standard.

Ok. Acm. 3/7/17

3. The Infection Control Officer will initially monitor all personnel working in restricted areas on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO, or an appointed designee, shall also be responsible for providing immediate remediation if non-compliance is later observed by conducting a mandatory in-service with non-complying personnel and shall report non-compliance to the QAC.

4. The AMD is responsible for the implementation of this POC.

5. Compliance to these standards was initiated following identification of the deficiency by the Survey Team on Nov 2, 2016. In-service was completed on Mar 6, 2017.

Q242 D

1. Personnel will wear appropriate personal protective equipment. The ASC provides easily accessible and appropriate personal protective equipment, such as, gloves, gowns, masks and eye protection to its staff.

Ok. Acm 4/17/17

2. Systemic compliance will be achieved by an in-service reviewing universal precaution standards and OSHA's blood borne pathogens guidelines as delineated under CFR 1910.1030. The important role of consistent and appropriate PPE use to staff safety and infection / exposure control will be reviewed.

3. The Infection Control Officer will initially monitor all personnel on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO, or an appointed designee, shall also be responsible for providing immediate remediation if non-compliance is later observed by conducting a mandatory in-service with non-complying personnel and shall report non-compliance to the QAC.

4. The AMD and ICO are responsible for instituting this POC.

5. The in-service was completed on March 7, 2017.

Q261

1. The medical chart will include a complete medical history and physical examination, performed, signed and dated by the patient's attending physician prior to any procedure performed at the ASC.

2. The medical chart was revised to reflect this POC and assure a systemic change. A mandatory in-service occurred on Jan 10, 2107 informing the physician staff of the need for this corrective action.

3. Monitoring of this POC will be monthly and on going via the chart audit process. Ten random charts per month will be reviewed by the DON. Lack of compliance will be reported to the QAC.

4. The AMD was responsible for this POC.

5. This corrective action was completed on Jan 11, 2017, following the identification of the deficiency by the Site Survey Team on Nov 2, 2016.

K161 NFPA 101 Building Construction Type and Height

1. The ASC shall ensure that it's building construction type and height is compliant with the National Fire Protection Association's 2012 Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to conduct a thorough analysis of the building's the facility's exterior walls, and it's interior walls and floors. On February 20th, 2017 an initial inspection of the ASC revealed masonry exterior walls, and concrete interior walls and floors.

3. Axis Architectural Studio is currently in the process of determining the specific need of the building in order to comply with the National Fire Protection Association's 2012 Life Safety Code. Once all evaluation is complete the and corresponding architectural plans are completed and approved, the ASC will retain the services of the appropriate contracting company to make all necessary changes to ensure the ASC is in compliance with code. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun preparing a plan for the ASC to be in compliance with the National Fire Protection Association's 2012 Life Safety Code. All work shall be completed by September 1, 2017

K211 Means of Egress – General

1. The ASC shall ensure that all inside stairs serving as an exit or an exit component shall be enclosed in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the staircase leading up from the basement to the Pre/Post Operative Care Unit so that it is a protected path to an Exit Discharge.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the basement into the Pre/Post Operative Care Unit. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

K223 NFPA 101 Doors with Self-Closing Devices

1. The ASC shall ensure that all self-closing doors are equipped with a release device that complies with the National Fire Protection Associate Life Safety Code.

2. The manual folding door stop that was attached to the basement door in the Pre/Post Operative Care unit has been replaced with a release device that is in compliance with the National Fire Protection Associate Life Safety Code.

3. A complete and thorough sweep will be conducted of the ASC to ensure that all manually folding doors equipped with a manual doorstop are inspected and the manual doorstops are either removed or replaced with an approved hold-open device compliant with the National Fire Protection Associate Life Safety Code.

4. The ASC Fire Safety Coordinator shall conduct a final inspection of all self-closing doors and assure that all hold-open devices are in compliance with the National Fire Protection Association's Life Safety Code.

5. The manual doorstop on the cited door has been replaced as of February 24, 2017 and a full inspection by the ASC Fire Safety Coordinator shall be conducted no later that June 1, 2017.

K311 Vertical Openings - Enclosures

1. The ASC shall ensure that all vertical openings shall be enclosed or protected in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the required exit from the second floor that was down a set of stairs, which was open at the second floor to the waiting room.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the second floor to the waiting room. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

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Q040 416.41 Governing Body and Management

1. The Governing Body held a meeting to review the specific findings for every deficiency as a result of the Federal Re-certification survey of the Facility on November 2, 2016. The Governing Body will effectively carry out the responsibilities of the Facility until all deficiencies are completely corrected and will ensure that the Facility remains complaint with all rules and regulation going forward.

2. As a direct result of the November 2, 2016 Federal Re-certification survey, the Governing Body has proactively decided to set short-term monthly meetings in order to review the findings of the survey and the proposed plan of correction. Monthly meetings will be held until all deficiencies are corrected and the plan of correction has been carried out.

3. The Governing Body has ultimate responsibility for assuring and monitoring that the Plan of Correction is implemented and that all deficiencies are corrected.

4. The Governing Body shall take all necessary actions to assure the Facility continues to provide quality healthcare in a safe environment.

5. The Governing Body met on February 15, 2017 to initially review the specific deficiencies identified as a result of the November 2, 2016 Federal Re-certification survey. The Governing Body will continue to meet on a monthly basis, or as needed if greater frequency is required, until all deficiencies have been corrected and the final approved Plan of Correction is completed. Once completed, the Governing body will resume its normal scheduled meetings.

Q100 416.44 Environment

1. The Governing Body held a meeting to review the specific findings of the Federal Re-certification survey of the Facility on November 2, 2016. The Governing Body contracted with Axis Architectural Studios for assistance in evaluating the requirements for fully complying with the National Fire Protection Association's Life Safety Code, 2012 edition.

2. Axis Architectural Studios completed a full inspection of the ASC's structural facility on February 20, 2017 to assess full compliance with the NFPA. The building will be brought up to all code requirements in order to ensure a safe and sanitary environment to protect the health and safety of patients.

OK 2/22/17 CP

3. The Governing Body has ultimate responsibility for assuring and monitoring that the Plan of Correction is implemented and that all deficiencies are corrected.

4. The Governing Body shall take all necessary actions to assure that the ASC has a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients

5. The Governing Body met on February 15, 2017 to initially review the specific deficiencies identified as a result of the November 2, 2016 Federal Re-certification survey. The Governing Body will continue to monitor the progress of Axis Architectural Studios until all deficiencies are corrected and the final plan of correction is fully completed.

CP

Q 104(1)/K161 NFPA 101 Building Construction Type and Height

1. The ASC shall ensure that it's building construction type and height is compliant with the National Fire Protection Association's 2012 Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to conduct a thorough analysis of the facility's exterior walls, and it's interior walls and floors. On February 20th, 2017 an initial inspection of the ASC revealed masonry exterior walls, and concrete interior walls and floors, which confirmed that the building is Type III (211).

3. Axis Architectural Studio is currently in the process of determining the specific need of the building in order to comply with the National Fire Protection Association's 2012 Life Safety Code. Once all evaluation is complete the and corresponding architectural plans are completed and approved, the ASC will retain the services of the appropriate contracting company to make all necessary changes to ensure the ASC is in compliance with code. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

ok 2/22/17 CW

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun preparing a plan for the ASC to be in compliance with the National Fire Protection Association's 2012 Life Safety Code. All work shall be completed by July 1, 2017.

Q104 (2)/ K211 Means of Egress – General

1. The ASC shall ensure that all inside stairs serving as an exit or an exit component shall be enclosed in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the staircase leading up from the basement to the Pre/Post Operative Care Unit so that it is a protected path to an Exit Discharge. Plans for this renovation will be submitted to the Englewood Building Inspector no later than May 15, 2017 and we will have an anticipated completion date of July 1, 2017 pending final approval by the building department. In the meantime two (2) additional smoke detectors and two (2) additional fire extinguishers have been added to the area, one (1) of each has been added at the top and bottom of the staircase leading up from the basement.

ok 4/22/17 CW

3. Architectural plans are scheduled to be completed and submitted to the building department no later than May 15th, 2017. The ASC has retained the services of a contracting company to complete the construction of the proposed enclosed staircase leading up from the basement into the Pre/Post Operative Care Unit. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall

be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. Barring any setbacks from the city of Englewood, all work shall be completed by July 1, 2017

Q104 (3) K223 NFPA 101 Doors with Self-Closing Devices

1. The ASC shall ensure that all manual door stops have been removed.

2. The manual folding door stop that was attached to the b sement door in the Pre/Post Operative Care unit has been removed.

3. A complete and thorough sweep will be conducted of the ASC to ensure that all manually folding doors equipped with a manual doorstop are inspected and that the manual doorstops are either removed or replaced with an approved hold-open device compliant with the National Fire Protection Associate Life Safety Code.

AC 2/22/17

4. The ASC Fire Safety Coordinator shall conduct a final inspection of all self-closing doors and assure that all hold-open devices are in compliance with the National Fire Protection Association's Life Safety Code.

5. The manual doorstop on the cited door has been replaced as of February 28, 2017.

Q104 (4) K311 Vertical Openings - Enclosures

1. The ASC shall ensure that all vertical openings shall be enclosed or protected in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the required exit from the second floor that was down a set of stairs, which was open at the second floor to the waiting room. Plans are now complete and because no electrical work needs to be done to close off the second floor waiting room, plans do not have to be submitted to the town of Englewood and work can now begin. Until work has been completed, two (2) additional smoke detectors and two (2) additional fire extinguishers have been added to the area, one (1) of each at the top and bottom of the staircase leading up to the waiting room on the second floor.

JK 2/22/17

3. The ASC has retained the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up to the waiting room. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. All work with regards to closing off the waiting room shall be completed by June 1, 2017

Q 141 Reference 1, 2 (1, 2, 3)

1. There is now on going documentation of patients' pain assessment by the nursing staff.

2. The PACU portion of the medical chart was amended to provide a systemic record of this assessment and an in-service was held with the nursing staff to inform them of this change.

3. Compliance of this corrective action will be monitored via the chart review process. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. Identified deficiencies will be addressed by the Director of Nursing to the nursing staff and reported to the Quality Assurance Committee.

4. The DON and the Assistant Medical Director (AMD) were responsible for implementing this plan of correction. The QAC will report the POC and the results of the compliance monitoring to the Governing Body at its next meeting. The Governing Body will be responsible for ensuring full compliance with all rules and regulation.

5. The POC was implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 1, 2 (3)

1. Nursing staff has been reminded, during an in-service held on February 22, 2017, that merely not dispensing medication that may share hypersensitivity concerns with a patient's known allergy is insufficient and that potential interactions must be positively identified and clarified with the prescribing physician. The medical chart has also been revised to facilitate systemic correction of this deficiency. It has been amended to contain a template for the listing of allergies directly over the prescribing orders template so that potential drug interactions are easier to note.

2. Systemic correction of this deficiency will be assured by comparison of documented allergies to the prescribing orders for every patient by the responsible RN and resolution of any identified concerns with prescribing physician.

3. Monitoring to assure the effectiveness of this POC will occur via chart review. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. Any potential identified deficiencies will be addressed by the Director of Nursing to the nursing staff and reported to the Quality Assurance Committee.

4. The DON and the Assistant Medical Director (AMD) were responsible for implementing this plan of correction. The QAC will report the POC and the results of the compliance monitoring to the Governing Body at its next meeting. The Governing Body will be responsible for ensuring full compliance with all rules and regulation.

5. This POC was implemented as of February 22, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 2 (4, 5)

1. Upon transfer from the OR to the PACU the attending physician must perform a medication reconciliation to avoid errors of duplication or omission. All medicine and intravenous fluid orders must be reviewed and rewritten upon transfer of the patient between the two care areas.

2. The medical chart has been modified to assure effective systemic compliance with this corrective action. The order templates have been amended to facilitate comparison and prescribing of medications and intravenous fluids between the OR and PACU. The identified deficiency and the POC was reviewed in separate attendance mandated meetings of the nursing and physician staff. The in-service meetings were held on January 11 and January 17, 2017.

3. Monitoring to assure compliance with this corrective action will be via chart review by the DON or a DON designee. For the first month following the implementation of the plan of correction, 10 random charts were selected per week for compliance review by a DON designee. Weekly random chart audits were conducted until 4 successive weeks of 100% compliance. Following this, ongoing compliance became part of the standard chart review process. Any potential identified deficiencies will be addressed by the Director of Nursing to the nursing staff and reported to the Quality Assurance Committee.

4. The DON and the Assistant Medical Director (AMD) were responsible for implementing this plan of correction. The QAC will report the POC and the results of the compliance monitoring to the Governing Body at its next meeting. The Governing Body will be responsible for ensuring full compliance with all rules and regulation.

5. This POC was fully implemented as of January 17, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q141 Reference 2 (6)

1. Physicians transferring a patient from the Facility to the hospital will enter such an order in the patient's medical record.

2. Identification of this deficiency and the corrective action was reviewed at an attendance mandated quality assurance meeting of the medical staff held on January 17, 2017. Awareness by the physician staff to document a transfer order, along with, awareness by the nursing staff of such a requirement, will assure ongoing and systemic compliance.

3. The DON will review the charts of patients entered into the Transfer Log to assess for ongoing compliance. Deficiencies will be brought to the QAC for follow up.

4. The DON and the AMD were responsible for this corrective action.

5. This POC was fully implemented as of February 1, 2017, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q181

1. Medications from cartridge-like syringes will not be withdrawn into a second syringe for administration.

2. The Facility has purchased an adequate supply of Carpujet Injectors and a memo has been issued by the DON and the ASC's Pharmacy Consultant informing the medical staff of this deficiency and its correction. The memo also delineated the location of the injectors.

3. The DON will monitor for compliance of this corrective action via assessment polling during staff meetings, as well as, via observation of daily routines. Any deviations will be corrected if and when they are identified. Repeated observations of continued deficiencies in this matter will be reported to the Pharmacy Consultant and QAC for further attention.

4. The DON and Pharmacy Consultant were responsible for this POC.

5. This POC was fully implemented as of Nov 12, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q223

1. The ASC will now provide written disclosure of physician ownership prior to care at the facility. This disclosure information is provided to patients via the Internet directly on ASC's website. This information is both viewable and printable online. Patients contacting the ASC via telephone are instructed to visit the website to view patient disclosure information. Additionally, upon arrival to the ASC and prior to receiving any treatment, all patients will be provided a written copy of this information by the receptionist as per the in-service completed on March 28, 2017.

2. The universal availability and active provisioning of this information prior to rendering of any services by the Facility and its staff will assure continuous systemic correction of this deficiency.

3. Counseling staff shall be responsible for documenting that patients have received written disclosure of physician ownership prior to the initiation of care. Compliance will be documented in the counseling portion of the patients' medical record. Following phone conference with the DOH on March 29, 2017 an intensive monitoring period shall include 10 random charts per week for compliance review by a DON designee. Monitoring will continue until four (4) successive weeks of 100% compliance. Following this, ongoing compliance will continue to be part of the standard chart review process.

4. The Facility Administrator is responsible for this POC and its implementation. Facility Administrator will report any variance from this proposed POC directly to the Governing Body.

5. The POC will be implemented by April 10, 2017 and reported as such to the QAC.

Q224

1. Following the identified deficiency, the Facility has updated its methods of assuring patients and their designated representatives are adequately provided with written information regarding their ability to make informed decisions in respect to their care, as well as, their ability to institute Advance Directives prior to the initiation of care at this ASC. The Facility will update its online information to include facts, questions and answers regarding advance directives, as well as, provide directing links to information, documents and resources provided by this State's Dept. of Health.

All patients scheduling appointments are to be queried regarding their desire to be furnished with written information relating to patient rights and advance directives. Such requested information will be provided prior to the initiation of care at the Facility and provided by the method most convenient to the patient; either, on line, via e-mail, fax or directly at the ASC.

Finally, the patient's medical record will be revised to better document provision of information with regards to patients' rights and advance directives. The patient record will have written confirmation that the information was given. Furthermore, the history portion of the medical chart will be amended to provide documentation of whether an advance directive exists.

2. The above corrective action provides systemic correction of the identified deficiency and will be applicable to all patients of this ASC.

3. Once the POC is implemented the Facility Administrator will assess the completeness and functioning of the on line corrective actions and the DON will add assessment of the completion of the advance directive section of the medical record to the chart review process. Both will report their findings to the QAC.

4. The Facility Administrator and the ASC's Information Technology Consultant will be responsible for implementing these planned corrections.

5. The POC is scheduled to be fully in place by Mar 31, 2017.

Q240/~~Q241~~

The Facility aims to diligently adhere to professionally acceptable standards and provide the most sanitary environment possible to its staff and in its provision of patient care and surgical services. The following POC objective is help assure its policies and procedures are in accordance with nationally recognized guidelines and that its quality assurance mechanisms adequately monitor compliance, as well as, identify and correct deficiencies on timely and ongoing basis. The observed deficiencies are addressed below.

Q241 A

1. The use of an oxygen concentrator in a manner not consistent with the Manufacturer's Operator Manual was immediately ceased and by immediately removing the equipment the corrective action assured that this deficiency would not recur. Equipment at the ASC will be used in a manner consistent with the Manufacturer's Operator Manual.

2. A meeting of the QAC was held on Nov 4, 2017, Members of the Committee were informed of the Site Survey Team's finding by the AMD. Following this, and at the request of the QAC, the MD and the DON reviewed a catalogue of the ASC's available medical equipment to ensure that no other was being utilized outside its manufacturer's described parameters.

3. To assure systemic compliance going forward, the QAC has charged the MD with assuring that any medical equipment purchased in the future will be utilized in a manner consistent with the Manufacturer's Operating Manual. Quarterly environmental rounds will now include inspection of new medical equipment to assure that this standard is complied with.

4. The AMD and the Infection Control Officer were responsible for this corrective action.

5. This POC to immediately remove the oxygen concentrator from the ASC was fully implemented and accepted by the DOH on November 2, 2016. The next environmental rounds will include review of any new medical equipment to assure compliance

Q241 B

1. During the course of its inspection, the Site Survey Team identified several instances of incomplete adherence to both the ASC's and CDC-HICPAC policies and standards with regards to infection control and hand hygiene by at least two of its staff members. The ASC held a mandatory in-service on February 21, 2017 for the medical, SPD and cleaning staffs and chaired by the Infection Control Officer. The meeting's purpose was to review the cited findings, review the ASC's policies regarding hand hygiene and infection control, as well as, role-play scenarios so that staff can better understand the real life applications of these standards.

2. Continued periodic meetings of the above staff addressing these infection control concerns will serve to address these concerns in a systemic fashion.

3. Monitoring by the Infection Control Officer or designee will include random observations of one employee from each department (medical, SPD and cleaning staffs) per week for a period of one month until 100% compliant with the relevant ASC policies. Corrective guidance will be provided during the course of this monitoring as needed and if systemic deficiencies are encountered, the Infection Control Officer will report to the QAC so that further remediate steps are taken.

4. The Infection Control Officer and the AMD were responsible for the implementation of this POC.

5. The in-service was conducted on February 21, 2017 and monitoring will continue until full compliance has been reported to the QAC by the Infection Control Officer.

Q241 C

1. The OR's are to be adequately prepared prior to reuse. The reestablishment of a clean environment includes the cleaning of the floor under the OR table after every case regardless whether is obvious soiling.

2. An in-service to review of the Facility Cleaning Manual to assure delineation of this step and a review of this corrective action with the cleaning staff by the Infection Control Officer was held on November 15, 2016 to assure systemic correction.

3. The Infection Control Officer observed the staff and the ORs for compliance on a daily basis for a two-week period to assure complete compliance; continued compliance, is assured via the monthly Infection Control rounds. Shortcomings will be brought to the attention of the cleaning staff for correction and reported to the QAC.

4. The ICO and the AMD were responsible for this POC.

5. This POC was implemented as of Nov 15, 2016, following the identification of this deficiency by the Site Survey Team on Nov. 2, 2016.

Q241 D Reference #1

1. The ASC, to improve its adherence to professionally acceptable standards regarding the achievement of an optimal sanitary environment held an in-service on February 21, 2017, on hand hygiene and review AORN's Guidelines of Perioperative Practice as they relate to nail grooming and restrictions to various nail enhancement products.

2. In addition to the in-service of applicable members of the Facility staff, review of these guidelines during orientation of new employees will provide systemic assurance of continued vigilance.

3. The observational monitoring of the ASC's relevant staff by the Infection Control Officer will initially be on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. This will provide a mechanism to confirm the POC has been successfully implemented and will be complied with in the future.

4. The implementation of this POC was tasked to the Infection Control Officer.

5. In-service was held on February 21, 2017

Q241 D Reference #2, 3

1. The ASC's Safe Medication Administration Guidelines policy incorporates the CDC's recommendations as delineated in Safe Practices for Medical Injections, as well as, Guidelines for the Prevention of Intravascular Catheter Related Infections. An in-service of the Physician and Nursing staff was held on Feb 23, 2017 to review this policy, the recommendations on which it is based and its importance to infection control.

The need to wipe IV injector ports with 70% alcohol and that single dose vials entered more than once for the same patient must be done with new needle and syringe will be discussed in particular. Note will be made of the Survey Team's identification of deficiencies in this regard.

2. Review of the Facility's Safe Medication Administration Guidelines will be incorporated into the ASC's continuing education program and reviewed on at least an annual basis.

3. The ICO, or an appointed designee, will monitor for compliance to these guidelines and provide immediate remediation to observed deficiencies. The Infection Control Officer will initially monitor the Physician and Nursing staff on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds.

4. The ICO and the AMD will be responsible for implementation of this corrective action and report its implementation and compliance to the QAC.

5. The POC was implemented on Feb 24, 2017.

Q242 A

1. The ASC recognizes that device manufacturers, in accordance with FDA and AAMI guidelines, have validated steps necessary for the proper processing of their devices and that Instructions For Use are an integral part of the correct preparation of equipment for safe patient use. During the survey an IFU was provided for a Shimadzu ultrasound vaginal probe. The staff member providing this was unaware that this ultrasound machine had long been replaced. As of July 2015, all of the Facility's ultrasound machines have been GE models. Staff members who would have been in a position to know this did not recognize what had occurred. The Facility uses and follows the correct IFU's for the processing of its equipment.

2. Following the recognition of this finding, the POC will be to review the catalogue of medical equipment and to remove outdated manuals.

3. On a biannual basis the AMD will review this catalogue to assure it remains current.

4. The AMD is responsible for the implementation of this POC.

5. The POC will be completed by Mar 3, 2017.

Q242 B Reference 1

1. ASC policies regarding the reprocessing of its reusable instruments follow ANSI/AAMI guidelines; this includes the placement of a chemical indicator strip in each pack that is to undergo sterilization. The corrective action was to provide an in-service to members of the Sterilization and Processing staff, not only with regards to the deviation from policy regarding the placement of a CI in each pack, but also as to its purpose and its importance to the infection control mechanisms in place at the ASC.

2. Systemic compliance should be ensured by the universal adherence to this standard. All sterile packages should have CI.

3. Monitoring for compliance of this POC will be accomplished by randomly checking two of each type of sterile packs, once a week for a period of 8 continuous weeks. If complete compliance is noted the Facility will return to its standard standard policy. The Certified Sterile Processing and Distribution Technician will then report to the QAC the effectiveness of this corrective action, or if deficiencies are noted and further remediate steps are needed.

4. The ICO, the AMD and the CSPDT were responsible for this POC.

5. The in-service was conducted on Feb 28, 2017.

Q 242 B Reference 2

1. The ASC policy regarding temperature controlled Decontamination area is drafted to reflect the guideline set forth in the AAMI Sterilization in Health care Facilities, 2014 Edition. An in-service was completed on March 15, 2017 to review new temperature recording procedures and safeguards by the Sterilization Consultant with the all Sterile Processing Technician (SPT), the Certified Sterile Processing and the Distribution Lead Technician (CSPDT).

2. The in-service by the Sterilization Consultant included specific instructions that during the time the sterilization equipment is running in the Decontamination area, the cooling units shall be adjusted accordingly to accommodate for the slight potential increase in room temperature.

3. The SPT shall be responsible for keeping a daily temperature log for the Decontamination area. In the event that the temperature is out of acceptable range the SPT shall immediately notify the CSPDT who shall immediately turn on cooling units until the Decontamination area temperature is within acceptable range. Additionally the CSPDT shall make monthly reviews of the daily temperature log to make sure all readings have either been within range or immediately addressed and recorded. If any deviation from this protocol has occurred the CSPDT shall notify the Sterilization Consultant for another in-service. In the event that the SPT has to notify the CSPDT of three (3) or more temperature variations within one (1) calendar month, the CSPDT shall immediately bring it to the attention of the Governing Body and the Governing Body will immediately act accordingly to bring in an independent specialist to fix whatever is causing the variations so as to resolve the issue

4. The Medical Director in conjunction with the Sterilization Consultant shall be responsible for ensuring this Plan of correction is properly implemented by the SPT and CSPDT.

5. This plan of correction was completed on January 16, 2017 following the identification of this deficiency buy the Site Survey Team on November 2, 2016.

Q242 C

1. The ASC recognizes that the integrity of the sterile field is paramount to infection control and patient safety. Non-scrubbed personal will wear long sleeved attire while in restricted areas of the ASC.

2. To ensure a systemic correction of this deficiency the ASC purchased long sleeved scrubs for personnel working in restricted areas, this is in addition to the long sleeve gowns that are available to the relevant staff. A mandatory in-service for the relevant staff will be held to review the referenced AORN guidelines. The ASC will also revise its own policy to clearly reflect this standard.

3. The Infection Control Officer will initially monitor all personnel working in restricted areas on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO, or an appointed designee, shall also be responsible for

providing immediate remediation if non-compliance is later observed by conducting a mandatory in-service with non-complying personnel and shall report non-compliance to the QAC.

4. The AMD is responsible for the implementation of this POC.

5. Compliance to these standards was initiated following identification of the deficiency by the Survey Team on Nov 2, 2016. In-service was completed on Mar 6, 2017.

Q242 D

1. Personnel will wear appropriate personal protective equipment. The ASC provides easily accessible and appropriate personal protective equipment, such as, gloves, gowns, masks and eye protection to its staff.

2. Systemic compliance will be achieved by an in-service reviewing universal precaution standards and OSHA's blood borne pathogens guidelines as delineated under CFR 1910.1030. The important role of consistent and appropriate PPE use to staff safety and infection / exposure control will be reviewed.

3. The Infection Control Officer will initially monitor all personnel on a daily basis for a two-week period; if complete compliance is noted, it will then become part of the monthly Infection Control Rounds. The ICO, or an appointed designee, shall also be responsible for providing immediate remediation if non-compliance is later observed by conducting a mandatory in-service with non-complying personnel and shall report non-compliance to the QAC.

4. The AMD and ICO are responsible for instituting this POC.

5. The in-service was completed on March 7, 2017.

Q261

1. The medical chart will include a complete medical history and physical examination, performed, signed and dated by the patient's attending physician prior to any procedure performed at the ASC.

2. The medical chart was revised to reflect this POC and assure a systemic change. A mandatory in-service occurred on Jan 10, 2107 informing the physician staff of the need for this corrective action.

3. Monitoring of this POC will be monthly and on going via the chart audit process. Ten random charts per month will be reviewed by the DON. Lack of complian :e will be reported to the QAC.

4. The AMD was responsible for this POC.

5. This corrective action was completed on Jan 11, 2017, following the identification of the deficiency by the Site Survey Team on Nov 2, 2016.

K161 NFPA 101 Building Construction Type and Height

1. The ASC shall ensure that it's building construction type and height is compliant with the National Fire Protection Association's 2012 Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to conduct a thorough analysis of the building's the facility's exterior walls, and it's interior walls and floors. On February 20th, 2017 an initial inspection of the ASC revealed masonry exterior walls, and concrete interior walls and floors.

3. Axis Architectural Studio is currently in the process of determining the specific need of the building in order to comply with the National Fire Protection Association's 2012 Life Safety Code. Once all evaluation is complete the and corresponding architectural plans are completed and approved, the ASC will retain the services of the appropriate contracting company to make all necessary changes to ensure the ASC is in compliance with code. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

OK 2/22/18 CB

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun preparing a plan for the ASC to be in compliance with the National Fire Protection Association's 2012 Life Safety Code. All work shall be completed by September 1, 2017

K211 Means of Egress – General

1. The ASC shall ensure that all inside stairs serving as an exit or an exit component shall be enclosed in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the staircase leading up from the basement to the Pre/Post Operative Care Unit so that it is a protected path to an Exit Discharge.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the basement into the Pre/Post Operative Care Unit. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

OK 2/22/18 CB

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

K223 NFPA 101 Doors with Self-Closing Devices

1. The ASC shall ensure that all self-closing doors are equipped with a release device that complies with the National Fire Protection Associate Life Safety Code.

2. The manual folding door stop that was attached to the basement door in the Pre/Post Operative Care unit has been replaced with a release device that is in compliance with the National Fire Protection Associate Life Safety Code.

3. A complete and thorough sweep will be conducted of the ASC to ensure that all manually folding doors equipped with a manual doorstop are inspected and the manual doorstops are either removed or replaced with an approved hold-open device compliant with the National Fire Protection Associate Life Safety Code.

OK 2/22/18 GP

4. The ASC Fire Safety Coordinator shall conduct a final inspection of all self-closing doors and assure that all hold-open devices are in compliance with the National Fire Protection Association's Life Safety Code.

5. The manual doorstop on the cited door has been replaced as of February 24, 2017 and a full inspection by the ASC Fire Safety Coordinator shall be conducted no later that June 1, 2017.

K311 Vertical Openings - Enclosures

1. The ASC shall ensure that all vertical openings shall be enclosed or protected in accordance with the National Fire Protection Association's Life Safety Code.

2. The ASC has already contacted and retained the services of Axis Architectural Studio to compose plans for enclosing the required exit from the second floor that was down a set of stairs, which was open at the second floor to the waiting room.

3. Once architectural plans are complete the ASC will retain the services of the appropriate contracting company to complete the construction of the proposed enclosed staircase leading up from the second floor to the waiting room. Once construction is complete, compliance shall be automatically and permanently maintained. For continual future monitoring, the Fire Safety Coordinator and a retained architect shall be made aware of any planned renovations in order to ensure that the building remains in continued compliance with the National Fire Protection Association's Life Safety Code, 2012 Edition.

OK 2/22/18 GP

4. The ASC Fire Safety Coordinator shall conduct a final inspection upon project completion to ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

5. Axis Architectural Studio has already begun drafting blueprints for the proposed project. All work shall be completed by September 1, 2017

Americans United for Life

Retropolitan Surg Assoc - add #3 recd 2/16/18 S

Federal Plan of Correction Addendum

Q224

6. The random monthly chart review will include an assessment of the completion of the advanced directive, patient rights and ownership notification to the chart review process. Ten random charts are reviewed monthly by the DON and all findings are reported to the Administrator and the QA Committee. OK 2/16/18 S

Any incomplete forms will be collected monthly by the Administrator and presented to the office staff in order to correct this error.

Americans United for Life

New Jersey State Department of Health
Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility	Date	Case Number
Cherry Hill Women's Center	7/16/19	NJ00124488
Administrator/CEO	**Type Facility**	**Time Required to Correct**
Jennifer Groves	Acute	

Type of Survey
☐ Revisit ☐ Investigation ☐ For Immediate Attention
☒ Complaint ☐ Surveillance

Matter Under Consideration
Pharmaceutical Services

Census/Bed Capacity	Units Toured	Charts Reviewed	Number of Patients Affected

Facility Representatives/Titles
Susan Sperry
Deputy Administrator

Remarks/Issues
NOT VALID

When this form is utilized for a survey, the following needs to be addressed:
This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to $5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.

Signature of Responsible Official	Signature of Investigator
	Hortense Venable

NARRATIVE

A Visit was made to this facility in response to the above referanced complaint. Administrative staff was made aware of the visit and the nature of the complaint.

The investigation included:

- √ **Tour.**
- √ **Staffing reports.**
- √ **Medical record review.**
- √ **Staff interviews.**
- ___ **Patient interviews.**
- √ **Review of other facility documentation.**
- ___ **Meal/Medication pass observation.**
- ___ **Water/Room temperature.**

An exit conference was held with administrative staff (discussed findings and concerns). An addendum may follow after review by the Department of Health and Senior Services.

Comments:

ENTERED ON 11/15/19
BY:

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360
www.nj.gov/health

PHILIP D. MURPHY
Governor
SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Acting Commissioner

October 10, 2019

Jenifer Groves
Administrator
Cherry Hill Womens Center
502 Kings Highway North
Cherry Hill, NJ 08034

Re: Complaint #NJ00124488

Dear Ms. Groves:

Thank you for the courtesy and cooperation extended during the Complaint Investigation conducted July 16, 2019 by a surveyor from the New Jersey Department of Health.

Enclosed is a copy of the State deficiency form indicating that no deficiencies were found during the survey. Please sign the first page of the State deficiency form and return the original copy to my attention. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me at (609) 292-9900.

Sincerely,

Lisa Heim for

Hortense Xenakis, RPh, CCP
Field Rep. Pharmaceuticals 2
Survey and Certification

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS The facility is in substantial compliance with 8:43A- Standards for Licensure of Ambulatory Care Facilities for this complaint only (C# NJ00124488).	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS The facility is in substantial compliance with 8:43A- Standards for Licensure of Ambulatory Care Facilities for this complaint only (C# NJ00124488).	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/13/19

STATE FORM 6899 BYP811 If continuation sheet 1 of 1

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Acting Commissioner

October 21, 2019

Complaint #NJ00124488

A representative from Health Facility Survey and Field Operations conducted an investigation of your complaint concerning possible drug theft at Cherry Hill Womens Center. The investigation included a tour, document review, and staff interview.

After evaluating this information, the surveyor was unable to identify a citable deficient practice related to your concerns based on State regulations. The results of this investigation were presented to and reviewed with administrative staff for continued monitoring of patient care.

If you have questions concerning this letter, please do not hesitate to call (609) 292-9900 and ask to speak to a supervisor.

Thank you for forwarding your concerns to this office.

Sincerely,

The Acute Care Program
Survey and Certification

COPY

New Jersey Department of Health
Health Facility Survey & Field Operations

SURVEY & CERTIFICATION APPROVAL REPORT

TO:	☐ J. Brown	☐ F. Harris	☒ (	DATE: 9/28/2018
THROUGH:	Susan Kelley, Director			
9/28/18 LC	Louise Steska, Program Manager, Acute Care			
HFS&FO RECOMMENDATION:	☒ Approval	☐ Denial	☐ Initial License	☐ Amended License

Name of Applicant **Cherry Hill Women's Center**	CN or Reference Number **22445**
Applicant Address **502 Kings HWY, North** **Cherry Hill, NJ 08002**	Work Site Address **Surgical Suite**
Contact Person **Jenifer Groves, MEd, MBA**	Contact Title **Regional Executive Director**
Contact Email Address **jgroves@thewomanscenters.com**	Telephone Number **(856) 834-0100**

Visit Conducted by **E. DeCicco**	Date of Visit **9/26/2018**	Date of Revisit Select date.

Description
New heating and air conditioning system installed throughout the surgical suite.

Waiver Requested	☐ YES ☒ NO	☐ Approved ☐ Disapproved	**WAIVER No.: N/A DATE ISSUED:** Select date.

This is an approval visit for **Cherry Hill Women's Center** *(Name of Facility)*

providing **ambulatory surgical services** *(Services)*

Area of Approval / Findings
New heating and air conditioning system (HVAC) for the surgical suite including the relocation of heating and cooling units from the basement to the roof.

DCA Approved Plans	☒ YES ☐ NO **EXPLAIN: 5013-18**
Staffing Reviewed and Adequate	☐ YES ☒ NO **EXPLAIN: No new staff.**

Certificate of Occupancy **TOWNSHIP: Cherry Hill Township DATE ISSUED: 9/24/2018**	Temporary Certificate of Occupancy **TOWNSHIP: DATE ISSUED:** Select date. **EXPIRES:** Select date.

Policies and Procedures ☒ **Reviewed and adequate for services provided.** ☐ **Not applicable for this approval survey.**

Deficiencies
Due to excessive humidity levels throughout the facility (Sterile Processing Room – 86%, OR #1 - 76%, OR #2 - 78%) monitoring was put in place. Portable dehumidifiers were put in place to reduce the humidity. Portable dehumidifiers were removed on 9/27/18 at 6:00 AM. Results of this monitoring was provided to HFS&FO for the past 24 hours and the building's HVAC is maintaining humidity within an acceptable range. Monitoring results are attached.

Other

New Jersey Department of Health
Health Facility Survey & Field Operations

HEALTH CARE FACILITY APPROVAL REPORT (Continued)

Signature of Surveyor	Surveyor Recommendation ☒ Approval ☐ Denial
Supervisor of Inspections ☐ D. Gorski-Galla ☒ L. Kiernan ☐ A. Sousa	☒ Check if additional sheets are attached.

Americans United for Life

CHERRY HILL TOWNSHIP
820 Mercer Street, Room 205
Cherry Hill, NJ 08002

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Certificate

Construction Code Division

(Certificate of Approval)

Date Issued 9/24/2018
Control Number 106595
Permit Number 20181513
Permit Issue Date 6/7/2018
Certificate Number 20181513

Identification

Block: 286.18 Lot: 12 Qual:

Work Site Location: 502 KINGS HWY N CHERRY HILL TOWNSHIP, NJ 08002

Owner in Fee: CHERRY HILL WOMEN'S CENTER
Owner Address: 502 KINGS HWY N CHERRY HILL NJ 08002
Telephone: (856) 667-5910

Contractor HUTCHINSON
Address 621 CHAPEL AVENUE CHERRY HILL NJ 08002
Telephone: (856) 429-5007 Fax: (856) 429-4995
License Number or Builders Registration Number: 34EI01325500
Federal Emp. Number: 223766253 36BI00504100 19HC0022700

Home Warranty Number:
Type of Warranty Plan: ☐ State ☐ Private

Construction Classification: TYPE VB Use Group: B
Maximum Occupancy Load: 0 Maximum Live Load: 0

Description of Work/Use:
REPLACE RTUs - 4 UNITS - THE WOMEN'S CENTER
(LESS 20% DCA PLAN REVIEW)

Certificate Comments:

☐ **Certificate of Occupancy**
This serves notice that said building or structure has been constructed in accordance with the New Jersey Uniform Construction Code and is approved for occupancy.

☑ **Certificate of Approval**
This serves notice that the work completed has been constructed or installed in accordance with the New Jersey Uniform Construction Code and is approved. If the permit was issued for minor work, this certificate was based upon what was visible at the time of inspection.

☐ **Certificate of Continued Occupancy**
This serves notice that based on a general inspection of the visible parts of the building there are no imminent hazards and the building is approved for continued occupancy.

☐ **Temporary Certificate of Compliance**
The following conditions must be met no later than
or the owner will be subject to fine or order to vacate:
This certificate has an expiration date of:
Conditions to be met:

☐ **Certificate of Clearance - Lead Abatement 5:17**
This serves notice that based on written certification, lead abatement was performed as per NJAC5:17 to the following extent.
☐ Total removal of lead-based paint hazards in scope of work
☐ Partial or limited time period (years); see file

☐ **Certificate of Clearance - Asbestos Abatement**
This serves notice that based on written certification, asbestos abatement was performed to the following extent.
☐ Total removal of asbestos hazards in scope of work
☐ Partial or limited time period (years); see file

☐ **Certificate of Compliance**
This serves notice that said potentially hazardous equipment has been installed and/or maintained in accordance with the New Jersey Uniform Construction Code and is approved for use until

☐ **Temporary Certificate of Occupancy**
The following conditions must be met no later than:
or the owner will be subject to fine or order to vacate:
This certificate has an expiration date of:
Conditions to be met:

Construction Official

UCC F250 (rev. 08/05)

Fee: $0.00

Check Number:

Collected By:

Date Printed: 9/24/2018

Cherry Hill Women's Center

Plan of Correction

Objectives: Monitor humidity levels to ensure acceptable range

Terminal cleaning of any areas that may have been impacted

1. Due to HVAC upgrades, the humidity levels have been out of range. Per the Joint Commission, alongside AAMI, the acceptable humidity range of the sterile corridor and operating suites is between 30-60%. Per the CDC, the acceptable temperature range is between 68-73 degrees F.

Action plan:

We got de-humidifiers. We created a log to track the temperature and humidity in the sterile corridor to ensure that the climate is getting to and staying within an acceptable range. The data collection includes DicksonOne Temperature/Humidity Wall monitors as well as wall thermometers, both of which are inspected and calibrated yearly. Once the data stays within the acceptable temperature/humidity ranges for 12 consecutive hours, we will consider the system to be functioning properly, without any additional support (i.e. de-humidifier).

Because the Sterile Corridor registered data that was outside of the acceptable temperature/humidity ranges, the area needs to be thoroughly cleaned/sanitized to ensure a workspace that supports good infection control programming. First, the de-humidifiers will be removed from the premises, and then all surfaces in these spaces will be terminally cleaned.

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State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

October 9, 2018

Jenifer Groves
Regional Executive Director
Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034

Dear Ms. Groves:

Thank you for the courtesy and cooperation extended during the Approval Survey conducted September 26, 2018 by surveyors from the New Jersey Department of Health.

Enclosed is a copy of them State Deficiency Form indicating that no deficiencies were found during the survey. Please sign the first page of the State Deficiency Form and return the original copy to my attention. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me at (609) 292-9900.

Sincerely,

Eric DeCicco
Surveyor Physical Plant/Life Safety
Survey and Certification

Americans United for Life

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS This was an Approval Survey conducted on 9/26/18 for the installation of a new heating and air conditioning system. The facility is in compliance with N.J.A.C. Title 8 Chapter 43A-Standards for Licensure of Ambulatory Care Facilities for this Approval Survey only.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CHERRY HILL WOMEN'S CENTER
TEMPERATURE/HUMIDITY LOG – STERILIZATION

TEMPERATURE NORMAL RANGE: 68°F - 73°F
HUMIDITY NORMAL RANGE: 30% - 60%
Please report any abnormal findings to the supervisor

DATE: 9/27/18

TIME	TEMP	HUMIDITY %	INITIALS	NOTES
6:30 A	68°	49%	OT	reading @ opening
9:30 A	69°	51%	OT	2 people in room
11:30 A	68°	51%	OT	temp check
2:30pm	70°	52%	(TH)	Autoclaves A & B running

COPY

Cherry Hill Women's Center

Temperature/Humidity Log – OR 1

Temperature Normal Range: 68°F - 73°F

Humidity Normal Range: 30% - 60%

(Please report any abnormal findings to your supervisor)

DATE: 9/27/18

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
10:40am	68.2	52.2%	KB	Readings at opening
9:30am	72.2	46.6%	KB	Temp check @ activity
11:30am	71.8	50.4%	KB	Temp check @ activity
2:30pm	71.3	53.9%	DM	no activity in room, 2 staff

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Cherry Hill Women's Center

Temperature/Humidity Log – Decontamination

Temperature Normal Range: 60°F - 65°F

Humidity Normal Range: 30% - 60%

(Please report any abnormal findings to your supervisor)

DATE: 9/27/18

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
6:30A	64°	48%	OT	reading @ opening
9:30A	64°	49%	OT	3 people in room
11:30A	65°	50%	OT	temp check
2:30pm	63°	50%	DM	no activity

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CHERRY HILL WOMEN'S CENTER
TEMPERATURE/HUMIDITY LOG - PACU

TEMPERATURE NORMAL RANGE: 68°F - 73°F
HUMIDITY NORMAL RANGE: 30% - 60%
Please report any abnormal findings to the supervisor

DATE 9/27/18

TIME	TEMP	HUMIDITY %	INITIALS	NOTES
6:30am	70°F	52%	ym	reading at opening
9:30 am	71°F	51%	ym	8 staff members in room
11:30 am	72°F	52%	ym	6 staff members in room
2:33pm	71°F	52%	ym	temp check

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Cherry Hill Women's Center

Temperature/Humidity Log – OR 2

Temperature Normal Range: 68°F - 73°F

Humidity Normal Range: 30% - 60%

(Please report any abnormal findings to your supervisor)

DATE: 9/27/13

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
6:30 am	68.7°F	49.9 %	[illegible]	readings at opening
9:30 am	71.8°F	46.1 %	[illegible]	no activity in room
11:30 am	69.6°F	54.6 %	[illegible]	temp. check
2:30 pm	68.2°F	55.1 %	[illegible]	no activity in room, 2 staff

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CHERRY HILL WOMEN'S CENTER

Biological Testing Record

Month: Sept 2018

BI= Biological Test *CV= Control Vial*

DATE	Ster.#	Load#	BI Lot#	Time BI put in Inc.	Date BI Removed	Time BI Removed	BI Result	Control Vial Lot#	Date CV in Inc.	Time CV in Inc.	Date CV Removed	CV Results	Tech Initials	COMMENTS
9/25	H	1	675 exp 5/20	9:00A	9/26	9:00A	—	675 exp 5/20	9/25	9:00A	9/26	+	MCJ	—
9/25	D	1	675 exp 5/20	9:00A	9/26	9:00A	—	675 exp 5/20	9/25	9:00A	9/26	+	MCJ	—
9/25	C	1	675 exp 5/20	9:00A	9/26	9:00A	—	675 exp 5/20	9/25	9:00A	9/26	+	MCJ	—
9/26	A	1	675 exp 5/20	8:00A	9			675 exp 5/20	9/26					
9/26	B	1	675 exp 5/20	8:00A				675 exp 5/20	9/26					
9/26	C	1	675 exp 5/20	8:00A				675 exp 5/20	9/26					

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Cherry Hill Women's Center

Temperature/Humidity Log – OR 1

Temperature Normal Range: 68°F - 73°F

Humidity Normal Range: 30% - 60%

(Please report any abnormal findings to your supervisor)

DATE: 9/28/18

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
6:36am	71.1° F	50.2%	(JM)	readings at opening
9:39am	70.7°F	50.2%	(JM)	Ø activity in room

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Cherry Hill Women's Center

Temperature/Humidity Log – OR 2

Temperature Normal Range: 68°F - 73°F
Humidity Normal Range: 30% - 60%
(Please report any abnormal findings to your supervisor)

DATE: 9/28/18

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
6:35am	70.2°F	59.9%	[illegible]	readings at opening
9:35am	71.1°F	47.7%	[illegible]	Ø activity in room

COPY

Cherry Hill Women's Center

Temperature/Humidity Log – Decontamination

Temperature Normal Range: 60°F - 65°F
Humidity Normal Range: 30% - 60%
(Please report any abnormal findings to your supervisor)

DATE: 9/28/18

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
10:32am	64°F	53%	[illegible]	readings at opening
9:37am	65°F	54%	[illegible]	no activity in room

CHERRY HILL WOMEN'S CENTER
TEMPERATURE/HUMIDITY LOG - PACU

TEMPERATURE NORMAL RANGE: 68°F - 73°F
HUMIDITY NORMAL RANGE: 30% - 60%
Please report any abnormal findings to the supervisor

DATE 9/28/18

TIME	TEMP	HUMIDITY %	INITIALS	NOTES
6:37am	71°F	50%	DB	readings at opening
9:40am	71°F	51%	DB	3 staff in room

CHERRY HILL WOMEN'S CENTER
TEMPERATURE/HUMIDITY LOG – STERILIZATION

TEMPERATURE NORMAL RANGE: 68°F - 73°F
HUMIDITY NORMAL RANGE: 30% - 60%

Please report any abnormal findings to the supervisor

DATE: 9/28/18

TIME	TEMP	HUMIDITY %	INITIALS	NOTES
6:33am	69°F	51%	(Dey)	readings at opening
9:37am	69°F	50%	(Dey)	no activity in room

Cherry Hill Women's Center

Plan of Correction

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CHERRY HILL WOMEN'S CENTER
INFECTION PREVENTION AND CONTROL PROGRAM
REVISED 4/2018

The Infection Control Program includes ongoing surveillance, investigation, prevention, and control of infections and communicable diseases while adhering to safe practices for patients, employees, medical staff, and all other visitors. In addition, as a result of consideration and selection by Cherry Hill Women's Center's Infection Control Committee, the Infection Control and Prevention Program in this facility has been designed and implemented according to CDC (Centers for Disease Control and Prevention) guidelines, a major component of the Department of Health and Human Services. The facility also follows OSHA and AAMI guidelines. The goal is to identify and minimize the risks of acquiring and transmitting infections and communicable diseases among patients, employees, physicians and other licensed independent practitioners, contract workers, volunteers, students, and visitors. The Program is based on current scientific knowledge, accepted practice guidelines, and applicable law and regulation.

Key Functions of Plan:

- Providing a safe environment for all patients, including adequate safeguards to protect the patient from cross-infection by ensuring the provision of adequate space, equipment, supplies and personnel.
- Prevent, identify, minimize and manage infections and communicable diseases.
- Immediate implementation of corrective action and preventive measures that result in performance improvements.
- Development and implementation of infection control activities related to all CHWC personnel including but not limited to: medical staff, employees, any on-site contract workers (i.e. housekeepers, etc.) and others.
- Mitigation of risks associated with healthcare-associated infections (HAI's, which are the same as nosocomial infections evidenced by education and active surveillance).
- Monitoring compliance with all policies, procedures, protocols and other infection control program requirements
- Program evaluation and revision of the program by the Governing Body (annually and as indicated)
- Coordination as required by law with federal, state and local emergency preparedness and health authorities to address communicable and infectious disease threats and outbreaks
- Compliance with reportable disease requirements of the local, state and federal health authorities.

Structure of Infection Control Plan:
The Infection Control Program, which is governed by the facility's Quality Improvement Committee, Governing Body, and pertinent State and Local regulations, is responsible for

providing a plan of action for preventing, identifying and managing infections and communicable diseases as well as immediate implementation of corrective and preventive measures that result in improvement. This Program remains to be an integral part of the facility's quality assessment and performance improvement plan.

Infection Control Officer (Infection Preventionist):
The Infection Control Officer (Infection Preventionist), a designated, qualified healthcare professional who has training and current competence in infection control) is in charge of information gathering, coordination of the program, and education of the staff.

PROCEDURE:

I. Scope of Responsibility:
   - A. Written policies and procedures will be maintained defining all Program elements and infection control precautions required.
   - B. Written department-specific policies and procedures will be developed and implemented by department managers describing the departmental role in infection prevention and control activities. This shall be reviewed at least annually and revised as necessary.
   - C. Adherence to professionally accepted standards of practice, manufacturer recommendations, state and federal regulations including but not limited to: cleaning, disinfection and sterilization of instruments, equipment, supplies and implants.
   - D. Maintenance of a functional and sanitary environment for the provision of services.
   - E. Identifying infections
   - F. Mitigation of risks associated with patient infections present upon admission
   - G. A Sharps Injury prevention program shall be implemented and maintained.
   - H. Development of specific policies pertaining to housekeeping for patient care areas.
   - I. Ensuring that a process has been established for the isolation or immediate transfer of patients with communicable disease.
   - J. A safe environment for treating patients shall be provided with the implementation of safeguards to protect the patient from supplies and personnel for the provision of patient care.
   - K. A surveillance plan will be in place to monitor facility infections for unusual epidemics, clusters of infections, those due to unusual pathogens and any nosocomial infection rate that exceeds the usual baseline levels.
   - L. Active surveillance shall also be used to assess hand hygiene, safe injection practices and precautions used to minimize communicable disease exposure involving patients, employees, medical staff and others; ongoing education based on identified needs shall be provided.
   - M. Definitions will be provided for surgical site infections and other nosocomial infections* for surveillance purposes to provide for uniform identification and reporting of infections.

N. A Performance Improvement Plan for trending and tracking of pertinent data will be in place with recommendations and actions providing for re-evaluation after initiation of actions.

O. All Infection Control Program policies and procedures will be reviewed and evaluated at least annually by the Infection Control professional and revised as necessary to reflect new or modified tasks, procedures or regulations.

P. The facility will provide for necessary laboratory support, supplies/equipment to accomplish goals and policies/procedures of the Program.

Q. Appropriate education will be provided to all new employees and to all employees on an annual (and as needed basis). This education will include their role in the ICP, prevention and control activities; including, but not limited to, hand hygiene,, adherence to bloodborne pathogens standard and exposure control plan, evaluation of safer medical devices and tuberculosis.

R. The Exposure Control Plan shall remain in compliance with the OSHA Bloodborne Pathogen standard and shall be evaluated by the Governing Body on a yearly basis.

(*Infections that are a result of treatment in a hospital or other type of healthcare service provider. Infections are considered nosocomial if they first appear 48 hours or more after hospital or other type of healthcare facility admission or within 30 days after discharge. This type of infection is also known as a hospital-acquired infection or, in generic terms, healthcare-associated infection).

- All Nosocomial Infections shall be considered an occurrence and followed up through the established Infection Control Program process.

- The Medical Director shall be kept informed of all Nosocomial Infections.

- Corresponding, pertinent information shall be reported to the Patient Care Committee, Quality Improvement Committee and forwarded to the Governing Body for final review and follow-up discussions as needed.

II. Infection Control Reporting Procedures:

A. The Infection Control Program will consist of the Medical Director or designee, the Infection Control Officer, and representatives or persons available on, at least, a consulting basis, as needed, from various areas of the facility.. A physician shall be involved on a current and ongoing basis to assure the effectiveness of the Program.

B. The Infection Control Officer will provide at least quarterly, compiled nosocomial infection reports, including employee health reports and other pertinent facility issues; reports will include conclusions, recommendations and actions.

C. The Infection Control Officer will delegate actions of preventative and corrective programs or policies to minimize the spread of infection including education, interventions and studies.

D. The Infection Control Officer will review, revise and enforce infection control policies and procedures for all service areas.

E. The Infection Control Officer will monitor and provide advice concerning the employee health activities in the facility.

F. The Infection Control Officer will provide reports including conclusions, recommendations and actions to the medical staff through the Medical Director (where applicable), and Administrator, and finally to the Governing Body. This information will be made available as appropriate.

G. The Infection Control Officer has the authority, through the Infection Control Committee, to carry out the above functions and institute any appropriate control measures or studies when there is reasonably considerable danger to any patient or persons.

H. The Infection Control Officer will support and participate in the current facility performance improvement plans and activities.

III. Education:

A. A coordinated education plan will be in place regarding infection control in accordance with applicable State and Federal guidelines, as well as facility needs determined by the patient population, high risk, high volume events, new policies and procedures, and as deemed necessary by the Infection Control Officer.

IV. Orientation of employees will include at least:

A. Infection Control Program overview and role of employee in Program
B. Hand Hygiene practices
C. OSHA/Bloodborne Pathogens and Exposure Control Plan
D. Hazardous Communication
E. Tuberculosis Exposure Control Plan
F. Employee Health
G. Area-specific Infection Control Education by the corresponding Manager
H. Bio-Medical Waste Management
I. Review Risk Management Plan
J. Review Safety Plan

V. Annual education will include at least:

A. Hand Hygiene
B. OSHA/Bloodborne Pathogens (including Exposure Control Plan)
C. Review of Infection Control Plan
D. Review Risk Management Plan
E. Review of Safety Plan
F. Evaluation of Safer Medical Devices

G. Tuberculosis
H. Bio-Medical Waste management update

VI. Risk Reduction:

A. Annually (and as needed) the Infection Control Professional will conduct a risk assessment. This assessment will include but is not limited to:
   1. Communicable disease exposures
   2. Blood /body fluids exposures patient
   3. Blood/body fluids exposures staff
   4. Epidemic related to infections
   5. Isolation precautions
   6. Antibiotic resistant organisms of epidemiological significance
   7. Targeted surgical site infections
   8. Construction hazards
   9. Environmental rounds
   10. Hand Hygiene monitoring

B. This facility shall also utilize an Infection Control Surveyor Worksheet along with additional tools for self-assessment of various corresponding areas.

C. Reporting: The results of the above Risk Assessment and Infection Control Surveyor Worksheet shall be reported to the appropriate quality and medical leadership committees as well as the Governing Body for final review, discussion and determination of needed follow-up actions.

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancin

DATE: 9/18 PAGE: ____

UNIT PROFILE

SYSTEM = RTU-4 LOCATION = Roof MODEL = 48HCEB07A2A5A6F0A0

MANUFACTURER = Carrier SERIAL = 3318P81111

STATIC PROFILE

	STATIC	APPARATUS
FILTER SP IN =	-0.41"	filter
COIL SP IN =		DX Coil
COIL SP IN =		
COIL SP IN =		
FAN SUCTION SP =	-0.69"	
FAN DISCHARGE IN SP =	+0.77"	Gas Heat
COIL SP OUT =		

29.5

CFM ANALYSIS	DESIGN	ACTUAL
SUPPLY FAN TRAVERSE =	2400	Not Duct Work
TERMINAL =	2350	2314
RETURN TERMINAL =	1605	1302
OUTSIDE AIR =	865	868
RELIEF AIR=	0	—
DRIVE PACKAGE		
FAN PULLEY PD =	----------	8.5"
FAN SHAFT DIAMETER =	----------	1"
FAN RPM =	None	897
MOTOR FULL PITCH =	----------	4.75
FINAL MOTOR PITCH =	----------	4.25"
MOTOR SHAFT DIAM =	----------	0.875"
MOTOR RPM =	1725	1768
DIRECT DRIVE FINAL SPEED=	----------	—
FILTER DATA		
NUMBER OF FILTERS =	----------	2
SIZE =	----------	16x25x2
CONDITION OF FILTERS =	----------	Clean

SUPPLY FAN	DESIGN	ACTUAL
VOLTAGE =	208-230	210-211-21
AMPERAGE =	8.8-9.6	5.4-5.6-5.8
SERVICE FACTOR =	----------	1.15
FRAME NUMBER =	----------	56HZ
MOTOR MANUFACTURER =	----------	Marathon
PRINT DESIGN HP =	1.05	—
MOTOR TAG HP =	----------	JJL
APPROXIMATE BHP=	----------	N/A
FINAL HZ SET PT.=	----------	—
FINAL SP SET PT.=	----------	—
MIN. SP SET PT.=	----------	—
BELT INFORMATION		
BELT SIZE =	----------	AX37
BELT QTY =	----------	2
CENTERLINE =	----------	17.025"
CARRIAGE ADJ. =	----------	+1.50"-1.0
IDLER PULLEY YES / NO	----------	—

TEMPERATURES	DRY BULB	WET BULB
OUTSIDE AIR =	78.6	48.1
MIXED AIR =	69.8	—
RETURN AIR =	68.6	64.0
SUPPLY AIR =	57.9	52.1

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

DATE: 3/18 PAGE: ____

UNIT PROFILE

SYSTEM = RTU-1 LOCATION = Roof MODEL = 48KCEB04A2A5A1F0A0

MANUFACTURER = Carrier SERIAL = 3318C89510

STATIC PROFILE

	STATIC	APPARATUS
FILTER SP IN =	-0.40"	Filters
COIL SP IN =		DX Coil
COIL SP IN =		
COIL SP IN =		
FAN SUCTION SP =	-0.161"	
FAN DISCHARGE IN SP =	+0.64"	Gas Heat
COIL SP OUT =		

CFM ANALYSIS	DESIGN	ACTUAL
SUPPLY FAN TRAVERSE =	1400	VA Duct Conf.
TERMINAL =	1250	1208
RETURN TERMINAL =	1125	938
OUTSIDE AIR =	225	208
RELIEF AIR=	—	—
DRIVE PACKAGE		
FAN PULLEY PD =	----------	4.25"
FAN SHAFT DIAMETER =	----------	0.6225"
FAN RPM =	None	1272
MOTOR FULL PITCH =	----------	3.125
FINAL MOTOR PITCH =	----------	3.125"
MOTOR SHAFT DIAM =	----------	0.625"
MOTOR RPM =	1725	1747
DIRECT DRIVE FINAL SPEED=	----------	—
FILTER DATA		
NUMBER OF FILTERS =	----------	2
SIZE =	----------	16x25x2
CONDITION OF FILTERS =	----------	Clean

	DESIGN	ACTUAL
SUPPLY FAN		
VOLTAGE =	208-230	211-211-210
AMPERAGE =	5.2-4.6	3.0-3.1-3.2
SERVICE FACTOR =	----------	1.15
FRAME NUMBER =	----------	56HZ
MOTOR MANUFACTURER =	----------	Marathon
PRINT DESIGN HP =	1.42	—
MOTOR TAG HP =	----------	N/L
APPROXIMATE BHP=	----------	N/A
FINAL HZ SET PT.=	----------	—
FINAL SP SET PT.=	----------	—
MIN. SP SET PT.=	----------	—
BELT INFORMATION		
BELT SIZE =	----------	A38
BELT QTY =	----------	2
CENTERLINE =	----------	14.25"
CARRIAGE ADJ. =	----------	10.75"-1.75"
IDLER PULLEY YES / NO	----------	No
TEMPERATURES	**DRY BULB**	**WET BULB**
OUTSIDE AIR =	71.0°F	
MIXED AIR =	68.0°F	
RETURN AIR =	67.5°F	
SUPPLY AIR =	55.7°F	49.5°F

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

DATE: 9/18 PAGE: ____

TRAVERSE DATA SHEET

THIS PAGE WILL SHOW A CFM (CUBIC FEET PER MINUTE) MEASUREMENT AT A PRECISE POINT IN THE DUCT SYSTEM. THIS MEASUREMENT IS USED FOR DETERMINING CAPACITY FOR BRANCHES, MAINS OR THE ENTIRE SYSTEM. FROM THIS POINT A DETERMINATION CAN BE MADE FOR TOTAL AIR (CFM) AVAILABLE DOWN STREAM OF THE READING TO BE BALANCED. IT CAN ALSO BE USED FOR A COMPARISON TO DETERMINE IF DUCT LEAKAGE OR AIR LOSS IS OCCURRING.
THE MEASUREMENTS WILL BE EITHER BY PITOT TUBE INSERTIONS IN THE DUCT SYSTEM OR BY FACE VELOCITY READINGS AT FILTER BANKS, COIL FACES ETC.

THE AIR SYSTEM THAT IS ASSOCIATED WITH THIS TRAVERSE = RTU-1

THE MODE OF AIR BEING TRAVERSED = (supply), return, outside air, mixed, exhaust, relief

THE LOCATION OF THIS TRAVERSE = Roof (intake)

THE AREA OF THE BUILDING THAT THIS TRAVERSE SERVES = RTU-1

THE CFM DESIGN FOR THIS TRAVERSE POINT = 225

THE ACTUAL CFM (VELOCITY X FREE AREA) AT THE TRAVERSE = 208

THE SIZE OF THE O.E.D. AT THIS TRAVERSE POINT = 28 X 14.25

THE FREE AREA (LENGTH X WIDTH DIVIDED BY 144) = 2.77

THE AVERAGE FPM (VELOCITY) AT THE TRAVERSE POINT = 75

THE STATIC PRESSURE AT THE TRAVERSE POINT = -0.004"

THE AIR TEMPERATURE AT THE TRAVERSE POINT = 71.0°F

INSTRUMENT USED= Velgrid

93	99	94							
56	60	50							

452 ÷ 6 = 75

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

DATE: 9/18 PAGE: _____

AIR TERMINAL DATA SHEET

SYSTEM: RTU-1

TERMINAL NUMBER	TERMINAL SIZE	ROOM NAME	DESIGN AK	DESIGN FPM	DESIGN CFM	TEST CFM	FINAL CFM	FPM	NOTES
1	48" x 24"	ORI			250	165	235		
2	"	"			250	162	250		
3	"	"			250	188	246		
4	"	"			250	224	241		
5	"	"			250	229	236		
					1250	968	1208		
Return 1	1410	ORI			375	258	317		
2	"	"			375	246	315		
3	"	"			375	165	306		
					1125	669	938		

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancir

(10)

DATE: 9/18 PAGE: ____

UNIT PROFILE

SYSTEM = RTU-2 LOCATION = Roof MODEL = 48KLEF04A2A5AF0A0

MANUFACTURER = Carrier SERIAL= 3318C89511

STATIC PROFILE

	STATIC	APPARATUS
FILTER SP IN =	-0.30"	filters
COIL SP IN =		Dx Coil
COIL SP IN =		
COIL SP IN =		
FAN SUCTION SP =	-0.53"	
FAN DISCHARGE IN SP =	+0.55"	Gas Heat
COIL SP OUT =		

CFM ANALYSIS	DESIGN	ACTUAL
SUPPLY FAN TRAVERSE =	1400	N/A Duct 6 ft
TERMINAL =	1250	1229
RETURN TERMINAL =	1125	957
OUTSIDE AIR =	225	211
RELIEF AIR=	—	—
DRIVE PACKAGE		
FAN PULLEY PD =	----------	4.25"
FAN SHAFT DIAMETER =	----------	0.625"
FAN RPM =	None	1114
MOTOR FULL PITCH =	----------	3.125"
FINAL MOTOR PITCH =	----------	2.75"
MOTOR SHAFT DIAM =	----------	0.625"
MOTOR RPM =	1725	1763
DIRECT DRIVE FINAL SPEED=	----------	
FILTER DATA		
NUMBER OF FILTERS =	----------	2
SIZE =	----------	16x25x5
CONDITION OF FILTERS =	----------	Clean

SUPPLY FAN	DESIGN	ACTUAL
VOLTAGE =	208-230	209-211-216
AMPERAGE =	5.2-4.6	2.5-2.6-2.7
SERVICE FACTOR =	----------	1.15
FRAME NUMBER =	----------	56HZ
MOTOR MANUFACTURER =	----------	Marathon
PRINT DESIGN HP =	1.42	----------
MOTOR TAG HP =	----------	N/L
APPROXIMATE BHP=	----------	N/A
FINAL HZ SET PT.=	----------	—
FINAL SP SET PT.=	----------	—
MIN. SP SET PT.=	----------	—
BELT INFORMATION		
BELT SIZE =	----------	AX38
BELT QTY =	----------	1
CENTERLINE =	----------	14.3125
CARRIAGE ADJ. =	----------	+1.5 -3.25
IDLER PULLEY YES / NO	----------	N/A

TEMPERATURES	DRY BULB	WET BULB
OUTSIDE AIR =	71.0°F	57.8°F
MIXED AIR =	68.1°F	54.1°F
RETURN AIR =	67.7°F	53.7°F
SUPPLY AIR =	55.3°F	49.4°F

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

DATE: 9/18 PAGE: _____

TRAVERSE DATA SHEET

THIS PAGE WILL SHOW A CFM (CUBIC FEET PER MINUTE) MEASUREMENT AT A PRECISE POINT IN THE DUCT SYSTEM. THIS MEASUREMENT IS USED FOR DETERMINING CAPACITY FOR BRANCHES, MAINS OR THE ENTIRE SYSTEM. FROM THIS POINT A DETERMINATION CAN BE MADE FOR TOTAL AIR (CFM) AVAILABLE DOWN STREAM OF THE READING TO BE BALANCED. IT CAN ALSO BE USED FOR A COMPARISON TO DETERMINE IF DUCT LEAKAGE OR AIR LOSS IS OCCURRING.
THE MEASUREMENTS WILL BE EITHER BY PITOT TUBE INSERTIONS IN THE DUCT SYSTEM OR BY FACE VELOCITY READINGS AT FILTER BANKS, COIL FACES ETC.

THE AIR SYSTEM THAT IS ASSOCIATED WITH THIS TRAVERSE = RTU-2

THE MODE OF AIR BEING TRAVERSED = _____
supply, return, outside air, mixed, exhaust, relief

THE LOCATION OF THIS TRAVERSE = Roof (intake)

THE AREA OF THE BUILDING THAT THIS TRAVERSE SERVES = RTU-2

THE CFM DESIGN FOR THIS TRAVERSE POINT = 225

THE ACTUAL CFM (VELOCITY X FREE AREA) AT THE TRAVERSE = 211

THE SIZE OF THE O.A.D. AT THIS TRAVERSE POINT = 28.0" x 14.25"

THE FREE AREA (LENGTH X WIDTH DIVIDED BY 144) = 2.77

THE AVERAGE FPM (VELOCITY) AT THE TRAVERSE POINT = 76

THE STATIC PRESSURE AT THE TRAVERSE POINT = -0.005"

THE AIR TEMPERATURE AT THE TRAVERSE POINT = 71.0°F

INSTRUMENT USED= Velgrid

101	93	97							
55	52	51							

453 ÷ 6 = 76 x 2.77

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

DATE: 9/18 PAGE: _____

AIR TERMINAL DATA SHEET

SYSTEM: RTU-2

TERMINAL NUMBER	TERMINAL SIZE	ROOM NAME	DESIGN AK	DESIGN FPM	DESIGN CFM	TEST CFM	FINAL CFM	FPM	NOTES
1	48"x24"	OR II			250	243	248		
2	"	"			250	215	238		
3	"	"			250	180	235		
4	"	"			250	265	248		
5	"	"			250	227	260		
					1250	1130	1229		
Return									
1	14x10	OR II			375	304	323		
2	"	"			375	233	316		
3	"	"			375	302	318		
					1125	839	957		

Americans United for Life

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

(1) DATE: 9/18 PAGE: ____

UNIT PROFILE

SYSTEM = RTU-3 LOCATION = Roof MODEL = 48KCEB06A2A5H5F0H0

MANUFACTURER = Carrier SERIAL= 3318C89518

STATIC PROFILE

	STATIC	APPARATUS
FILTER SP IN =	-0.32"	Filters
COIL SP IN =		DX Coil
COIL SP IN =		
COIL SP IN =		
FAN SUCTION SP =	-0.54"	
FAN DISCHARGE IN SP =	+0.46"	Gas Heat
COIL SP OUT =		

CFM ANALYSIS	DESIGN	ACTUAL
SUPPLY FAN TRAVERSE =	1200	Not Det Cfms
TERMINAL =	1330	1370
RETURN TERMINAL =	1100	955
OUTSIDE AIR =	300	318
RELIEF AIR=	—	—
DRIVE PACKAGE		
FAN PULLEY PD =	----------	4.25"
FAN SHAFT DIAMETER =	----------	0.625"
FAN RPM =	None	1125
MOTOR FULL PITCH =	----------	3.75
FINAL MOTOR PITCH =	----------	2.75
MOTOR SHAFT DIAM =	----------	0.875
MOTOR RPM =	1725	1774
DIRECT DRIVE FINAL SPEED=	----------	
FILTER DATA		
NUMBER OF FILTERS =	----------	4
SIZE =	----------	16x16x2
CONDITION OF FILTERS =	----------	Clean

	DESIGN	ACTUAL
SUPPLY FAN		
VOLTAGE =	208-230	210-209-210
AMPERAGE =	8.8-8.6	4.1-4.3-4.6
SERVICE FACTOR =	----------	1.15
FRAME NUMBER =	----------	Sc. HT.
MOTOR MANUFACTURER =	----------	Marathon
PRINT DESIGN HP =	2.72	—
MOTOR TAG HP =	----------	N/L
APPROXIMATE BHP=	----------	N/A
FINAL HZ SET PT.=	----------	—
FINAL SP SET PT.=	----------	—
MIN. SP SET PT.=	----------	—
BELT INFORMATION		
BELT SIZE =	----------	AX38
BELT QTY =	----------	2
CENTERLINE =	----------	14.5"
CARRIAGE ADJ. =	----------	1.0-1.625
IDLER PULLEY YES / NO	----------	—
TEMPERATURES	**DRY BULB**	**WET BULB**
OUTSIDE AIR =	71.0°F	62.2°F
MIXED AIR =	67.1°F	—
RETURN AIR =	66.0°F	59.6°F
SUPPLY AIR =	57.5°F	51.8°F

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

DATE: 9/18 PAGE: _____

TRAVERSE DATA SHEET

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THE MEASUREMENTS WILL BE EITHER BY PITOT TUBE INSERTIONS IN THE DUCT SYSTEM OR BY FACE VELOCITY READINGS AT FILTER BANKS, COIL FACES ETC.

THE AIR SYSTEM THAT IS ASSOCIATED WITH THIS TRAVERSE = RTU-3

THE MODE OF AIR BEING TRAVERSED = _____
supply, return, outside air, mixed, exhaust, relief

THE LOCATION OF THIS TRAVERSE = Roof (Intake)

THE AREA OF THE BUILDING THAT THIS TRAVERSE SERVES = RTU-3

THE CFM DESIGN FOR THIS TRAVERSE POINT = 300

THE ACTUAL CFM (VELOCITY X FREE AREA) AT THE TRAVERSE = 318

THE SIZE OF THE D.E.D. AT THIS TRAVERSE POINT = 28.25 X 14

THE FREE AREA (LENGTH X WIDTH DIVIDED BY 144) = 2.74

THE AVERAGE FPM (VELOCITY) AT THE TRAVERSE POINT = 116

THE STATIC PRESSURE AT THE TRAVERSE POINT = -0.008"

THE AIR TEMPERATURE AT THE TRAVERSE POINT = 71.0°F

INSTRUMENT USED= Veligrid

134	131	126							
110	97	96							

694 ÷ 6 = 116

BUTLER BALANCING CO. INC.

AABC Certified Testing & Balancing

DATE: 9/18 PAGE: _____

AIR TERMINAL DATA SHEET

SYSTEM: RTU-3

TERMINAL NUMBER	TERMINAL SIZE	ROOM NAME	DESIGN AK	DESIGN FPM	DESIGN CFM	TEST CFM	FINAL CFM	FPM	NOTES
1	24x8	Recovery			185	208	186		
2	"	"			190	220	200		
3	"	"			185	235	195		
4	12x6	TLT.			45	117	48		
5	"	entrance			85	88	97		
6	"	Corridor			30	87	31		
7	"	Utility Rm			45	92	46		
8	24x8	Recovery			190	214	189		
9	"	"			185	229	193		
10	"	"			190	213	190		
					1330	1703	1370		
Return									
1	24x24	Recovery			275	185	248		
2	"	"			275	299	240		
3	"	"			275	318	239		
4	"	"			275	253	228		
					1100	1055	955		

Americans United for Life

Plan Review Release Notification

Attention Jacqueline:

Thank you for using ePlans, the State of New Jersey's electronic plan review system.

Congratulations, drawings and/or specifications on Project **5013-18** have been issued a final release.

1. Please login to ProjectDox below to access the released drawings and documents. These can be found in the "Released" folder.
2. You may download and/or print the released documents for your use.

Project:	5013-18
-	Cherry Hill Womens Center /NJPRP-1893
Assigned by:	Susan Soffel
Online Plan Review System	

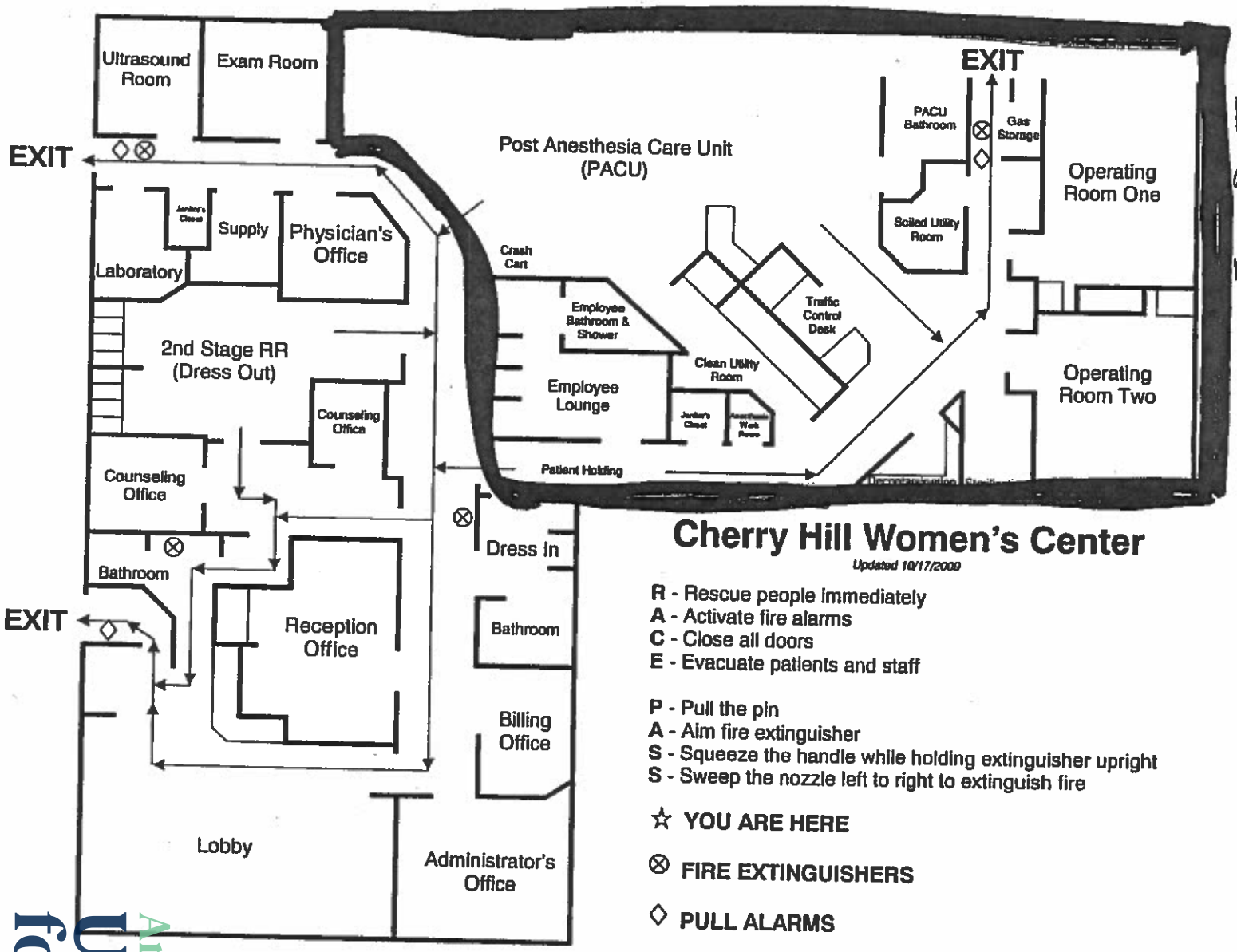
THIS NOTIFICATION IS NOT A CONSTRUCTION PERMIT

All prior approvals must be secured, all permit fees must be paid, and a construction permit must be applied for and issued before any work can be performed. Construction plans and specifications for the subject structure proposed to be built have been reviewed and released in conformance with the provisions of the Regulations for the New Jersey Uniform Construction Code, N.J.A.C. 5:23.

If you do not have access to the specified folder or have questions related to this plan review, please contact us at (609) 633-0800 or at planreviewintake@dca.nj.gov.

For any technical issues please contact the System Administrator at planreviewintake@dca.nj.gov.

This is an automated email notification and this email account is not monitored. Please do not reply to this email.



highlighted area to the left is renovated area

Cherry Hill Women's Center

Updated 10/17/2009

R - Rescue people immediately
A - Activate fire alarms
C - Close all doors
E - Evacuate patients and staff

P - Pull the pin
A - Aim fire extinguisher
S - Squeeze the handle while holding extinguisher upright
S - Sweep the nozzle left to right to extinguish fire

☆ **YOU ARE HERE**

⊗ **FIRE EXTINGUISHERS**

◇ **PULL ALARMS**

Americans United for Life

CHERRY HILL WOMEN'S CENTER

Biological Testing Record

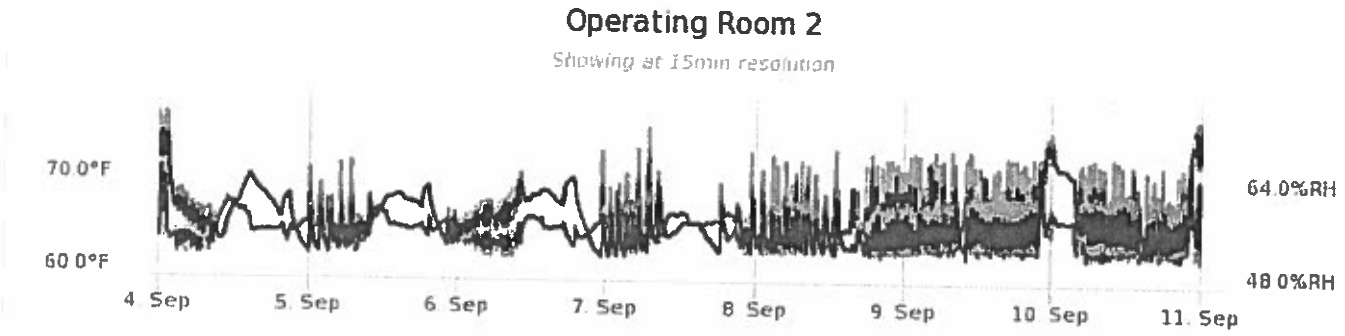
Month: Sept 2018

BI= Biological Test *CV= Control Vial*

DATE	Ster.#	Load#	BI Lot#	Time BI put in Inc.	Date BI Removed	Time BI Removed	BI Result	Control Vial Lot#	Date CV in Inc.	Time CV in Inc.	Date CV Removed	CV Results	Tech Initials	COMMENTS
9/25	A	1	675 exp 5/20	9:00A	9/26	9:00A	—	675 exp 5/20	9/25	9:00A	9/26	+	MCJ	—
9/25	B	1	675 exp 5/20	9:00A	9/26	9:00A	—	675 exp 5/20	9/25	9:00A	9/26	+	MCJ	—
9/25	C	1	675 exp 5/20	9:00A	9/26	9:00A	—	675 exp 5/20	9/25	9:00A	9/26	+	MCJ	—
9/26	A	1	675 exp 5/20	8:00A	9			675 exp 5/20	9/26					
9/26	B	1	681 exp 5/20	8:00A				675 exp 5/20	9/26					
9/26	C	1	675 exp 5/20	8:00A				675 exp 5/20	9/24					

United for Life Americans

Operating Room 2



Channel	Average	Minimum	Maximum	Mean Kinetic Temp
Dew Point	51.0°F	46.3°F	64.0°F	50.9°F
Temperature	66.5°F	62.3°F	77.7°F	66.4°F
Relative Humidity	57.5%RH	51.9%RH	74.4%RH	N/A

Annotation At	Channel	Comment

There were no annotations for this time period

Americans United for Life

Phone: 1-800-757-3747 Fax: 1-800-676-0498 Email: support@dicksonone.com

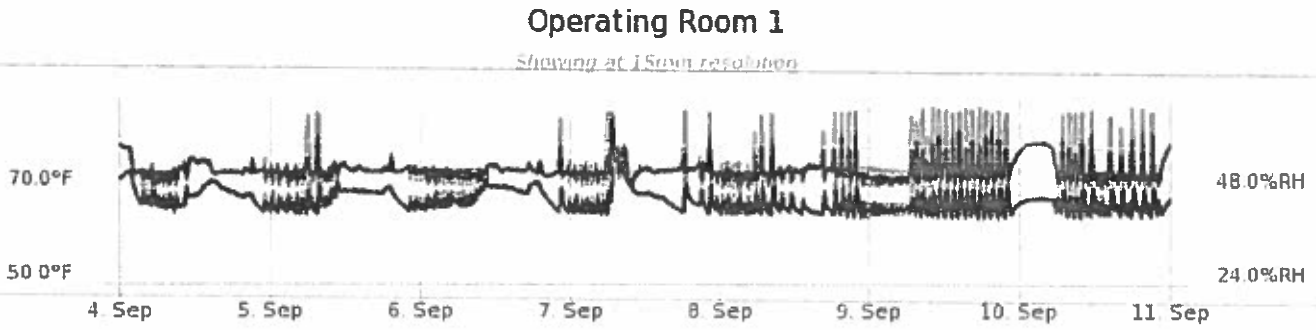
For calls outside the US please call: 1-630-543-3747

DicksonOne

09/04/2018 - 09/10/2018

Temperature and Humidity Operating Room (1&2) log

Operating Room 1



Channel	Average	Minimum	Maximum	Mean Kinetic Temp
Temperature	67.7°F	63.9°F	79.8°F	67.7°F
Relative Humidity	53.1%RH	48.0%RH	69.1%RH	N/A
Dew Point	49.9°F	45.9°F	62.6°F	49.9°F

Annotation At	Channel	Comment

There were no annotations for this time period

Americans United for Life

Phone: 1-800-757-3747 Fax: 1-800-676-0498 Email: support@dicksonone.com

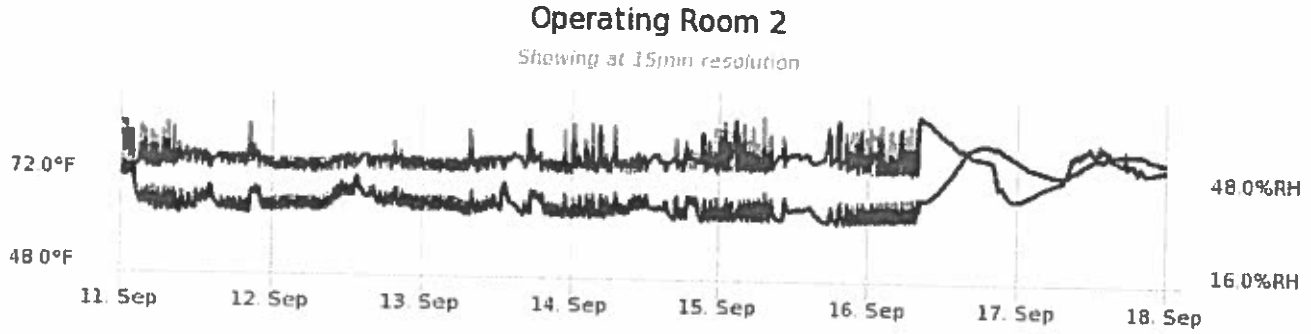
For calls outside the US please call: 1-630-543-3747

DicksonOne

09/11/2018 - 09/17/2018

Temperature and Humidity Operating Room (1&2) log

Operating Room 2



Channel	Average	Minimum	Maximum	Mean Kinetic Temp
Dew Point	52.9°F	46.5°F	67.2°F	52.8°F
Temperature	69.1°F	62.5°F	83.3°F	69.1°F
Relative Humidity	56.6%RH	44.2%RH	73.1%RH	N/A

Annotation At	Channel	Comment

There were no annotations for this time period

Americans United for Life

Phone: 1-800-757-3747 **Fax:** 1-800-676-0498 **Email:** support@dicksonone.com

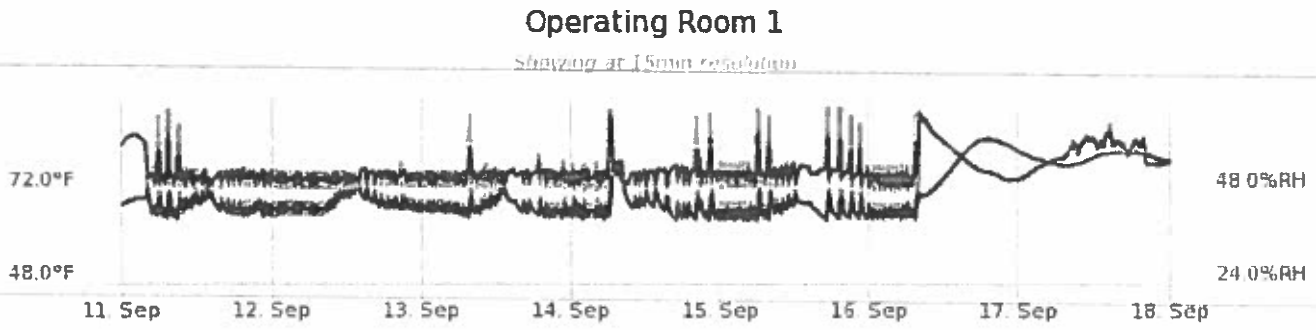
For calls outside the US please call: 1-630-543-3747

DicksonOne

09/11/2018 - 09/17/2018

Temperature and Humidity Operating Room (1&2) log

Operating Room 1



Channel	Average	Minimum	Maximum	Mean Kinetic Temp
Temperature	70.6°F	63.8°F	85.0°F	70.5°F
Relative Humidity	53.2%RH	47.5%RH	69.2%RH	N/A
Dew Point	52.7°F	46.2°F	68.7°F	52.6°F

Device Not Reporting	
Triggered	09/12/2018 10:28:06 PM EDT
Duration	1 hr, 37 mins
Comments	0

Annotation At	Channel	Comment

There were no annotations for this time period

Americans United for Life

Phone: 1-800-757-3747 Fax: 1-800-676-0498 Email: support@dicksonone.com

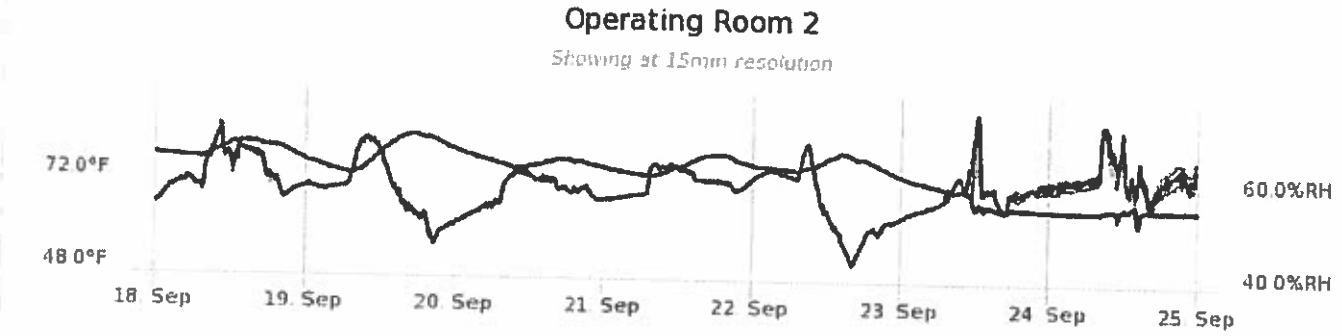
For calls outside the US please call: 1-630-543-3747

DicksonOne

09/18/2018 - 09/24/2018

Temperature and Humidity Operating Room (1&2) log

Operating Room 2



Channel	Average	Minimum	Maximum	Mean Kinetic Temp
Dew Point	60.4°F	50.1°F	70.8°F	60.3°F
Temperature	75.7°F	63.4°F	84.8°F	75.7°F
Relative Humidity	60.9%RH	43.8%RH	76.2%RH	N/A

Annotation At	Channel	Comment

There were no annotations for this time period

Americans United for Life

Phone: 1-800-757-3747 **Fax:** 1-800-676-0498 **Email:** support@dicksonone.com

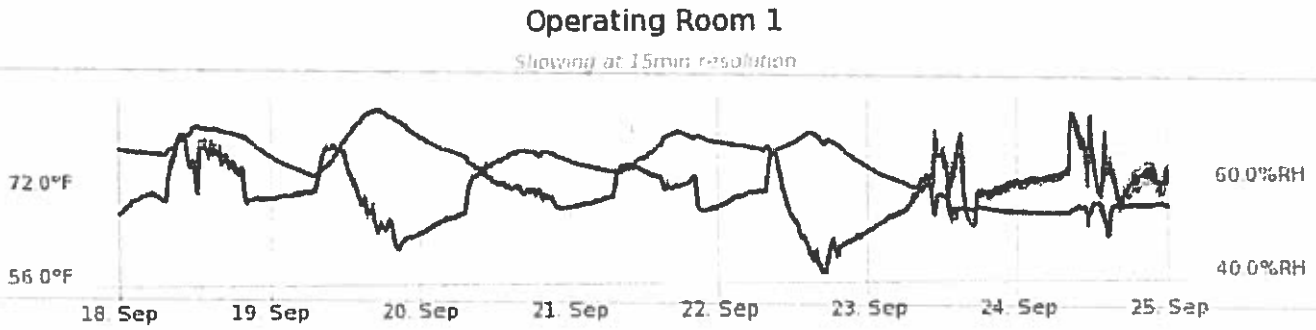
For calls outside the US please call: 1-630-543-3747

DicksonOne

09/18/2018 - 09/24/2018

Temperature and Humidity Operating Room (1&2) log

Operating Room 1



Channel	Average	Minimum	Maximum	Mean Kinetic Temp
Temperature	76.2°F	63.2°F	85.6°F	76.2°F
Relative Humidity	59.1%RH	41.7%RH	75.7%RH	N/A
Dew Point	60.7°F	49.2°F	72.4°F	60.7°F

Annotation At	Channel	Comment

There were no annotations for this time period

Americans United for Life

Phone: 1-800-757-3747 Fax: 1-800-676-0498 Email: support@dicksonone.com

For calls outside the US please call: 1-630-543-3747

CHERRY HILL WOMEN'S CENTER
INFECTION CONTROL PROGRAM
REVISED 3-2010, Revised, 12-11

Cherry Hill Women's Center Infection Control Mission Statement:
Cherry Hill Women's Center (CHWC) is dedicated to giving high-quality patient care in a constantly changing field and environment. CHWC is always working on ways to improve in the area of patient care and infection control. Our mission is to promote a healthy and safe environment by preventing transmission of infectious agents among patients, staff and visitors. This will be accomplished in an efficient and cost-effective manner by the continual assessment and modification of our services based on regulations, standards, guidelines, scientific studies, and internal evaluations.

CHWC offers a variety of gynecological services and abortion care up to 24.6 weeks in a safe, kind, compassionate, and non-judgmental environment. CHWC believes that every patient (woman) has the right to make decisions about her healthcare and well-being based on her beliefs, experiences and circumstances; and that this decision should be done in a private, compassionate, dignified, and safe manner. CHWC is dedicated to providing these services even under the unique position of dealing with protestor activity by people with opposing views on this very controversial topic. CHWC sees beyond the controversy and strives to understand the heart of a woman as she makes this decision. . CHWC is here to see that every woman seeking an abortion has the right to quality healthcare in an environment that offers support, guidance and options to women in need.

In an effort to exceed these standards of quality service CHWC has agreements in place with a Sterilization/Decontamination Consultant as well as an Infection Control Consultant. Each consultant meets with CHWC at least annually, or as needed, to review all policies and procedures, ensure staff and physicians are adhering to the written policies, and advise CHWC on any new rules, regulations, or requirements in compliance with AAMI, OSHA, and current CDC guidelines.

The program includes written policies for Hazard Communication, Exposure Control Plan, Communicable Disease Reporting to the Department of Health, Hand washing, Housekeeping, Linens, Record Keeping, OSHA and Regulated Medical Waste. These policies will all be reviewed, updated and revised annually.

Cherry Hill Women's Center Tracking/Monitoring System:
The tracking system is designed to track any and all patterns, issues, and complications. It is to be used as a teaching tool for staff, physicians, Administration and Governing Body. It is also a useful tool to help in revisions or implementation of new procedures based on findings. Some of the tracking forms included but are not limited to:
Complication Tracking Form
Hotline Tracking Form
Ineligible Patient Log

Sterilization Tracking Log
Environmental Log
Housekeeping Logs
Medical Record Review Form
Physician Peer Review Form
Hand washing Form

GOALS AND OBJECTIVES:

Cherry Hill Women's Center's ongoing goals are to ensure patients are cared for and safely treated according to our written protocols and guidelines for staff, doctors, patients and visitors. CHWC will review the following topics in relation to abortion care to ensure our systems, policies and practices are being adhered to.

CHWC will start in the area of sterilization and decontamination. CHWC will ensure that all packs, peels, and instruments are clearly labeled, initialed, dated, etc. We will conduct biological indicators to ensure the sterilization process is functioning according to manufacturer's instructions. This will ensure the sterilization of all instruments is at optimum performance for patient care and safety. This will be monitored and checked weekly until we reach the desired outcome and then changed to a quarterly basis. The Director of Nursing and/or designee will randomly supervise the sterile technician once d a month to ensure his/her testing is meeting with CHWC, state, and federal standards, and he/she is maintaining the sterility and environment set forth by CHWC. These monthly reports will be given to the Administrator on a quarterly basis; or as needed, to discuss and review. The Administrator is responsible for reviewing this with the Governing Body quarterly.

Another goal and objective for CHWC is to ensure our SOP for hand washing is being adhered to and monitored for all staff, physicians and visitors. This will be done monthly by the Director of Nursing and/or designee and the reports will be given to the Administrator on a quarterly basis. The Administrator will then be responsible for supplying the Governing Body with our findings on sterility and decontamination on a quarterly basis. Topics will be chosen as each goal is met to our satisfaction.

CHWC's other goal and objective is a challenge as CHWC is a small ASC performing surgery five days a week. We seek to incorporate staff in our QI and Infection Control. We are aware that we have such a tremendous impact on so many women's lives; and the input and ideas from staff are welcomed and encouraged. We plan on selecting topics for staff to become involved in and educate other staff members and the community. As we know the community to which we serve is very diverse and we see an overwhelming amount of women living in poverty who can benefit from education. Some examples include birth control, smoking during pregnancy, malignant hyperthermia, drug use and risk factors during pregnancy and abortion care.

In addition, to the topics above CHWC will also maintain:

Employee Health Records
Inform and Educate staff on Communicable Diseases as well as reporting to DOH
Track and log any and all infections/Fevers
Maintain policy on Handwashing
Maintain all logs for temperature and humidity control
Maintain a log on environmental issues
Maintain an ongoing monthly checklist and review with housekeeping
Traffic patterns
Proper attire
Patient Records and maintenance

Annually CHWC will present the surveillance gathered to the Infection Control committee for review and discussion. Our Infection Control Committee meets quarterly, where most of the information gathered weekly and submitted monthly to the Administrator will be brought for review. The Infection Control Consultant is required to attend one of our quarterly meetings in addition to her annual facility walkthrough and policy and procedure check. Yearly tracking information will also be given the Governing Body for review and discussion. The goals and objectives for the year will be brought to the committee with our tracking system and documents to support the findings. At the final quarter, new objectives and goals will be set for the following year to ensure growth and care for the patients, staff, physicians and facility.

CHWC QI and Infection Control Program is an integral part in the care and safety we provide to patients, staff and visitors. These programs will be constantly monitored, tracked and revised as medicine changes, state and federal requirements change, our own findings change and as we change and grown within our own organization.

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Cherry Hill Women's Center
Policy and Procedure Manual

Policy: Temperature, Air Flow and Humidity Levels	Date Effective: 8/22/2011 Date Revised/Reviewed: 1/23/12, 6/19/12
Approved By: Administrator	File Under: Sterilization Folder

POLICY: Temperature and humidity levels shall be monitored daily whenever the facility is open to ensure compliance with recommended environmental conditions. Air flow should be verified if there are issues with compliance.

PROCEDURE:

1. The Decontamination Area requires the following:
   Temperature of 60-65°F
   Humidity – 30-60%
   Air flow – 10 air exchanges per hour under **negative pressure.** This air is not to be re-circulated.

2. The Prep/Packaging/Sterilization area requires the following:

   Temperature of 68-73°F
   Humidity – 35-60% (NOTE: While AAMI states 30-60%, the **ideal humidity for the prep/packaging area is 50% with a minimum of 35%. These levels will prevent dehydration of packaging materials which can interfere with steam sterilization.**
   Air flow – 10 air exchanges per hour under positive pressure. This air can be re-circulated.

3. Each day the facility is open, the sterile processing staff is required to document the temperature and humidity in the Decontamination and Prep/Packaging/Sterilization areas in note books kept in each area (separate books for Decontam ,Prep/Pkg/Sterilization, and Sterile Storage).

4. Any variance from the above norms should immediately be reported to the Head Nurse or facility Administrator for corrective action.

5. The action taken should be documented in the log book.

TITLE: Temperature, Humidity and Air Flow Requirements for the Processing Areas

REFERENCE: AAMI "Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities ST-79" 2006.

REVIEWED: Every 3 years: 4/2009

Americans United for Life

Developed 8/21/07

REVISED: 8/22/11

Americans United for Life

CHERRY HILL WOMEN'S CENTER
DEPARTMENT OF ANESTHESIA
POLICY AND PROCEDURES

B. Operating Rooms

- The operating rooms are to allow for clean air exchange at a rate of twenty times per hour with a temperature range of 68 to 76 degrees F with a relative humidity of 30% -60% based on CDC recommendations.
- All general OR rooms are equipped with piped oxygen which is indexed specifically of O2 lines. In the GAS STORAGE AREA outside the OR near the EMERGENCY EXIT is a valve, which is labeled and controls the oxygen flow to that specific operating room this valve is to be turned off.
- Oxygen gauges for the flow and volume are located in the FRONT OFFICE RECEPTION AREA. These gauges are quipped with visual and audible alarms to indicate a low reserve of liquid oxygen. The alarms are set to sound when the reserve falls to a specific level. O2 tanks are checked daily, prior to the start of surgery. In addition, we have a back -up tank reserve of six cylinders; type E, in the event that the oxygen supply is completely depleted.

C. Fire

- A fire hazard manual is located in the Department of Anesthesia and reviewed by all personnel. In the event of a fire occurring in the general surgical area, all doors to the operating room are closed and no personnel are allowed to move in or out without special permission, Generally speaking, no change in the regular operating schedule occurs, however, no new operative procedures are begun until an all-clear is sounded. In the event that we are notified of a serious problem, attempts should be made to terminate any operative procedures as soon as safely possible.

D. Electrical Equipment

- All electrical anesthetic equipment must be properly grounded and checked for safety by biomedical engineers prior to its use/operation in the operating room. The line isolation monitor should immediately indicate any electrical leakage defects of the equipment while in use in the operating area, This will be discussed at greater length further on in the manual. The equipment is periodically checked for proper functioning, grounding and leakage. Also defibrillator equipment is checked by the biomedical engineers to insure function and determine adequate output. The condition of all electrical used by the Department of Anesthesia is inspected periodically and written records are kept on fine in the administrator's office.

WHEN DEFECT IN THE ELECTRICAL EQUIPMENT IS DISCOVEREDM THE ITEM IS TO BE IMMEDIATELY DISCONNECTEDM REMOVED FROM THE OPERATING ROOM AREA, LABELED AS TO DEFECTM AND REPORTED FOR REPAIRS.

E. Anesthetic Machines

1. the anesthesia machines are standardized and equipped with required safety features such as pressure gauges, as well as flow meter and inhalation/exhalation valves. In addition, the anesthesia machines are equipped with the following:

- Pin Index System
- Oxygen Analyzers e.g. Pulse oxymeter
- Oxygen tanks with at least one being full
- EKG monitor
- Ct CO_2 monitor

Cherry Hill Women's Center

Temperature/Humidity Log – Decontamination

Temperature Normal Range: 60°F - 65°F

Humidity Normal Range: 30% - 60%

(Please report any abnormal findings to your supervisor)

Month: SEPT. 2018

DATE	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
9-1-18	65°F	60%	[illegible]	
9-4-18	65°F	60%	[illegible]	
9-5-18	65F	60%	MCS	
9/6/18	65F	60%	MCS	
9/7/18	66F	60%	BB	
9/8/18	61°F	60%	[illegible]	
9/11/18	60F	60%	MCS	
9/12/18	60°F	60%	BB	
9/13/18	60°F	60%	BB	
9/14/18	60°F	59%	[illegible]	
9/15/18	60.F	58%	[illegible]	
9/18/18	closed			
9/19/18	"			
9/20/18	"			
9/21/18	"			
9/22/18	"			
9/25/18	"			
9/26/18	"			
9/27/18				
9/28/18				
9/29/18				

Americans United for Life

Rationale: Items with torn or wet packaging are considered contaminated. Wet packaging might indicate problems with package composition, loading procedures, sterilizer performance or operation, or the steam generation and distribution system.

8.9 Sterile storage

8.9.1 Sterility maintenance covers

Sterility maintenance covers (dust covers) may be used to protect and extend the shelf life of properly packaged and sterilized items that could be subjected to environmental challenges or multiple handling before use. Only products specifically labeled as sterility maintenance covers should be used for this purpose. A sterility maintenance cover or dust cover should be clearly designated as such to prevent its being mistaken for a sterile wrap. Sterility maintenance covers are designed to provide protection against outside elements (e.g., dust), not to provide a microbiological barrier. If sterility maintenance covers are to be applied to sterilized packages, they should be applied as soon as possible after sterilization, but not before the items are thoroughly cool and dry. Sterilized packages should be handled as little as possible.

The sterility maintenance cover is sealed using either a heat sealer designed to seal plastic to plastic or an alternative method that is similarly effective; a self-sealing cover also may be used. The lot or load control number and expiration statement should be visible through the sterility maintenance cover, or an additional label should be used on the sterility maintenance cover. (See also 10.3.)

Rationale: Plastic provides a barrier to moisture and dust; this barrier might be necessary to preserve the sterile integrity of the package, especially one that is not going to be used immediately or that will be subjected to uncontrolled environments (e.g., during transport between facilities). Because a sterility maintenance cover is applied after sterilization, the outer surface of the actual packaging material should be considered contaminated for purposes of sterile presentation.

Applying sterility maintenance covers soon after sterilization enhances sterility maintenance. However, placing a sterility maintenance cover on a package that is not cool and dry could result in condensation inside the sterility maintenance cover and, because the sterility maintenance cover is not sterile, contaminate the package contents. To be an effective barrier, the sterility maintenance cover has to be sealed. The sterility maintenance cover is only a protective device; the identity and traceability of the package within has to be maintained.

8.9.2 Storage facilities

Sterile items should be stored in a manner that reduces the potential for contamination. In general, the temperature in storage areas should be approximately 24°C (75°F). There should be at least 4 air exchanges per hour, and relative humidity should be controlled so that it does not exceed 70% (AIA, 2006). Traffic should be controlled to limit access to sterile items to those individuals who know how to handle them properly. Sterile items should be stored far enough away from the floor, the ceiling, and outside walls to allow for adequate air circulation, ease of cleaning, and compliance with local fire codes. Sterile items should be stored at least 8 to 10 inches above the floor, at least 18 inches below the ceiling or the level of the sprinkler heads, and at least 2 inches from outside walls. The items should be positioned so that packaging is not crushed, bent, compressed, or punctured and so that their sterility is not otherwise compromised. Medical and surgical items, including those packaged in rigid sterilization container systems, should not be stored next to or under sinks, under exposed water or sewer pipes, or in any location where they could become wet. Supplies should not be stored on floors, on windowsills, or in areas other than designated shelving, counters, or carts. Heavy instrument trays should be stored on middle shelves (but not stacked) for ease of handling by staff; transport trays with solid or perforated bottoms may be used to prevent tears in wrappers during handling. (See also 3.3.7.4.)

Closed or covered cabinets are recommended for the storage of seldom-used supplies. Open shelving may be used, but requires special attention to traffic control, area ventilation, and housekeeping. Shelving or carts used for sterile storage should be maintained in a clean and dry condition. For sterile and clean supplies stored on the bottom shelf of an open-shelf (wire) cart, there should be a physical barrier between the shelf and traffic or housekeeping activities. Outside shipping containers and corrugated cartons should not be used as containers in sterile storage areas. (See also 5.2.1.)

Shelving or racks used for the storage of rigid sterilization container systems should be designed for the weight and configuration of the containers. The racks or shelves should be kept clean and dry in a controlled environment. When stacking container systems, the user should take care to ensure that they are firmly seated one upon another and that they can be removed easily. Written policies and procedures for the storage, handling, rotation, and labeling of container systems should be developed and enforced.

COPY

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360
www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

October 9, 2018

Jenifer Groves
Regional Executive Director
Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034

Dear Ms. Groves:

Thank you for the courtesy and cooperation extended during the Approval Survey conducted September 26, 2018 by surveyors from the New Jersey Department of Health.

Enclosed is a copy of them State Deficiency Form indicating that no deficiencies were found during the survey. Please sign the first page of the State Deficiency Form and return the original copy to my attention. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me at (609) 292-9900.

Sincerely,

Eric DeCicco
Surveyor Physical Plant/Life Safety
Survey and Certification

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS	A 000		
	This was an Approval Survey conducted on 9/26/18 for the installation of a new heating and air conditioning system. The facility is in compliance with N.J.A.C. Title 8 Chapter 43A-Standards for Licensure of Ambulatory Care Facilities for this Approval Survey only.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Transaction Report

For: CHERRY HILL WOMENS CENTER - NJ310001113

Certification ID: 6K3J **Provider #:**31C0001113 **Survey Date:** 02/08/2010

Printed: 07/15/2010

300
3/1/13
2/8/10

Transaction Number: 310003394764 **On:** 07/09/2010 **By:** SKED, S LYNN
Tran Type: 03 - ADD **Status:** -1 - Failed Prevalidation in ASPEN

Message Detail:
<0172R-1539: CMS-1539 THE DETERMINATION APPROVAL DATE (L33) IS REQUIRED.>

Transaction Number: 310003395664 **On:** 07/12/2010 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Americans United for Life

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6K3J

Facility ID: NJ310001113

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 31C0001113
2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) CHERRY HILL WOMENS CENTER
(L4) 502 KINGS HIGHWAY NORTH
(L5) CHERRY HILL, NJ (L6) 08034

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY 02/08/2010 (L34)

8. ACCREDITATION STATUS: 0 (L10)
0 UNACCREDITED 1 TJC
2 AAAHC 3 AAAASF

7. PROVIDER/SUPPLIER CATEGORY 15 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) 12/31

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___ 1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
On the survey of 2/2/10 the following Conditions for Coverage were not met: 416.43 Quality Assessment & Performance Improvement, 416.51 Infection Control,416.48 Pharmacy, and 416.52 Patient Admission Assessment & Discharge.
On the revisit of 6/18/10 all Conditions were met. Recommend recertification.

17. SURVEYOR SIGNATURE Date: 07/09/2010 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 07/09/2010 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY (L21)
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION 05/20/1999 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00865 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 07/09/2010 (L32)

32. DETERMINATION OF APPROVAL DATE 07/12/2010 (L33)

DETERMINATION APPROVAL

AMBULATORY SURGICAL CENTER REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Please see statement on reverse and read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions of Coverage are met. Assistance in completing the form is available from the State agency.

Answer all questions as of the currrent date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Medicare Supplier Number - Insert the facility's six-digit supplier number. Leave blank on initial requests for certification.

Related Provider Number - Complete this block when a facility is participating under more than one provider number, such as a facility also participating as a hospital. The number in this block for each related provider will be the provider number of the highest level of care.

NOTE: If an ASC is operated by a hospital, has a Distinct Part SNF, ICF and ICF/MR, the related provider number field on the application for each provider (including the hospital) will have the hospital provider number.

State/County and State Region Codes - Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Item III - If a service is provided directly by the facility, place a '1' in the appropriate block. If a service is provided through an outside source (i.e., by contract or referral), place a '2' in the appropriate block.

Item IV - 'X' the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties).

Medicare Supplier Number AS1	Related Provider Number AS2	State/County Code AS3	State Region Code AS4	Fiscal Year Ending Date 12-31-09 AS5	
I IDENTIFYING INFORMATION	Name of Facility Cherry Hill Women's Center		Street Address 502 Kings Highway North		
	City, County, and State Cherry Hill NJ		Zip Code 08034	Telephone No. (Include Area Code) 856-667-5910 AS6	
II TYPE OF CONTROL (x one box) AS7	1. ☒ Proprietary	2. ☐ Non-Profit	3. ☐ Government		
III ANCILLARY SERVICES (Place '1' or '2' in blocks) AS8	1. 2 Laboratory	2. 2 Radiology	3. 2 EKG	4. 2 Pharmacy	
IV SURGICAL SPECIALTIES (X appropriate blocks) AS9	1. ☐ Cardiovascular 2. ☐ Foot 3. ☐ General 4. ☐ Neurological 5. ☒ ~~Obstetrics~~/Gynecology	6. ☐ Ophthalmology 7. ☐ Oral 8. ☐ Orthopedic 9. ☐ Otolaryngology 10. ☐ Plastic	11. ☐ Thoracic 12. ☐ Urology 13. ☐ Other (Specify) _____		
V FACILITY CHARACTERISTICS	1. Number of Operating Rooms 2 AS10		2. Date Center Began Providing Services 1995 AS11		

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Signature of Authorized Official (sign in ink)	Title	Date AS12
Clara Mordo	Administrator	2/26/2010

Form CMS-377 (1-97)

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

June 23, 2010

Elaina Nardo
Administrator
Cherry Hill Womens Center
502 Kings Highway North
Cherry Hill, NJ 08034

Dear Ms. Nardo:

Thank you for the courtesy and cooperation extended during the Federal revisit survey of your facility on June 18, 2010 by surveyors from the Department of Health and Senior Services.

Enclosed is the CMS-2567B form which indicates that the Federal deficiencies, identified during the survey of February 8, 2010, were corrected.

Should you have questions, please do not hesitate to contact S. Lynn Sked, Supervising Health Care Evaluator, at (609) 292-9900.

Sincerely,

Christine Muszynski BSN, RN
for

S. Lynn Sked B.S., R.N., CPM
Supervising Health Care Evaluator
Assessment and Survey

Encl.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
31C0001113	A. Building B. Wing	6/18/2010

Name of Facility	Street Address, City, State, Zip Code
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Q0080 Reg. # 416.43 LSC	Correction Completed 06/18/2010	ID Prefix Q0081 Reg. # 416.43(a), 416.43(c)(1) LSC	Correction Completed 06/18/2010	ID Prefix Q0082 Reg. # 416.43(b), 416.43(c)(2), 416 LSC	Correction Completed 06/18/2010
ID Prefix Q0083 Reg. # 416.43(d) LSC	Correction Completed 06/18/2010	ID Prefix Q0084 Reg. # 416.43(e) LSC	Correction Completed 06/18/2010	ID Prefix Q0101 Reg. # 416.44(a)(1) LSC	Correction Completed 06/18/2010
ID Prefix Q0180 Reg. # 416.48 LSC	Correction Completed 06/18/2010	ID Prefix Q0181 Reg. # 416.48(a) LSC	Correction Completed 06/18/2010	ID Prefix Q0221 Reg. # 416.50(a)(1) LSC	Correction Completed 06/18/2010
ID Prefix Q0240 Reg. # 416.51 LSC	Correction Completed 06/18/2010	ID Prefix Q0241 Reg. # 416.51(a) LSC	Correction Completed 06/18/2010	ID Prefix Q0242 Reg. # 416.51(b) LSC	Correction Completed 06/18/2010
ID Prefix Q0244 Reg. # 416.51(b)(2) LSC	Correction Completed 06/18/2010	ID Prefix Q0245 Reg. # 416.51(b)(3) LSC	Correction Completed 06/18/2010	ID Prefix Q0260 Reg. # 416.52 LSC	Correction Completed 06/18/2010

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	C Kuszyk	6/22/10	S Lynn Shed	6/22/10
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
31C0001113	A. Building B. Wing	6/18/2010

Name of Facility	Street Address, City, State, Zip Code
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

his report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously eported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be ully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each equirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Q0261 Reg. # 416.52(a)(1) LSC	Correction Completed 06/18/2010	ID Prefix Q0264 Reg. # 416.52(b) LSC	Correction Completed 06/18/2010	ID Prefix Q0266 Reg. # 416.52(c)(2) LSC	Correction Completed 06/18/2010

teviewed By tate Agency	Reviewed By	Date: 6/22/10	Signature of Surveyor: Lynn Steed	Date: 6/18/10
teviewed By MS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 2/8/2010

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES (NO)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001113	A. BUILDING _____ B. WING _____	02/08/2010

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Q 000	INITIAL COMMENTS Surveyor: 11609 Medical Records reviewed - 21 Employee Files reviewed - 14 Abbreviations ASC - Ambulatory Surgery Center	Q 000		
Q 080	416.43 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT 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: Surveyor: 11609 Based on a review of information provided, lack of evidence and staff interview, it was determined that the ASC failed to implement and maintain an on-going, data-driven quality assessment and performance improvement (QAPI) program. Findings include: 1. The facility failed to develop an ongoing program of quality improvement that measures , analyzes, and tracks quality indicators, adverse patient events, and infection control outcomes. (Cross refer Q 81) 2. The facility failed to formulate a Quality Assurance Program that established indicators, monitors effectiveness and safety of services, track adverse events and implement	Q 080		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 080	Continued From page 1 improvements.(Cross refer Q 82) 3. The facility failed to formulate a Quality Assurance Program that established distinct improvement projects.(Cross refer Q 83) 4. The facility failed to implement a QAPI program that addresses the ASC's priorities and evaluates effectiveness, specifies data collection methods, frequency, and details, clearly establishes its expectations for safety and adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. (Cross refer Q 84)	Q 080		
Q 081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (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.	Q 081		

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Q 081	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 11609 Based on a review of information provided and staff interview, it was determined that the facility failed to develop an ongoing program of quality improvement that measures , analyzes, and tracks quality indicators, adverse patient events, and infection control outcomes. Findings include: 1. Even though th facility has developed an quality assurance plan for th facility the plan failed to identify thresholds and indicators to be analyzed. 2. The facility failed to provide evidence of measuring any quality indicators. 3. The facolity failed to provide evidence of reviewing problems, tracking and trending and establishing indicators. 4. On interview employee #1 stated that she could not provide evidence of any of the above. 5. This was confirmed by employee #2.	Q 081		
Q 082	416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (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	Q 082		

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Q 082	Continued From page 3 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: Surveyor: 11609 Based on a review of information provided and staff interview on 1/21/10, it was determined that the facility failed to formulate a Quality Assurance Program that established indicators, monitors effectiveness and safety of services, track adverse events and implement improvements. Findings include: 1. When requested at the entrance conference on 1/20/10 at approximately 10AM and again on 1/21/10 at approximately 1PM, the facility staff failed to provide evidence of a Quality Assurance Program that established indicators, monitors effectiveness and safety of services, track adverse events and implement improvements. 2. This was confirmed by employees 1 & 2.	Q 082		
Q 083	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct	Q 083		

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Q 083	Continued From page 4 improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results This STANDARD is not met as evidenced by: Surveyor: 11609 Based on a review of information provided and staff interview on 1/21/10, it was determined that the facility failed to formulate a Quality Assurance Program that established distinct improvement projects. Findings include: 1. When requested at the entrance conference on 1/20/10 at approximately 10AM and again on 1/21/10 at approximately 1PM, the facility staff failed to provide evidence of a Quality Assurance Program that established distinct improvement projects. 2. This was confirmed by employees 1 & 2.	Q 083		
Q 084	416.43(e) GOVERNING BODY RESPONSIBILITIES 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.	Q 084		

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Q 084	Continued From page 5 (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: Surveyor: 11609 Based on staff interview and a lack of evidence on 1/20 and 1/21/10, it was determined that the facility failed to implement a QAPI program that addresses the ASC's priorities and evaluates effectiveness, specifies data collection methods, frequency, and details, clearly establishes its expectations for safety and adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. Findings include: 1. When requested at the entrance conference on 1/20/10 at approximately 10AM and again on 1/21/10 at approximately 1PM, the facility staff failed to provide evidence of a Quality Assurance Program that addresses the ASC's priorities and evaluates effectiveness, specifies data collection methods, frequency, and details, clearly establishes its expectations for safety and adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. 2. This was confirmed by employees 1 & 2.	Q 084		
Q 101	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary	Q 101		

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Q 101	Continued From page 6 environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is not met as evidenced by: Surveyor: 11609 Based on a tour and observation of the facility on 2/2/10 and staff interview, it was determined that the facility lacked a functional environment for surgical services. Findings include: 1. In OR #1: a. There was cracking observed under the mattress of the OR table. b. Rusting was observed at the base of the OR table. 2. In OR #2 chipping of paint was observed on the door jam. 3. This was confirmed by employee #2. Surveyor: 15481 Based on observation, it was determined the facility failed to ensure the room was equipped so that surgery can be performed in a manner that assures physical safety. Findings include:	Q 101		

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Q 101	Continued From page 7 1. On 2/28/10, at 10:10 AM, in the presence of Staff #1, in Operating Room #1, the base of the surgery table was rusted.	Q 101		
Q 221	416.50(a)(1) NOTICE OF RIGHTS The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands. This STANDARD is not met as evidenced by: Surveyor: 11609 Based on a review of 19 of 19 medical records and staff interview, it was determined tha ASC failed to notify patients, in advance to the date of the procedure, a notification of Patient Rights. Findings include: 1. Medical record documentation of the reception of a copy of Patient Rights in 19 of 19 patients, who had procedures performed, was dated the date of the procedure. These were records1 through 4, 6 through 11 and 13 through 21. 2. When employee #2 was questioned regarding the notification of rights he/she stated that Patient Rights statements are provided to patients on the day of the procedure.	Q 221		
Q 240	416.51 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:	Q 240		

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Q 240	Continued From page 8 Surveyor: 11609 Based on a review of information provided, lack of evidence and staff interview on 1/20 and 1/21/10, it was determined that the facility failed to establish an infection control program that seeks to minimize infections and communicable diseases. Findings include: 1. The facility failed to maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. (Cross refer Q 242) 2. The facility failed to make infection control an integral part of the quality assurance program. (Cross refer Q 244) 3. The facility failed to provide and implement a plan of action for preventing, identifying and managing infections. (Cross refer Q 245)	Q 240		
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Surveyor: 15481 Based on observation, it was determined the facility failed to provide a functional and sanitary environment. Findings include: 1. On 2/8/10, at 10:05 AM, in the presence of Staff #1, in Operating Room #1, a ceiling tile was	Q 241		

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Q 241	Continued From page 9 stained, in the west corner of the room. 2. On 2/8/10, at 10:20 AM, in the recovery room, a ceiling tile was stained, in the center of the room.	Q 241		
Q 242	416.51(b) INFECTION CONTROL PROGRAM 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: Surveyor: 11609 Based on a review of information provided, lack of evidence and staff interview, it was determined that the facility failed to maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. Findings include: 1. Even though the QA Plan provided states: "Any patient with fever, severe pain or very heavy vaginal bleeding... will always be referred to the operating physician or back up physician." No evidence of followup could be provided to survey staff on the days of the survey. 2. No evidence of patient phone call regarding infections, contacting physicians or patients in any way to trend infection rate or evidence of a formal	Q 242		

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Q 242	Continued From page 10 infection control program could be provided. 3. There was no documented evidence provided to indicate which nationally recognized standards that have been adopted by the ASC. 3. When requested at the entrance conference on 1/20/10 at approximately 10AM and again on 1/21/10 at approximately 1PM, the facility staff failed to provide evidence of a formalized infection control program. 4. This was confirmed by employees #1 and 2.	Q 242		
Q 244	416.51(b)(2) INFECTION CONTROL PROGRAM - QAPI [The program is -] An integral part of the ASC's quality assessment and performance improvement program This STANDARD is not met as evidenced by: Surveyor: 11609 Based on a review of information provided, lack of evidence and staff interview, it was determined that the facility failed to make infection control an integral part of the quality assurance program. Findings include: 1. Even though the QA Plan provided states: "Any patient with fever, severe pain or very heavy vaginal bleeding... will always be referred to the operating physician or back up physician."No evidence of followup could be provided to survey staff on the days of the survey. 2. No evidence of patient phone call regarding	Q 244		

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Q 244	Continued From page 11 infections, contacting physicians or patients in any way to trend infection rate or evidence of a formal infection control program could be provided. 3. When requested at the entrance conference on 1/20/10 at approximately 10AM and again on 1/21/10 at approximately 1PM, the facility staff failed to provide evidence of a formalized infection control program. 4. This was confirmed by employees #1 and 2.	Q 244		
Q 245	416.51(b)(3) INFECTION CONTROL PROGRAM - RESPONSIBITIES The program is - 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: Surveyor: 11609 Based on a review of information provided, lack of evidence and staff interview, it was determined that the facility failed to provide and implement a plan of action for preventing, identifying and managing infections. Findings include: 1. Even though the QA Plan provided states: "Any patient with fever, severe pain or very heavy vaginal bleeding... will always be referred to the operating physician or back up physician."No evidence of followup could be provided to survey staff on the days of the survey.	Q 245		

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Q 245	Continued From page 12 2. No evidence of patient phone call regarding infections, contacting physicians or patients in any way to trend infection rate or evidence of a formal infection control program could be provided. 3. When requested at the entrance conference on 1/20/10 at approximately 10AM and again on 1/21/10 at approximately 1PM, the facility staff failed to provide evidence of a formalized infection control program. 4. This was confirmed by employees #1 and 2.	Q 245		
Q 261	416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by: Surveyor: 11609 Based on a review of 19 of 19 medical records where patients had procedures performed and staff interview, it was determined that the ASC did not perform or obtain a comprehensive history & physical assessment of surgical patients performed by a physician. Findings include: Reference Policy entitled: "Medical History & Physical" states:	Q 261		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 261	Continued From page 13 "1. ALL patients are required to complete a medical history form prior to each procedure. 2. The RN will review the history during the History & Physical interview... 3. The RN will auscultate the lungs, check heart rate and rhythm and document. 4. In the event of a medical issue, the RN will discuss the case with doctor/anesthesiologist to determine whether or not the patient can complete the procedure." 1. In 21 of 21 medical records reviewed, the medical record lacked evidence of a history & physical performed by a physician.These were records 1 through 21. 2. This was confirmed by employees # 1 and 2.	Q 261		
Q 266	416.52(c)(2) DISCHARGE - ORDER [The ASC must -] Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy. This STANDARD is not met as evidenced by: Surveyor: 11609 Based on a review of 19 of 19 medical records where patients had procedures performed and staff interview, it was determined that physicians did not have a discharge order by a physician.	Q 266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001113	A. BUILDING _____ B. WING _____	02/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 266	Continued From page 14 Findings include: 1. In 19 of 19 medical records where patients had procedures performed, the section on the "PACU Record" entitled "Discharge Order" was blank .These were records 1 through 4, 6 through 11, and 13 through 21. 2. This was confirmed by employees 1 and 2.	Q 266		

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

June 23, 2010

Elaina Nardo
Administrator
Cherry Hill Womens Center
502 Kings Highway North
Cherry Hill, NJ 08034

Dear Ms. Nardo:

Thank you for the courtesy and cooperation extended during the Federal revisit survey of your facility on June 18, 2010 by surveyors from the Department of Health and Senior Services.

Enclosed is the CMS-2567B form which indicates that the Federal deficiencies, identified during the survey of February 8, 2010, were corrected.

Should you have questions, please do not hesitate to contact S. Lynn Sked, Supervising Health Care Evaluator, at (609) 292-9900.

Sincerely,

Christine Muszynski BSN, RN
for

S. Lynn Sked B.S., R.N., CPM
Supervising Health Care Evaluator
Assessment and Survey

Encl.

New Jersey State Department of Health
Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility	Date	Case Number
Cherry Hill Womens Center	10/20/14	NJ6007521 9
Administrator/CEO	**Type Facility**	**Time Required to Correct**
Jenifer Groves	ASC	
Type of Survey	**Matter Under Consideration**	
☐ Revisit ☒ Investigation ☐ For Immediate Attention ☒ Complaint ☐ Surveillance		

Census/Bed Capacity	Units Toured	Charts Reviewed	Number of Patients Affected

Facility Representatives/Titles	Remarks/Issues
Jenifer Groves / Administrator	Not Valid

When this form is utilized for a survey, the following needs to be addressed:
This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to $5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.

Signature of Responsible Official	Signature of Investigator
Sheila Brown	Louise Steska

NARRATIVE

An unannounced visit was made to this facility to investigate a complaint. The complaint was discussed with facility representative (s). The investigation included review of documentation and staff interviews. Preliminary concerns regarding the investigation were discussed with the facility representative (s). After supervisory review, deficiencies may follow.

ENTERED ON 10/29/14
BY.

Americans United for Life

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

COPY

November 10, 2014

Jenifer Groves
Administrator
Cherry Hill Womens Center
502 Kings Highway North
Cherry Hill, NJ 08034

Re: Complaint # NJ00075219

Dear Ms. Groves:

Thank you for the courtesy and cooperation extended during the Complaint Investigation Survey conducted October 20, 2014 by a surveyor from the Department of Health.

Enclosed is a copy of the State deficiency form indicating that no deficiencies were found during the survey. Please sign the first page of the State deficiency form and return the original copy to my attention. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me, at (609) 292-9900.

Sincerely,

Louise A. Steska

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse
Assessment and Survey

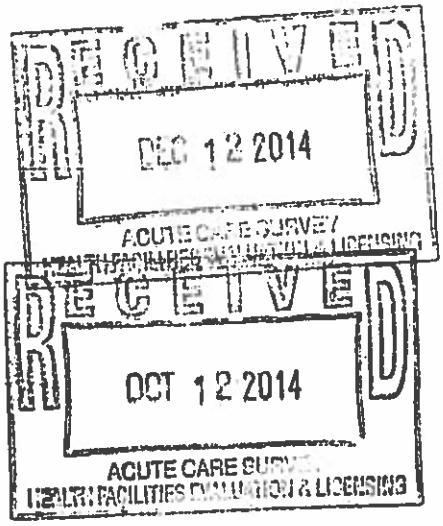
Encl./LS

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	C 10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS Cherry Hill Women's Center is in substantial compliance with the requirements of N.J.A.C. 8:43A Licensing Standards for Ambulatory Care Facilities for this complaint visit only. Complaint #: NJ00075219	A 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

11/21/14

STATE FORM 6899 VIMP11 If continuation sheet 1 of 1

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO

MARY E. O'DOWD, M.P.H.
Commissioner

November 21, 2014

[redacted]

Re: Cherry Hill Womens Center
Complaint # NJ00075219

[redacted]

A representative from Health Facility and Field Operations conducted an investigation of your complaint concerning quality of care issues at Cherry Hill Womens Center. The South Jersey Womens Center was not investigated. It is a registered facility; it is not licensed by the New Jersey Department of Health. Therefore, Health Facility and Field Operations has no jurisdiction over the South Jersey Womens Center.

The investigation of Cherry Hill Womens Center included a review of facility documents and staff interview.

After evaluating this information, the surveyor was unable to identify a citable deficient practice related to your concerns based on State regulations. The results of this investigation were presented to and reviewed with administrative staff for continued monitoring of patient care.

Thank you for forwarding your concerns to this office.

Health Facility Survey and Field Operations

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

November 21, 2014

[redacted]

Re: Cherry Hill Womens Center
Complaint # NJ00075219

Dear [redacted]

A representative from Health Facility and Field Operations conducted an investigation of your complaint concerning quality of care issues at Cherry Hill Womens Center. The South Jersey Womens Center was not investigated. It is a registered facility; it is not licensed by the New Jersey Department of Health. Therefore, Health Facility and Field Operations has no jurisdiction over the South Jersey Womens Center.

The investigation of Cherry Hill Womens Center included a review of facility documents and staff interview.

After evaluating this information, the surveyor was unable to identify a citable deficient practice related to your concerns based on State regulations. The results of this investigation were presented to and reviewed with administrative staff for continued monitoring of patient care.

Thank you for forwarding your concerns to this office.

Health Facility Survey and Field Operations

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

September 19, 2014

[redacted]

Dear [redacted]

Your email to Commissioner Mary E. O'Dowd has been referred to me for response.

An investigation will be conducted by Department staff. At its conclusion, you will be notified in writing of the results of the investigation.

In the interim, if you have any additional concerns, please contact the Complaint Program at 609-292-9900.

Sincerely,

Alison Gibson, RN, MA, MPA
Assistant Commissioner
Health Facility Survey & Field Operations

IQ802890
C# 75219

Americans United for Life

New Jersey State Department of Health
Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility	Date	Case Number
Cherry Hill Women's Center	5/8/14	NJ00072404
Administrator/CEO	**Type Facility**	**Time Required to Correct**
Jenifer Graves / Administrator	ASC	
Type of Survey	**Matter Under Consideration**	
☐ Revisit ☒ Investigation ☐ For Immediate Attention ☒ Complaint ☐ Surveillance		
Census/Bed Capacity	**Units Toured**	**Charts Reviewed**	**Number of Patients Affected**
N/A	N/A	1	
Facility Representatives/Titles	**Remarks/Issues**	
Jenifer Graves / Administrator	Not Valid	

When this form is utilized for a survey, the following needs to be addressed:
This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to $5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.

Signature of Responsible Official	Signature of Investigator
	Louise Stoska

NARRATIVE

An unannounced visit was made to this facility to investigate a complaint. The complaint was discussed with facility representative (s). The investigation included review of documentation and staff interviews. Preliminary concerns regarding the investigation were discussed with the facility representative (s). After supervisory review, deficiencies may follow.

ENTERED ON: 8/29/14
BY:

Americans United for Life

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

COPY

May 28, 2014

Jenifer Groves
Administrator
Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034

Re: Complaint #: NJ00072404

Dear Ms. Groves:

Thank you for the courtesy and cooperation extended during the Complaint Investigation Survey conducted on May 8, 2014 by a surveyor from the Department of Health.

Enclosed is a copy of the State deficiency form indicating that no deficiencies were found during the survey. Please sign the first page of the State deficiency form and return the original copy to my attention. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me at (609) 292-9900.

Sincerely,

Louise A. Steska

Louise A. Steska, MSN, RN
Health Care Services Evaluator Nurse
Assessment and Survey

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	C 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	8:43A INITIAL COMMENTS Cherry Hill Women's Center is in substantial compliance with the requirements of N.J.A.C. 8:43A Licensing Standards for Ambulatory Care Facilities for this complaint visit only. Complaint #: NJ00072404	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE EXECUTIVE DIRECTOR (X6) DATE

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	C 05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	8:43A INITIAL COMMENTS Cherry Hill Women's Center is in substantial compliance with the requirements of N.J.A.C. 8:43A Licensing Standards for Ambulatory Care Facilities for this complaint visit only. Complaint #: NJ00072404	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

New Jersey State Department of Health
Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility	Date	Case Number
Cherry Hill Women's Center	2/20/14	NJ000701153
Administrator/CEO	**Type Facility**	**Time Required to Correct**
Jenifer Graves/Administrator	ASC	
Type of Survey ☐ Revisit ☒ Complaint ☒ Investigation ☐ Surveillance ☐ For Immediate Attention	**Matter Under Consideration**	
Census/Bed Capacity	**Units Toured**	**Charts Reviewed** / **Number of Patients Affected**
N/A	ASC	
Facility Representatives/Titles	**Remarks/Issues**	
Luz Caraballo/DON Susan Sperry/Director of Patient Services	Unsubstantiated	

When this form is utilized for a survey, the following needs to be addressed:
This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to $5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.

Signature of Responsible Official	Signature of Investigator
Luz Caraballo	Louise Steska

NARRATIVE

An unannounced visit was made to this facility to investigate a complaint. The complaint was discussed with facility representative (s). The investigation included review of documentation and staff interviews. Preliminary concerns regarding the investigation were discussed with the facility representative (s). After supervisory review, deficiencies may follow.

ENTERED ON: 6/2014
BY:

COPY

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

March 11, 2014

Jenifer Groves
Administrator
Cherry Hill Womens Center
502 Kings Highway North
Cherry Hill, NJ 08034

Dear Ms. Groves:

Thank you for the courtesy and cooperation extended during the Complaint Survey at your facility on February 20, 2014 by a surveyor from the Department of Health.

Enclosed is a copy of the visit report which indicates that no deficiencies were found during the survey. Please date and sign on the bottom of the form, make a copy for your records and return the signed originals to our office, to the attention of Louise Steska, Health Care Services Evaluator/Nurse.

Should you have questions concerning this letter, please do not hesitate to contact me at (609) 292-9900.

Sincerely,

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse
Assessment and Survey

Encl.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001113	A. BUILDING _____ B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS Cherry Hill Women's Center is in substantial compliance with the requirements of 42 CFR Part 416 Subpart C requirements for Ambulatory Surgical Centers for this complaint visit only. Complaint #: NJ00070153	Q 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CHWC DIRECTOR (X6) DATE: 3/6/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 358
TRENTON, N.J. 08625-0358
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

CHRISTOPHER R. RINN
Acting Commissioner

December 19, 2017

BY FACSIMILE AND FIRST-CLASS MAIL

Jennifer Groves, Administrator
Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034

RE: Revised Clarification of Curtailment of All Surgical Procedures Issued on December 7, 2017 and Lifted on December 8, 2017
Facility ID# NJ310001113

Dear Ms. Groves,

This revised letter clarifies the reason for the curtailment of all surgical procedures that was imposed on December 7, 2017 and lifted on December 8, 2017, and replaces and supersedes the letter dated December 18, 2017. The curtailment was imposed on December 7, 2017 when surveyors from Health Facilities Survey and Field Operations ("Survey"), conducting a State re-licensure and re-certification survey, identified a serious infection control issue due to the lack of on-site availability of equipment sterilization manuals. The next day, Survey found that the facility had corrected this deficiency, and therefore the curtailment was lifted on the morning of December 8, 2017.

Please call (609) 984-8128 if you have any questions regarding this clarification of the curtailment imposed on December 7, 2017 and lifted on December 8, 2017.

Sincerely,

Gene Rosenblum, Director
Program Compliance and Health Care Financing
Division of Certificate of Need and Licensing
New Jersey Department of Health

GR
Control # AX17034
cc: Alison Gibson (By Electronic Mail)
Susan J. Dougherty (By Electronic Mail)
Joy L. Lindo (By Electronic Mail)
Stefanie Mozgai (By Electronic Mail)

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 358
TRENTON, N.J. 08625-0358
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

CHRISTOPHER R. RINN
Acting Commissioner

December 18, 2017

BY FACSIMILE AND FIRST-CLASS MAIL

Jennifer Groves, Administrator
Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034

RE: Clarification of Curtailment of All Surgical Procedures Issued on December 7, 2017 and Lifted on December 8, 2017
Facility ID# NJ310001113

Dear Ms. Groves,

This letter clarifies the reason for the curtailment of all surgical procedures that was imposed on December 7, 2017 and lifted on December 8, 2017. The curtailment was imposed on December 7, 2017 when surveyors from the Health Facilities Survey and Field Operations ("Survey"), conducting a State complaint survey, identified a serious infection control issue due to the lack of on-site availability of equipment sterilization manuals. The next day, Survey found that the facility had corrected this deficiency, and therefore the curtailment was lifted on the morning of December 8, 2017.

Please call (609) 984-8128 if you have any questions regarding this clarification of the curtailment imposed on December 7, 2017 and lifted on December 8, 2017.

Sincerely,

Gene Rosenblum, Director
Program Compliance and Health Care Financing
Division of Certificate of Need and Licensing
New Jersey Department of Health

GR
December 18, 2017
Control # AX17034
cc: Alison Gibson (By Electronic Mail)
Susan J. Dougherty (By Electronic Mail)
Joy L. Lindo (By Electronic Mail)
Stefanie Mozgai (By Electronic Mail)

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 358
TRENTON, N.J. 08625-0358
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

CHRISTOPHER R. RINN
Acting Commissioner

December 8, 2017

Jennifer Groves, Administrator
Cherry Hill Women's Center
502 Kings Highway North
Cherry Hill, NJ 08034

VIA FACSIMILE (856) 667-8304 & Regular Mail

RE: Lifting of Curtailment of All Surgical Procedures Facility ID# NJ310001113

Dear Ms. Groves,

As you were advised today by telephone by members of my staff in the Office of Program Compliance, the Department has lifted the curtailment of all surgical procedures that was imposed by Health Facilities Survey and Field Operations during a State Licensure Survey on December 7, 2017. The curtailment was imposed due to the lack of on-site availability of equipment sterilization manuals.

The curtailment is lifted effective immediately. This action is taken based on a recommendation from Health Facilities Survey and Field Operations and is based on receipt and implementation of an acceptable Plan of Correction.

Please call (609) 984-8128 if you have any questions regarding the lifting of the curtailment.

Sincerely,

Gene Rosenblum, Director
Program Compliance and Health Care Financing
Division of Certificate of Need and Licensing
New Jersey Department of Health

GR:jn
December 8, 2017
Control # AX17034
C: Susan Dougherty, Joy Lindo, Stefanie Mozgai

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 358
TRENTON, N.J. 08625-0358
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

CHRISTOPHER R. RINN
Acting Commissioner

December 7, 2017

Jennifer Groves, Administrator
Cherry Hill Woman's Center
502 Kings Highway North
Cherry Hill, NJ 08034

VIA FACSIMILE (856) 667-8304 & Regular Mail

RE: Curtailment of All Surgical Procedures Facility ID# NJ310001113

Dear Ms. Groves,

This will confirm that an order to curtail all surgery procedures was issued by Health Facilities Survey and Field Operations during a State Licensure Survey on December 7, 2017.

This action is taken in accordance with N.J.A.C. 8:43E-2.4, N.J.A.C. 8:43E-3.6, N.J.S.A. 26:2H-13 and N.J.S.A. 26:2H-14, in response to serious infection control issues identified during a state licensure survey on December 7, 2017.

Specifically, the curtailment applies to all surgical procedures. Please be advised that only after the Department receives confirmation from the Health Facility Survey and Field Operations staff that the facility has provided an acceptable Plan of Correction will the Department consider lifting the surgical procedures curtailment.

FORMAL HEARING

Cherry Hill Women's Center, is entitled to a prompt formal hearing at the Office of Administrative Law (OAL) to challenge this curtailment pursuant to N.J.S.A. 26:2H-13. Cherry Hill Women's Center, may request a hearing to challenge either the factual survey findings or the curtailment, or both. Please note that facility rights to IDR (Informal Dispute Resolution) and administrative law hearings are not mutually exclusive and both may be invoked simultaneously.

Cherry Hill Women's Center, must advise this Department within 30 days of receipt of this letter to request an OAL hearing regarding this matter.

Please forward your OAL hearing request to:

Attention: OAL Hearing Requests

Office of Legal and Regulatory Compliance, Room 805
New Jersey State Department of Health
P.O. Box 360
Trenton, New Jersey 08625-0360

Corporations are not permitted to represent themselves in OAL proceedings. Therefore, if Cherry Hill Women's Center, is owned by a corporation, representation by counsel is required.

In the event of an OAL hearing regarding this matter, Cherry Hill Womens Center, is further required to submit a written response to each and every charge as specified in this order, which shall accompany your written request for a hearing.

In addition, N.J.A.C. 8:43E-3.4(a)2 provides for a penalty of $250 per day for each patient admitted in violation of this curtailment order.

Please call at (609) 633-9034 if you have any questions regarding this curtailment.

Sincerely,

Gene Rosenblum, Director
Office of Program Compliance
Certificate of Need and Licensing

GR:jn
December 7, 2017
Control # AX17034
C: Susan Dougherty, Joy Lindo, Stefanie Mozgai

Transaction Report

For: METROPOLITAN SURGICAL ASSOCIATION - NJ31C0001006

Certification ID: RL8Z **Provider #:** 31C0001006 **Survey Date:** 01/25/2011

Printed: 09/16/2011

601
31C0001
1/25/11

Transaction Number: 310003852383 **On:** 06/10/2011 **By:** STESKA, LOUISE A.
Tran Type: 03 - ADD **Status:** -1 - Failed Prevalidation in ASPEN

Message Detail:
2101-2786E: CMS-2786E STATUS COMPL (K9) MUST BE A OR B.
<0172R-1539: CMS-1539 THE DETERMINATION APPROVAL DATE (L33) IS REQUIRED.>
0257-2567: CMS-2567 ADM SIGNOFF DATE (X6) IS REQUIRED WHEN DEFICIENCIES ARE PRESENT ON THE LSC SURVEY

Transaction Number: 310003888211 **On:** 07/12/2011 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

Americans United for Life

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RL8Z

Facility ID: NJ31C0001006

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 31C0001006

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY (L3) METROPOLITAN SURGICAL ASSOCIATION (L4) 40 ENGLE STREET (L5) ENGLEWOOD, NJ (L6) 07631

4. TYPE OF ACTION: 2 (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY 01/25/2011 (L34)

8. ACCREDITATION STATUS: 0 (L10)
0 UNACCREDITED 1 TJC 2 AAAHC 3 AAAASF

7. PROVIDER/SUPPLIER CATEGORY 15 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 IMR 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) 06/30

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
__1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)

And/Or Approved Waivers Of The Following Requirements:
__2. Technical Personnel
__3. 24 Hour RN
__4. 7-Day RN (Rural SNF)
__5. Life Safety Code
__6. Scope of Services Limit
__7. Medical Director
__8. Patient Room Size
__9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE L Steska Date: 06/10/2011 (L19)

18. STATE SURVEY AGENCY APPROVAL L Steska Date: 06/10/2011 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY (L21)
_X_ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION 10/29/1985 (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. 00805 (L31)

30. REMARKS

1. RO RECEIPT OF CMS-1539 06/10/2011 (L32)

32. DETERMINATION OF APPROVAL DATE 07/12/2011 (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RL8Z

Facility ID: NJ31C000100

C&T REMARKS - CMS 1539 FORM

On 1/25/11, a federal recertification survey took place that resulted in a condition level deficiency. The Patient Rights condition was found to be out of compliance.

On 6/9/11, a federal revisit was conducted. The Patient Rights condition was found to be back in compliance.

Americans United for Life

)RM CMS-1539 (7-84) (Destroy Prior Editions)

020499

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AMBULATORY SURGICAL CENTER REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

FORM APPROVED
OMB NO 0938-0266

(Please see statement on reverse and read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions of Coverage are met. Assistance in completing the form is available from the State agency.

Answer all questions as of the currrent date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Medicare Supplier Number - Insert the facility's six-digit supplier number. Leave blank on initial requests for certification.

Related Provider Number - Complete this block when a facility is participating under more than one provider number, such as a facility also participating as a hospital. The number in this block for each related provider will be the provider number of the highest level of care.

NOTE: If an ASC is operated by a hospital, has a Distinct Part SNF, ICF and ICF/MR, the related provided number field on the application for each provider (including the hospital) will have the hospital provider number.

State/County and State Region Codes - Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Item III - If a service is provided directly by the facility, place a '1' in the appropriate block. If a service is provided through an outside source (i.e., by contract or referral), place a '2' in the appropriate block.

Item IV - 'X' the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties).

Medicare Supplier Number: 305445 AS1	Related Provider Number: 2979802 AS2	State/County Code: 013/002 AS3	State Region Code: AS4
I IDENTIFYING INFORMATION	Name of Facility: METROPOLITAN SURGICAL ASSOC		Fiscal Year Ending Date: 06/30 AS5
	City, County, and State: ENGLEWOOD, N.J	Street Address: 40 ENGLE ST	
		Zip Code: 07631	Telephone No. (Include Area Code): (201) 567-0522 AS6
II TYPE OF CONTROL (x one box) AS7	1. ☐ Proprietary CORP. (SUB-S)	2. ☐ Non-Profit	3. ☐ Government
III ANCILLARY SERVICES (Place '1' or '2' in blocks) AS8	1. 2 Laboratory	2. 2 Radiology	3. 2 EKG 4. 2 Pharmacy
IV SURGICAL SPECIALTIES (X appropriate blocks) AS9	1. ☐ Cardiovascular 2. ☐ Foot 3. ☐ General 4. ☐ Neurological 5. ☒ Obstetrics/Gynecology	6. ☐ Ophthalmology 7. ☐ Oral 8. ☐ Orthopedic 9. ☐ Otolaryngology 10. ☐ Plastic	11. ☐ Thoracic 12. ☐ Urology 13. ☐ Other (Specify) _____
V FACILITY CHARACTERISTICS	1. Number of Operating Rooms: 4 AS10		2. Date Center Began Providing Services: 5/5/80 AS11

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Signature of Authorized Official (Sign in ink)	Title	Date
	Chairman of Board	01-20-2011 AS12

Form CMS-377 (01/97) [illegible] 10/2004)

Metropolitan Medical Associates

Fax

OCT 5 – 2016

Janet Diaz — From: Susan Martinelli

Fax: 609-826-3745 **Date:** 10/5/16

0000000

Phone: **Pages:2**

Re:

Urgent ☐ **For Review**

The document in this facsimile transmission may contain confidential health information that is privileged and legally protected from disclosure by law, the Health Insurance Portability and Accountability Act (HIPAA). You are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon or otherwise using the information contained in this facsimile is strictly prohibited. If you have received this information in error, please notify the sender immediately at Metropolitan Surgical Associates and destroy this facsimile.

Subject/Notes:

Re: AAAASF

License 10263

Americans United for Life

/1 # 1234

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

Americans United for Life

presents this certificate to

Metropolitan Surgical Associates, Inc.

for having met the standards of a CLASS C–M ambulatory surgery facility in which minor or major surgical procedures are performed under intravenous or parenteral sedation (including Propofol), analgesia, or dissociative drugs.

AAAASF President
Foad Nahai, MD Foad Nahai

Secretary/Treasurer
Lawrence S. Reed, MD Lawrence S Reed

The Gold Standard ASF In Accreditation

Certified from 4/13/2016 to 4/13/2017

Certification Number 4303

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

June 10, 2011

Susan Martinelli
Administrator
Metropolitan Surgical Association
40 Engle Street
Englewood, NJ 07631

Dear Ms. Martinelli:

Thank you for the courtesy and cooperation extended during the Federal revisit survey of your facility on June 9, 2011 by surveyors from the Department of Health and Senior Services.

Enclosed is the CMS-2567B form which indicates that the Federal deficiencies, identified during the survey of January 25, 2011 were corrected.

Should you have questions, please do not hesitate to contact Christine Muszynski, Supervisor of Inspections, at (609) 292-9900.

Sincerely,

Louise A. Steska

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse
Assessment and Survey

Encl.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
31C0001006	A. Building B. Wing	6/9/2011

Name of Facility	Street Address, City, State, Zip Code
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Q0103 Reg. # 416.44(a)(3) LSC	Correction Completed 06/09/2011	ID Prefix Q0104 Reg. # 416.44(b) LSC	Correction Completed 06/09/2011	ID Prefix Q0105 Reg. # 416.44(c) LSC	Correction Completed 06/09/2011
ID Prefix Q0162 Reg. # 416.47(b) LSC	Correction Completed 06/09/2011	ID Prefix Q0181 Reg. # 416.48(a) LSC	Correction Completed 06/09/2011	ID Prefix Q0220 Reg. # 416.50 LSC	Correction Completed 06/09/2011
ID Prefix Q0221 Reg. # 416.50(a)(1) LSC	Correction Completed 06/09/2011	ID Prefix Q0223 Reg. # 416.50(a)(1)(ii) LSC	Correction Completed 06/09/2011	ID Prefix Q0224 Reg. # 416.50(a)(2) LSC	Correction Completed 06/09/2011
ID Prefix Q0229 Reg. # 416.50(b)(1)(iii) LSC	Correction Completed 06/09/2011	ID Prefix Q0232 Reg. # 416.50(c)(2) LSC	Correction Completed 06/09/2011	ID Prefix Q0242 Reg. # 416.51(b) LSC	Correction Completed 06/09/2011
ID Prefix Q0261 Reg. # 416.52(a)(1) LSC	Correction Completed 06/09/2011	ID Prefix Q0267 Reg. # 416.52(c)(3) LSC	Correction Completed 06/09/2011	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Louise A. Steska	Date: 6/9/11
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/25/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES (NO)

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering a
maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of informati
including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperw
Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 31C0001006	**(Y2) Multiple Construction** A. Building B. Wing 01 - MAIN BUILDING 01	**(Y3) Date of Revisit** 6/9/2011
Name of Facility METROPOLITAN SURGICAL ASSOCIATION	**Street Address, City, State, Zip Code** 40 ENGLE STREET ENGLEWOOD, NJ 07631	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should b
fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix ____ Reg. # 416.44(b)(1) LSC K0029	Correction Completed 06/09/2011	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed

Reviewed By ____ State Agency	Reviewed By	Date:	Signature of Surveyor: Louise A Stesko	Date: 6/9/11
Reviewed By ____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/20/2011	____	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES [✓ NO]	

Form CMS - 2567B (9-92)

Event ID: RL8Z22

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

CONSENT FOR OBSERVATION IN THE AMBULATORY SURGERY CENTER

BENEFICIARY NAME: Eltaneiliya GEORGE

ADDRESS: 243 18th Avenue Paterson, NJ 07504

By this document, I hereby consent to have State/Federal health survey personnel observe care provided me at the ASC to ensure that the Federal requirements are met and to assist in evaluating the effectiveness and quality of care that I receive from the

_____
(Name of Ambulatory Surgery Center)

I understand that consent for this visit is voluntary and none of my rights to confidentiality or privacy are waived by my consent. I have been told and I understand that refusal to consent will have no effect on the level or nature of Health Insurance benefits to which I am entitled.

Eltaneiliya George
BENEFICIARY OR REPRESENTATIVE OF THE BENEFICIARY SIGNATURE

6/9/11
DATE

Americans United for Life

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

February 14, 2011

Susan Martinelli
Administrator
Metropolitan Surgical Association
40 Engle Street
Englewood, NJ 07631

Dear Ms. Martinelli:

Thank you for the courtesy and cooperation extended during the Federal Health Survey of your facility on January 20 , 2011 and January 25, 2011 by surveyors from the Department of Health and Senior Services.

As a result of observation and evaluation certain Federal deficiencies were evident. The deficiencies identified during this visit have resulted in the determination that your facility is not in compliance with the following Medicare Condition for Coverage:

416.50 Patient Rights.

A complete listing of the specific deficiencies identified by the surveyors is enclosed. These Federal deficiencies were discussed with you and/or your staff during the visit and are listed on the left side of the enclosed CMS-2567 form. Please reply to each deficiency, on an item by item basis, with your Plan of Correction (PoC) and the date you expect the correction to be completed.

The PoC should address the systemic problem that resulted in the deficiency. Please number your responses to correspond with the number of each deficiency statement.

The PoC must include:

1. How the corrective action will be accomplished for those patients found to have been affected by the deficient practice.

2. How the facility will identify other patients having the potential to be affected by the same deficient practice.

3. What measures or systemic changes will be instituted to ensure that the deficient practice will not recur.

4. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The plan must identify the individual responsible for monitoring, how and when the monioring will be conducted, and to whom the results will be reported.

5. The date on which each item addressed on the PoC will be corrected.

Please submit the PoC to the Department of Health and Senior Services Health Facilities Evaluation and Licensing, 120 South Stockton Street, Trenton, NJ 08611.

Sign and date the first page of the CMS-2567 form and return the form with your PoC to the attention of Christine Muszynski, Supervisor of Inspections. Please retain a copy of each page for your records. All responses must be returned within 10 calendar days of receipt of this letter.

It is important to return the completed forms promptly. Any delay or lack of response may jeopardize the certification status of your facility. If you have any questions concerning this report, please contact Christine Muszynski at (609) 292-9900.

Sincerely,

Christine Muszynski BSN, RN
for

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse
Assessment and Survey

Encl.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS This is a federal recertification survey. Medical records reviewed: 20 Staff interviews / staff files reviewed: 17	Q 000		
Q 103	416.44(a)(3) IDENTIFICATION, PREVENTION, AND MAINTENANCE [The ASC must provide a functional and sanitary environment for the provision of surgical services.] The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities. This STANDARD is not met as evidenced by: Based on staff interview and a review of documents on 1/20/11, it was determined that the facility failed to follow up on each patient after discharge, in order to identify and track infections associated with the patient's stay in the ASC. Findings include: 1. When asked on 1/20/11 at 11:08 AM, about how the facility monitors and tracks patient infections, Staff #8 stated the following: "Not all of the patients have primary physicians, but if the patient returns to the facility for their two week follow up visit, the facility staff will complete an infection control survey form. If the patient has a primary physician, a letter is sent to the physician asking about infections. A general letter (but not a list of patients seen) is also sent to Planned Parenthood every six months."	Q 103		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 104	Continued From page 3 (2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms (C) The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other; (D) Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet; (E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code; (F) The dispensers shall not be installed over or directly adjacent to an ignition source; (G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and (v) The dispensers are maintained in accordance with dispenser manufacturer guidelines. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to meet the provisions of the Life Safety Code concerning Alcohol Based Hand Rub dispenser (ABHR) locations above ignition sources. Findings include: 1. On 1/20/11, at 11:15 AM, in the presence of Staff #9, in the pre-op nurse station and PACU	Q 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 104	Continued From page 4 bay #11, ABHRs were located above electrical boxes, which can be an ignition source.	Q 104		
Q 105	416.44(c) EMERGENCY EQUIPMENT Emergency equipment available to the operating rooms must include at least the following: (1) Emergency call system. (2) Oxygen. (3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. (4) Cardiac defibrillator. (5) Cardiac monitoring equipment. (6) Tracheostomy set. (7) Laryngoscopes and endotracheal tubes. (8) Suction equipment. (9) Emergency medical equipment and supplies specified by the medical staff. This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 1/20/11, it was determined that the facility failed to ensure that there was emergency suction equipment available to the operating rooms. Findings include: 1. Upon interview at 11:00 AM on 1/20/11, Staff #1 stated that the only suction equipment available were the suction machines in each operating room. This suction equipment is used during the procedure and is not available as emergency suction equipment.	Q 105		
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for	Q 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 162	Continued From page 5 each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. This STANDARD is not met as evidenced by: A. Based on a review of the medical records of three patients (#1, #2, and #19) who underwent a surgical procedure at the facility it was determined that a properly executed informed patient consent was not obtained prior to the performance of the surgery. Findings include: 1. Review of an INFORMED CONSENT FOR CERVICAL DILATORS (SAME DAY) form dated [redacted] in the medical record of Patient #2 indicated that the 'Patient signature' section did not contain the signature of the patient. The form did not have a section to indicate the name or signature of the physican who obtained the informed consent. The only other signature line	Q 162		

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Q 162	Continued From page 6 on the form is for 'Witness signature." A dilator was used on the patient even though there was no documentation that she consented. 2. Review of INFORMED CONSENT FOR CERVICAL DILATORS (SAME DAY) forms in the medical records of Patient #1 and #19 did not indicate that a physician obtained informed consent. 3. Administrator #1, on the morning of January 20, 2011, stated that consent should have been obtained by the facility counselor. She further indicated that the counselor was not a physican. The 'counselor' was not qualified to obtain informed consent for use of a medical device. B. Based on a review of the medical records of five patients it was determined that not all medical records included patient identification. Findings include: 1. Review of two ENGLEWOOD PHYSICAN'S GROUP assessment forms, one dated [redacted] and one dated [redacted] in the medical record of Patient #19 did not include the name of the patient on the form. The 'NAME (Patient's)' section at the top of the form did not indicate an entry. Additionally, an INFORMED CONSENT FOR CERVICAL DILATORS (SAME DAY) form dated [redacted] did not contain the name of the patient. 2. Review of the medical records of Patients #1, #15, #16, and #19 indicated 'Size Check Sheets.' None of the completed forms indicated the names of the patients.	Q 162		

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Q 162	Continued From page 7 3. Not all of the pages in each medical record indicated at least one patient identifyer on each page. If a sheet without a patient identifyer were to become seperated from the medical record cover, it would be difficult, if not impossible, to determine which patient's medical record it belonged in. C. Based on observation on [redacted] a review of documents, and medical record review of #20, it was determined that the facility failed to ensure an accurate medical record. Findings include: Reference: The facility policy titled, "Informed Consent Policy," states "...The evaluating physician, treating physician and counselor together shall obtain appropriate informed consent from patients...before starting any treatment or activity that presents a risk to the patient's health or safety...Treatments and activities requiring informed consent include...Anesthesia...All operative procedures...Non-surgical Abortion..." 1. On [redacted], this surveyor followed Patient #20 throughout her stay at the ASC. a. Medical record #20 contains a document titled, "Counseling," which contains check marks in boxes next to the words, "The available methods anesthesia (sic) and their risks and benefits have been reviewed," and "Birth Control Methods have been reviewed". This document is signed by Staff #12.	Q 162		

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Q 162	Continued From page 8 (i) On [redacted] Patient #20 met with Staff #12, the facility counselor. During this meeting, Staff #12 gave Patient #20 the facility "Consent for Termination of Pregnancy and Anesthesia" to sign. This consent includes risks of anesthesia and the procedure. However, Staff #12 failed to review the available methods of anesthesia and their risks and benefits and failed to review birth control methods with Patient #20. b. The "Consent for Termination of Pregnancy and Anesthesia" in medical record #20 dated [redacted] contains signatures on the lines titled, "Evaluating Physician," and "Treating Physician." However, the evaluating physician and the treating physician failed to inform Patient #20 of the anesthesia risks and benefits or the risks and benefits of the surgical procedure, prior to the procedure on 1/20/11 at 1:30 PM.	Q 162		
Q 181	416.48(a) ADMINISTRATION OF DRUGS 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 a review of medical records and staff interview, it was determined that the facility failed to ensure that a physician order was in place to discontinue the intravenous solution and/or the hep lock from the patient. Findings include: 1. In 20 of 20 medical records reviewed on	Q 181		

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Q 181	Continued From page 9 1/20/11 and 1/25/11, there was no evidence that a physician order was written to discontinue the intravenous and / or hep lock from the patient. 2. This was confirmed by Staff #9 and Staff #15.	Q 181		
Q 220	416.50 PATIENT RIGHTS The ASC must inform the patient or the patient's representative of the patient's rights, and must protect and promote the exercise of such rights. This CONDITION is not met as evidenced by: Based on observation, document review, patient interview and medical record review, it was determined that the facility failed to promote and exercise patient rights. Findings include: 1. The facility failed to provide patients with verbal and written notice of the facility's patient rights, in advance of the date of the procedure. (Cross refer Q221). 2. The facility failed to provide patients with disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. (Cross refer Q223). 3. The facility failed to provide patients with information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. (Cross refer Q224). 4. The facility failed to fully inform patients about treatment options and failed to ensure that	Q 220		

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Q 220	Continued From page 10 patients are given the information needed in order to make an informed decision regarding care. (Cross refer Q229). 5. The facility failed to ensure that patients are treated with respect and dignity. (Cross refer Q232).	Q 220		
Q 221	416.50(a)(1) NOTICE OF RIGHTS The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands. This STANDARD is not met as evidenced by: Based on observation, patient interview and medical record review on 1/20/11, it was determined that the facility failed to provide patients with verbal and written notice of the facility's patient rights, in advance of the date of the procedure. Finding include: 1. On [redacted], Patient #20 stated that she was not informed of nor did she receive a copy of the facility's patient rights prior to [redacted]. 2. Medical Record #1 contained documentation that Patient #1, whose procedure was on [redacted], signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted], rather than in advance of the date of the procedure.	Q 221		

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Q 221	Continued From page 11 3. Medical Record #3 contained documentation that Patient #3, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted] rather than in advance of the date of the procedure. 4. Medical Record #4 contained documentation that Patient #4, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted] rather than in advance of the date of the procedure. 5. Medical Record #6 contained documentation that Patient #6, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted] rather than in advance of the date of the procedure. 6. Medical Record #8 contained documentation that Patient #8, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted], rather than in advance of the date of the procedure.	Q 221		
Q 223	416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure. This STANDARD is not met as evidenced by:	Q 223		

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Q 223	Continued From page 12 A. Based on observation and patient interview on [redacted] it was determined that the facility failed to provide Patient #20 with disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. Findings include: On [redacted], Patient #20 stated that she did not receive a copy of the facility's disclosure of information in writing regarding physician financial interests or ownership in the ASC prior to the visit scheduled for [redacted] While the facility counselor, Staff #12 interviewed Patient #20 on [redacted], Staff #12 advised Patient #20 of the physician ownership of the ASC, just prior to Patient #20's procedure on [redacted], rather than in advance of the date of the procedure. B. Based on medical record review and staff interview, it was determined that the facility failed to provide the patients with disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. Findings include: 1. On 1/20/11 and 1/25/11, during a review of medical records #1 through #19, the facility was unable to provide evidence that the patients received disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. 2. This was confirmed by Staff #15.	Q 223		

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Q 224	416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements: (i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms. (ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by: A. Based on observation and patient interview on [redacted] it was determined that the facility failed to provide Patient #20 with information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. Findings include: On [redacted] Patient #20 stated that she did not receive information about the facility's policies on advance directives prior to the visit scheduled for [redacted]. While the facility counselor, Staff #12 interviewed Patient #20 on [redacted], Staff #12 asked Patient #20 about a "Living Will" just prior to Patient #20's procedure on [redacted] rather than in advance of the date of the procedure.	Q 224		

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Q 224	Continued From page 14 B. Based on medical record review and staff interview, it was determined that the facility failed to provide the patients with information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. Findings include: 1. On 1/20/11 and 1/25/11, in a review of medical records #1 through #19, the facility was unable to provide evidence that the patients received information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. 2. This was confirmed by Staff #15.	Q 224		
Q 229	416.50(b)(1)(iii) EXERCISE OF RIGHTS - INFORMED CONSENT [The patient has the right to -] Be fully informed about a treatment or procedure and the expected outcome before it is performed. This STANDARD is not met as evidenced by: Based on document review and observation on [redacted] it was determined that the facility failed to fully inform Patient #20 about her treatment options, failed to ensure that Patient #20 was given the information needed in order to make an informed decision regarding her care and failed to follow the facility policy titled "Informed Consent Policy" prior to Patient #20's anesthesia and procedure.	Q 229		

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Q 229	Continued From page 15 Findings include: Reference: The facility policy titled "Informed Consent Policy" states "...The evaluating physician, treating physician and counselor together shall obtain appropriate informed consent from patients...before starting any treatment or activity that presents a risk to the patient's health or safety...Treatments and activities requiring informed consent include...Anesthesia...All operative procedures...Non-surgical Abortion..." 1. On [redacted] this surveyor followed Patient #20 throughout her stay at the ASC. a. On [redacted] Patient #20 stated to Staff #12, a counselor, [redacted] Staff #12 stated to Patient #20 "[redacted] [redacted] Staff #12 is not a health care professional, but a counselor. Staff #12 failed to direct Patient #20's question about "[redacted]" to a member of the facility medical staff. b. On [redacted], Staff #12, counselor, gave Patient #20 the surgical consent to sign. The evaluating physician and the treating physician failed to inform Patient #20 of the anesthesia risks and benefits or the risks and benefits of the surgical procedure prior to the procedure on [redacted]	Q 229		
Q 232	416.50(c)(2) SAFETY [The patient has the right to -] Receive care in a safe setting This STANDARD is not met as evidenced by:	Q 232		

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Q 232	Continued From page 16 Based on document review and observation on [redacted], it was determined that Patient #20 did not receive care in a safe setting. Findings include: Reference: The facility, "Protocol for Stocking of OR/PACU Supply Storage Closets," states, ". . .Medical assistants are responsible for maintaining adequate stock in the supply storage closets. . .After restocking, the medical assistant will sign and date the supply storage sheet (see attached). . . ." 1. On [redacted], Patient #20, while in the facility recovery room, stated to Staff #13 that she was "feeling sick." Staff #13 gave Patient #20 a garbage can, that was sitting on the floor next to the stretcher, to use as an emesis basin. There were no emesis basins available in the recovery room area on [redacted]. Providing a trash can rather than an emesis basin did not provide for the patient's emotional health and safety, of which respect and dignity are components. 2. The supply storage sheet, mentioned in the Referece above, failed to contain emesis basins, which Patient #20 required, as a supply to keep in the Supply Storage Closet.	Q 232		
Q 242	416.51(b) INFECTION CONTROL PROGRAM 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.	Q 242		

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Q 242	Continued From page 17 nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: A. Based on observation, staff interview and a review of documents on 1/20/11, it was determined that the facility failed to implement infection control policies and failed to maintain an infection control program that follows up on each patient after discharge, in order to identify and investigate infections associated with the patient's stay in the ASC. Findings include: 1. Staff #8 stated on 1/20/11 that the facility follows CDC (Centers for Disease Control) for infection control policies. Reference #1: The CDC "MMWR October 25, 2002 Guideline for Hand Hygiene in Health-Care Settings" states "...When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers..." Reference #2: The facility policy titled, "Bloodborne Pathogen Exposure Control Plan," states "...All personnel participating in direct patient care practices must wash hands for 10 seconds before and after patient contact regardless of the use of gloves..." Reference #3: The facility policy titled, "Hand Hygiene," states "...Wash hands thoroughly and effectively with running water and soap...Using	Q 242		

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Q 242	Continued From page 18 friction on front and back of hands and between fingers scrub for'10-15 seconds...Wash hands with soap and water...When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other bodily fluids..." 1. The facility policies in References #2 and #3 above fail to follow the CDC recommendation of washing hands for 15 seconds with soap and water. 2. On [redacted] Staff #10, while wearing gloves, was observed in the facility examination room, performing a vaginal examination of Patient #20. After removing his/her gloves, Staff #10 did not wash his/her hands and, then, without donning gloves, utilized the facility ultrasound machine to perform a uterine ultrasound. Staff #10 typed information into the ultra sound computer system and proceeded to document on Patient #20's paper medical record with a pen. Staff #10 then removed his/her gloves and washed his/her hands with hand gel, rather than soap and water, prior to leaving the examination room. Staff failed to comply with facility policy in Reference #2, above. Reference #4: The facility policy titled, "Surveillance for Health Care Associated Infections," states, "...Data Collecting...Patients will be encouraged to return to center two weeks post procedure for examination and investigation of any complications including symptoms of infection. Patients will be provided verbal and written instructions on discharge which includes information on symptoms of infection and a mail in card to complete as to whether or not there	Q 242		

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METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

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Q 242	Continued From page 19 was any evidence of this...Report of Infection Investigation will be completed for each suspected infection...Infections will be reported on Monthly Report of Infections...Reports will be reviewed monthly by Infection Control Committee...Data on percent of mail in cards returned will be reported..." 1. When asked on 1/20/11 at 11:08 AM, about how the facility monitors and tracks patient infections, Staff #8 stated, "Not all of the patients have primary physicians, but if the patient returns to the facility for their two week follow up visit, the facility staff will complete an infection control survey form. If the patient has a primary physician, a letter is sent to the physician asking about infections. A general letter (but not a list of patients seen) is also sent to Planned Parenthood every six months." a. Upon request on 1/20/11, Staff #8 could not provide evidence of how patients who do not return to the facility for the follow up visit or who do not have a primary physician are followed or tracked for evidence of infections. Staff #8 stated, "If we don't see them here, and we don't know the identity of the primary physician, we don't do anything." (about following up on possible infections) b. Documentation provided by Staff #8 of the facility "Infection Control Committee" meetings failed to include data regarding infections reported on the "mail in cards" or data regarding the percentage of "mail in cards" completed and returned by patients. c. The facility failed to comply with its policy, Reference #4.	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 20 B. Based on a review of the facility infection control plan, a review of the personnel files of four Employees (#1, #2, #4, and #5) and interview with administrative staff it was determined that the facility did not implement a policy regarding the rubella and rubeola status of employees. Findings include: 1. The EMPLOYEE HEALTH section of the facility 'Infection Prevention and Control Organizational Plan Metropolitan Medical Associates' stated: "NJDHSS (New Jersey Department of Health and Senior Services), OSHA (Occupational Safety and Health Administration), and CDC (Centers for Disease Control) standards are followed. ..... All employees born after 1957 are screened for rubeola. All employees are screened for rubella. ....." 2. Review of the personnel files of Employees #1 and #5 lacked evidence that the employees were screened for rubella or rubeola status. 3. Administrator #2, at 1:15pm on January 20, 2011, confirmed the findings. C. Based on a review of the facility infection control plan, a review of the personnel files of four Employees (#1, #2, #4, and #5) and interview with administrative staff it was determined that the facility did not implement a policy regarding physical examinations of employees. Findings include:	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 242	Continued From page 21 1. The EMPLOYEE HEALTH section of the facility 'Infection Prevention and Control Organizational Plan Metropolitan Medical Associates' stated: "NJDHSS (New Jersey Department of Health and Senior Services), OSHA (Occupational Safety and Health Administration), and CDC (Centers for Disease Control) standards are followed. ..... Physical examinations are required on employment. ....." 2. The personnel file of Employee #4 lacked evidence of a physical examination prior to, or subsequent to, his/her employment. 3. Administrator #2, at 1:15pm on January 20, 2011, confirmed the findings.	Q 242		
Q 261	416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by: Based on a review of medical records and staff interview, it was determined that the facility failed to ensure that each patient had a comprehensive medical history and physical assessment completed by a physician not more than 30 days before the date of the scheduled surgery. Findings include: 1. 20 of 20 medical records reviewed on 1/20/11 and 1/25/11 lacked evidence of a comprehensive	Q 261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 261	Continued From page 22 medical history and physical assessment. a. In 20 of 20 medical records, a "Physical Examination" was documented with the following areas checked off: "Abdomen, Extremities, Adnexae, External Genitalia, Vagina / Cervix and Uterus week size." b. This was confirmed by Staff #9 and Staff #15.	Q 261		
Q 267	416.52(c)(3) DISCHARGE WITH RESPONSIBLE ADULT [The ASC must -] Ensure all patients are discharged in the company of a responsible adult except those patients exempted by the attending physician. This STANDARD is not met as evidenced by: Based on a review of the medical records of five patients who underwent surgical procedures, a review of facility policy and procedure, and interview with administrative staff it was determined that patients needn't be discharged in the company of a responsible adult except if exempted by the attending physician. Findings include: Reference: The DISCHARGE CRITERIA section of an untitled facility policy and procedure stated: ". . ."It is the policy that all MSA (Medical Surgical Associates) patients receiving conscious or deep sedation have made arrangements for transportation that does not include operation of a motor vehicle themselves. They also must be accompanied by another person who accepts responsibility for the patient. This information is verified by the administrative staff as well as the	Q 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 267	Continued From page 23 surgery. In extenuating circumstances, (patient's ride leaves, patient has privacy issues), the patient's transportation must be arranged by our counseling staff or the patient herself if she prefers. Every effort must be made to find another escort. If one is not available, a taxi or medical transportation will be called." 1. The above referenced policy indicated that only patients who receive conscious sedation or deep sedation must be discharged in the company of a responsible adult. Exemptions must be specific to the individual patient. Blanket exemptions to entire classes of patients are not permitted. Additionally, the policy allows patients who have undergone conscious or deep sedation to be discharged without the company of a responsible adult if the facility fails to find one for the patient. 2. Staff #3, on the afternoon of January 20, 2011, stated that patients who not receive conscious or deep sedation are not required to be discharged in the company of a responsible adult, nor does the attending physician write an order that the patient may be discharged without a responsible adult in instances when the patient does not receive conscious or deep sedation.	Q 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems 38.3.2, 39.3.2 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to separate hazardous areas from other parts of the building with self closing doors. Findings include: 1. On 1/20/11, at 11:50 AM, in the presence of Staff #9, the door to the furnace room could not latch due to the door strike not being in place.	K 029		

)RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

leficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 103	Continued From page 1 a. Upon request on 1/20/11, Staff #8 could not provide evidence of how patients who do not return to the facility for the follow up visit, or who do not have a primary physician, are followed or tracked for evidence of infections, and stated "If we don't see them here, and we don't know the identity of the primary physician, we don't do anything" about following up on possible infections.	Q 103		
Q 104	416.44(b) SAFETY FROM FIRE (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to http://www.archives.gov/federalregister/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods	Q 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING _____ B. WING _____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Q 104	Continued From page 2 deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. (4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006. (5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if: (i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; (ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and (iv) The dispensers are installed in accordance with the following provisions: (A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m); (B) The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors	Q 104		

PoC Addendum #2

METROPOLITAN SURGICAL ASSOCIATES

40 Engle Street
Englewood, NJ 07631
Tel: (201) 567-0522 Fax: (201) 816-9863
Email: metmedical@aol.com

May 25, 2011

Department of Health and Senior Services
Attn: Louise A. Steska, MSN, RN
PO Box 367
Trenton NJ, 08625-0367

RE: Metropolitan Surgical Associates
Addendum to Plan of Correction

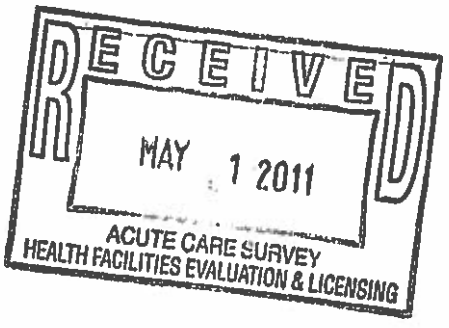
Dear Ms. Steska:

Enclosed please find an addendum to our Plan of Correction for the cited deficiencies as a result of the Health Survey conducted on January 20, 2011 and January 25, 2011 by the surveyors from the Department of Health and Senior Services. Should you have any additional questions or concerns please do not hesitate to contact us for immediate assistance.

We kindly thank you in advanced for your time and courtesies with regards to this matter.

Sincerely,

Susan Martinelli
Administrator



Americans United for Life

ADDENDUM TO FEEDERAL PLAN OF CORRECTION

ok 6/2/11

Q103

3. The Facility Administrator will be responsible for monitoring compliance and will report to the Infection Control Committee.

May 25, 2011

Americans United for Life

5/23/11 Q 103 not covered AF

ADDENDUM TO FEDERAL PLAN OF CORRECTION

PoC Addendum #1

Q162

3. The cited deficiencies of practice relating to CFR 416.47(b) are to be addressed as follows:

OK 5/23/11 AF

(i) and (ii): The Consent for Cervical Dilators was incorporated into the main Consent form so that Doctors are now required to sign the Cervical Dilator Consent. Both the Evaluating and Operating Physician are required to sign the Consent Form in order for a patient to receive care. Monthly Chart reviews are conducted by the director of nursing in order to monitor completeness of all charts. Her report is submitted to the facility administrator on a monthly basis and reported to the Quality Assurance Committee.

(iii): A separate Anesthesia Consent form has now been introduced into the patient's file. Consent is now obtained separately by the Anesthesiologist. Monthly Chart reviews are conducted by the director of nursing in order to monitor completeness of all charts. Her report is submitted to the facility administrator on a monthly basis and reported to the Quality Assurance Committee.

Q220

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q221 OK 5/23/11 AF

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q223 ok 5/23/11 AK

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q224 ok 5/23/11 AK

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q229 ok 5/23/11 AK

4. To monitor this corrective action the Evaluating Physicians will attend one session with each of the counselors on a weekly basis for a period of two months to assure that they are not exceeding the scope of their practice. They will report findings to the Medical Director and the Quality Assurance Committee.

5. April 1, 2011 – May 31, 2011

PoC

FEDERAL

Q103

1. The plan of correction will be implemented to survey potential patients starting from the beginning of the year.

3/31/11

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The facility will expand its efforts to track infections and has updated the Surveillance for Health Care Associated Infections policy in an effort to systematically address the need to maintain a proper environment for surgical procedures, as well as, identify and prevent infections. These efforts will include the tracking of patients returning to the facility for follow up, the provision of information relating to possible post operative infection and self reporting data cards, the serial contact of both private and institutional referrers regarding possible complications experienced by their patients, as well as, contact patients directly to as about possible post-op complication.

who RA T will that #3 is being done?

4. As with current practice, each response that indicates a potential infection will be brought to the attention of the Infection Control Designee (ICD). An Infection Investigation will promptly ensue and the results reviewed by the Medical Director and the Infection Control Committee. The Infection Control Committee will monitor these ongoing efforts on a regular ongoing basis.

5. This Plan of Correction should be effective by 3/31/2011

Q104

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The ABHRs in the pre-op nurse station and the PACU have been moved and are no longer located above electrical boxes.

4. The facility's Fire/Disaster Plan Coordinator, the Medical Director and the Chairman of the Board have conducted an inspection of the premises to ensure that the facility meets the provisions applicable to the Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association. Potential non-conforming conditions will be rectified so as to ensure this deficient practice will not recur. The results of the inspection will be reported at the ensuing Quality Assurance Meeting and to the facility's Fire Prevention Consultant.

5. The corrective action has been completed as of 2/8/2011

Q105

OK AH 4/13/11

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.
2. The corrective action systematically addresses this cited concern so that future patients will not be affected.
3. As a result of the cited deficiency, the Medical Director and the Senior Staff Anesthesiologist reviewed CFR 416.44(c). A list of the necessary medical equipment was placed in Anesthesia Policy and Procedure Manual for reference.
4. This equipment is expected by 2/25/11, the Medical Director will then report to the Quality Assurance Committee of the completion of this corrective action. Going forward, the Senior Staff Anesthesiologist will be charged with assuring that the facility possesses all requisite equipment.
5. The corrective action has been completed as of 2/25/2011

Q162

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.
2. The corrective action systematically addresses this cited concern so that future patients will not be affected.
3. The cited deficiencies of practice relating to CFR 416.47(b) are to be addressed as follows:

PoC ok 3/31/11 GH

   a. The "Consent for Cervical Dilators" form will be amended by 2/25/11 to include a section for the signature of the physician obtaining patient consent.
   b. On 2/22/11 forms which may be part of the medical record will be reviewed, any that do not provide a section for patient identification will be amended to do so by 3/25/11.
   c. By 2/23/11 the Facility Administrator and the Medical Director will issue to the counselor and physician staffs a memorandum pertaining to these cited deficiencies. The memorandum will review:
      i. That all patient sheets must be labeled so as to be properly identifiable.
      ii. That it is the duty of the Physician prior to the start of any procedure to assure that proper informed consent has been obtained and so documented.
      iii. That the operating physician and the Anesthesiologist together again obtain consent before performing a proposed procedure.

3/3/11 Deficiency was based on observation - QA does not include observation AH

iv. That the medical record must be accurate as to the treatment and management plans actually discussed.

4. Measures to assure the proper implementation of this plan of correction will include:

   a. A mandatory meeting of the Physician and Counseling staffs no later than 3/11/11 to review potential concerns and address questions relating to the corrective actions.

   b. The Director of Nursing will review, as part of the monthly Chart Audits, the medical records for proper documentation and report to the Quality Assurance Committee on a continuing basis.

   c. The importance of maintaining accurate and complete records, as well as, the proper obtainment of informed consent will be reviewed as part of the orientation of new staff.

   d. Identified lapses will be addressed via the Quality Assurance Committee.

5. Dates for implementation are as delineated above.

Q181

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. This deficiency of practice will be addressed in 2 parts.

   a. A memorandum was issued to all physicians on 2/23/11 informing them of this identified deficiency and reminding them that acceptable standards of practice require an order, both for the administration and discontinuance of medications, as well as, IV locks.

   b. Secondly, to help provide a systemic correction, the orders section of the chart will be amended to allow for better clarity and ease in adhering to this policy. The Medical Director will draft these changes and submit them to the Quality Assurance Committee for approval. This will be done by 3/14/11.

4. This plan of correction will be monitored for compliance by incorporating its review into the monthly Chart Audit process. Follow up and remedial action for identified deficient physicians will rest with the Quality Assurance Committee.

5. The final parts of plan of correction should be complete by 3/14/11.

OK 3/28/11

Q220

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive necessary documents that the patient must review prior to their visit; including the "Patient Rights" form, the "Ownership Disclosure" form and the "Advance Directives" form. The operator will document whether the patient requested the documents via fax, mail or whether the patient will download the forms from our website. Thus all documents are made available to patients in writing prior to their visit to the facility eliminating the possibility of the deficient practice to recur.

Not accepted how often (4) 3/28/11

4. The Faculty Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee

5. The corrective action has been completed as of 2/15/2011

Q221

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive the "Patient Rights" form. The operator will document whether the patient requested the document via fax, mail or whether the patient will download the forms from our website. Thus this document is made available to patients in writing prior to their visit to the facility, eliminating the possibility of the deficient practice to recur.

3/31/11 when how? AF

4. The Faculty Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee

5. The corrective action has been completed as of 2/15/2011

Q223

1. The cited deficiency that may affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive the "Ownership Disclosure" form. The operator will document whether the patient requested the document via fax, mail or whether the patient will download the forms from our website. Thus, this document is made available to patients in writing prior to their visit to the facility, eliminating the possibility of the deficient practice to recur.

3/31/11 how? when AF

4. The Faculty Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee.

5. The corrective action has been completed as of 2/15/2011

Q224

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive the "Advance Directives" notification. The operator will document whether the patient requested the document via fax, mail or whether the patient will download the forms from our website. Thus, this document is made available to patients in writing prior to their visit to the facility, eliminating the possibility of the deficient practice to recur.

3/31/11 how? When AF

4. The Faculty Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee.

5. The corrective action has been completed as of 2/23/2011

Q229

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The plan of correction focuses on the proper implementation of the "Informed Consent Policy". A memorandum will be drafted by 2/24/11, and issued by the Facility Administrator and the Medical Director to all Medical and Counseling staff members. It will emphasize the requirement that physicians adequately review proposed procedures with patients as part of

3/31/11 deficiency based on observation. OA does not include observation AF

the informed consent process. It will also discuss the Counseling Service, provided by the facility over and above the current standard regulations, which amongst other things, provides a public service to help educate the patients and prevent future unwanted pregnancies.

A mandatory meeting of the Physician and Counseling staffs, chaired by the Medical Director and the Facility Administrator will be held no later than 3/11/11. The meeting will review the scope of practice, as well as, the responsibilities of each staff.

4. To monitor this corrective action the Evaluating Physicians will attend sessions with each of the counselors to assure that they are not exceeding the scope of their practice. They will report findings to the Medical Director and the Quality Assurance Committee.

5. The plan of correction has been completed as of 3/11/2011

Q232

OK 3/31/11 AV

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Emesis basins have been added to the "Supply Storage Sheet" so that there is a daily restocking of this supply for the PACU. The Head Nurse shall conduct several spot inspections to ensure that there are an adequate number of emesis basins in the PACU.

4. By being placed on the "Supply Storage Sheet" and monitored for proper stocking, there should be no further shortage of readily accessible emesis basins in the PACU. The Head Nurse will be responsible for it's monitoring its adequate availability and report to the Quality Assurance Committee that this practice deficiency has been corrected or any shortcomings in the plan of correction.

5. This Plan of Correction has been put into effect as of 2/23/2011

Q242A

A OK 3/31/11 AV

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. On 2/22/2011 the Infection Control Committee approved revisions to the Bloodbourne Pathogen Exposure Control Plan and the Hand Hygiene policy to more accurately reflect the CDC "MMWR October 25, 2002 Guidelines for Hand Hygiene in Health-Care Settings". Also, a hand washing in-service will be conducted for applicable staff members to assure the systematic adoption of this practice. The Surveillance for Health Care Associated Infections policy has been updated to include monitoring of patients via telephone. The Infection

Control Committee minutes will further reflect the ongoing review of Health Care Associated Infections, including follow up on data cards returned by patients.

4. As part of the monitoring of this plan of correction, the facility's Infection Control Specialist shall add to her quarterly review a hand-washing monitoring review to make sure that all staff and employees are remaining consistent with the updated Policy. Any employee or staff member deviating from the hand washing policy shall immediately be corrected and receive a personal hand washing in-service. The Infection Control Committee will oversee the monitoring and investigation of health care related infection in its monthly meetings.

5. This corrective action has been completed as of 2/22/2011

Q242B

OK 3/31/11 RF

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. As of 2/18/2011 all staff members have documentation of Rubella/Rubeola status per the Infection Prevention and Control Organizational Plan Metropolitan Medical Associates. All employees must produce evidence of Rubella immune status, and those born after 1957 must produce evidence of Rubeola immune status or be screened prior to start of employment.

4. The Administrator will ensure that proper documentation is present in the personnel file prior to start of employment.

5. This corrective action has been completed as of 2/22/2011

Q242C

OK 3/31/11 RF

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The facility will require that a physical exam has been performed and documented in the personnel files per the Infection Prevention and Control Organizational Plan Metropolitan Medical Associates prior to the start of a staff member's employment thus ensuring the cited deficiency will not recur.

4. The Administrator will ensure that proper documentation is present in the personnel file prior to the start of employment.

5. This corrective action has been completed as of 2/22/2011

Q261

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The patient medical chart will be revised to comply with the 416.52(a)(1) statutory definition of a comprehensive History and Physical.

4. The completeness of the History and Physical will be assessed by incorporating its review into the monthly Chart Audit conducted by the Director of Nursing. It's successful implementation, or shortcomings will be reported to the Quality Assurance Committee.

5. Revised documents will be drafted by the Medical Director and submitted to the Quality Assurance Committee for review by 3/4/11 and will be used thereafter.

Q267

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The Quality Assurance Committee convened for a meeting on 2/24/2011 and updated the facility's "Discharge Criteria" so as to eliminate blanket exemptions to entire classes of patients.

4. The Quality Assurance Committee conducted a review of its "Discharge Criteria" and concluded that upon discharge, patients must be accompanied by another person that accepts responsibility for that patient. If extenuating circumstances exist and a patient cannot arrange for an escort, it will be the responsibility of the operating physician to approve an alternate discharge plan. Thus, discharge plans that fall outside of the facility's discharge parameters must be determined on an individualized basis and be based upon the judgment of the patient's attending physician.

5. This corrective action has been completed as of 2/24/2011

K029

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The door strike to the door of the furnace room has been replaced and the door can now latch properly.

4. The Housekeeping Sanitary and Safety Consultant shall conduct routine and regular inspections of the facility to ensure that all furnishings shall be in good working order and that broken or worn items shall be repaired, replaced or removed promptly. The Housekeeping Sanitary and Safety Consultant shall report his findings to the Facility Administrator should any furnishing need broken or worn and need to be repaired, replaced or promptly removed. The Facility Administrator shall report any such incidents to the Quality Assurance Committee and the ensuing Quality Assurance meeting.

5. This corrective action has been completed as of 2/8/2011

OK
SS
3/25/11

Americans United for Life

New Jersey State Department of Health
Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility	Date	Case Number
Metropolitan Surgical Associates	4/24/18	NJ00108847
Administrator/CEO	**Type Facility**	**Time Required to Correct**
	ASC	
Type of Survey	**Matter Under Consideration**	
☐ Revisit ☑ Complaint ☐ Investigation ☐ Surveillance ☐ For Immediate Attention	Alterations to physical Plant	
Census/Bed Capacity	**Units Toured**	**Charts Reviewed** / **Number of Patients Affected**
Facility Representatives/Titles	**Remarks/Issues**	
	Valid	

When this form is utilized for a survey, the following needs to be addressed:
This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to $5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.

Signature of Responsible Official	Signature of Investigator

NARRATIVE

A Visit was made to this facility in response to the above referanced complaint. Administrative staff was made aware of the visit and the nature of the complaint.

The investigation included:

- ✓ **Tour.**
- ___ **Staffing reports.**
- ___ **Medical record review.**
- ___ **Staff interviews.**
- ___ **Patient interviews.**
- ✓ **Review of other facility documentation.**
- ___ **Meal/Medication pass observation.**
- ___ **Water/Room temperature.**

An exit conference was held with administrative staff (discussed findings and concerns).

Comments:

ENTERED ONE 4/26/19 BY:

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367
www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

June 14, 2018

Susan Martinelli
Administrator
Metropolitan Surgical Associates
40 Engle Street
Englewood, NJ 07631

Re: Complaint #NJ 00108847

COPY

Dear Ms. Martinelli:

Thank you for your courtesy and cooperation extended during the Complaint Survey conducted on April 24, 2018 by a surveyor from the New Jersey Department of Health.

Enclosed is the statement of deficiencies; please reply to each deficiency on an item-by-item basis with your Plan of Correction (PoC).

The PoC must include:

1. How you will correct the specific findings cited for each deficiency.

2. What systemic changes will be implemented to ensure that each deficient practice does not recur.

3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The plan must identify the individual responsible for monitoring, how and when the monitoring will be conducted, how long and how often monitoring will take place, what the goal is for compliance, and to whom the results will be reported.

4. The date on which each item addressed on the PoC will be corrected.

5. Do not reference and/or include attachments with your PoC.

6. Do not include names of individuals in the PoC. Use of titles is acceptable, such as, Administrator, Director of Nursing, Infection Control Practitioner, etc.

Please be advised that the PoC will not be accepted for review by this office and will be returned to you if it contains reference to and/or attachments and/or names of individuals.

All responses should be numbered to correspond with the number of your deficiency statements. Please sign and date the first page of the deficiency statement with your plan of correction. Return these forms to this office within ten (10) business days of receipt of this letter, to my attention. Any delay or lack of response may jeopardize the licensure of your facility.

Please be advised that some or all of the deficiencies cited in the enclosed survey report may be referred to the Office of Program Compliance ("OPC") for imposition of enforcement remedies, including civil penalties. OPC will advise you, at a later date and under separate cover, of any enforcement actions and your appeal rights.

Please do not hesitate to contact me, if you have any questions regarding the deficiencies at (609) 292-9900.

Sincerely,

Eric DeCicco/SP

Eric DeCicco, CFI
Surveyor Physical Plant/Life Safety
Survey and Certification

Encl.

Americans United for Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10263	A. BUILDING: _____ B. WING _____	C 04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS The facility is not in compliance with N.J.A.C. Title 8 Chapter 43A-Standards for Licensure of Ambulatory Care Facilities for this complaint only (C# NJ00108847).	A 000		
A5016	8:43A-19.3(a) PHYSICAL PLANT: PLAN REVIEW FEES Prior to any construction, plans shall be submitted for review and approval, in accordance with the provisions of this chapter, to the Healthcare Plan Review Unit. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that prior to any construction, plans were submitted for review to the Healthcare Plan Review Unit of the Department of Community Affairs. Findings include: 1. During a tour of the facility on 4/24/18, this surveyor observed new construction, at the top of the stairs, to the main stairwell. The main stairwell was enclosed with a set of double doors which was not enclosed during the previous survey. Staff #1 was unable to provide plans for this new construction that was submitted and approved by the New Jersey Department of Community Affairs Plan Review Unit. a. Staff #1 confirmed plans were not submitted to the New Jersey Department of Community Affairs, Healthcare Plan Review Unit.	A5016		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

A5016 **8:43A-19.3(a) PHYSICAL PLANT: PLAN REVIEW FEES**

Plans for construction shall be submitted to the New Jersey Department of Community Affairs Plan Review Unit no later than June 29, 2018.

The Board of Directors and Chairman of the Board are aware that prior to any construction/renovations at the facility, plans must be submitted and approved by the Healthcare Plan Review Unit of the Department of Community Affairs. No other construction/renovation is planned and no future construction/renovation will be scheduled without first submitting plans to the Healthcare Plan Review Unit.

No new construction/renovation will be commenced without the prior written approval of the Board of Directors at a regularly scheduled or Special meeting of the Board. If any new construction/renovation is contemplated, it will be the responsibility of the Chairman of the Board to ensure that prior to any work being completed, plans will first be submitted and approved by the New Jersey Department of Community Affairs Plan Review Unit.

Plans for the construction at the top of the stairs to the main stairwell shall be submitted no later than June 29, 2018. The facility will follow the Procedures for Submission and inform the corresponding contact at the Department of Health when the Department of Community Affairs Plan Review Unit either approves and/or responds to the application.

Americans United for Life

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

April 23, 2019

Susan Martinelli
Administrator
Metropolitan Surgical Associates
40 Engle Street
Englewood, NJ 07631

Re: Complaint # NJ00108847

Dear Ms. Martinelli:

Thank you for providing the Survey and Certification Program with a Plan of Correction (PoC) for the deficiency found during the Complaint Survey at your facility on April 24, 2018.

Your Plan of Correction has been reviewed, found to be complete and approved by this office. Enclosed is a form indicating that all deficiencies have been corrected. Continued compliance with State Licensure Regulations will be required by your facility.

You are advised that this letter does not preclude a revisit from Assessment and Survey staff at a later date, to ensure that all elements of the PoC have been implemented.

Should you have further concerns regarding this investigation, please direct them to me at (609) 292-9900.

Sincerely,

Eric DeCicco, CFI
Surveyor Physical Plant/Life Safety
Survey and Certification

COPY

New Jersey State Department of Health
Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility: Planned Parenthood - Shrewsbury		Date: 9-12-14	Case Number: 74921
Administrator/CEO: Trista Brooks Administrator		Type Facility: ST-Amb	Time Required to Correct:
Type of Survey: ☐Revisit ☒Complaint ☒Investigation ☐Surveillance ☐For Immediate Attention		Matter Under Consideration: Infection control Physical Environment	
Census/Bed Capacity:	Units Toured: 1	Charts Reviewed: 0	Number of Patients Affected:
Facility Representatives/Titles:		Remarks/Issues: Not Valid	

When this form is utilized for a survey, the following needs to be addressed:
This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to $5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.

Signature of Responsible Official	Signature of Investigator
	Teresa Draham RN, BSN

NARRATIVE

An unannounced visit was made to this facility to investigate a complaint. The complaint was discussed with facility representative (s). The investigation included review of documentation and staff interviews. Preliminary concerns regarding the investigation were discussed with the facility representative (s). After supervisory review, deficiencies may follow.

ENTERED ON: 10/8/14
BY:

COPY

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

September 19, 2014

Triste Brooks
Administrator
Planned Parenthood Of Central & Greater Northern N. J.
69 East Newman Springs Road
Shrewsbury, NJ 07702

Re: Complaint #NJ00074921

Dear Ms. Brooks:

Thank you for the courtesy and cooperation extended during the complaint investigation conducted September 12, 2014 by a surveyor from the Department of Health.

Enclosed is a copy of the State deficiency form indicating that no deficiencies were found during the survey. Please sign the first page of the State deficiency form and return the original copy to the attention of Teresa Graham RN, BSN. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me, at (609) 292-9900.

Sincerely,

Teresa Graham RN, BSN

Teresa Graham RN, BSN
Health Care Service Evaluator/Nurse
Assessment and Survey

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71370	A. BUILDING: _____ B. WING _____	C 09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF CENTRAL & GRE	69 EAST NEWMAN SPRINGS ROAD SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	8:43A INITIAL COMMENTS The facility is in substantial compliance with N.J.A.C. Title 8 Chapter 43A-Standards for Licensure of Ambulatory Care Facilities for this complaint visit only. (C#NJ00074921)	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

September 19, 2014

Triste Brooks
Administrator
Planned Parenthood Of Central & Greater Northern N. J.
69 East Newman Springs Road
Shrewsbury, NJ 07702

Re: Complaint #NJ00074921

Dear Ms. Brooks:

Thank you for the courtesy and cooperation extended during the complaint investigation conducted September 12, 2014 by a surveyor from the Department of Health.

Enclosed is a copy of the State deficiency form indicating that no deficiencies were found during the survey. Please sign the first page of the State deficiency form and return the original copy to the attention of Teresa Graham RN, BSN. It is important to return the form promptly to this office.

If you have questions concerning this letter, please do not hesitate to contact me, at (609) 292-9900.

Sincerely,

Teresa Graham RN, BSN

Teresa Graham RN, BSN
Health Care Service Evaluator/Nurse
Assessment and Survey

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	71370	A. BUILDING _____ B. WING _____	C 09/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF CENTRAL & GRE	69 EAST NEWMAN SPRINGS ROAD SHREWSBURY, NJ 07702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	8:43A INITIAL COMMENTS The facility is in substantial compliance with N.J.A.C. Title 8 Chapter 43A-Standards for Licensure of Ambulatory Care Facilities for this complaint visit only. (C#NJ00074921)	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Cochrane TITLE: Director of Risk Management (X6) DATE: 9/24/14

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

September 30, 2014

Re: Planned Parenthood Of Central & Greater Northern New Jersey
Complaint #NJ00074921

A representative from Health Facility Survey and Field Operations conducted an investigation of your complaint concerning environmental issues at Planned Parenthood Of Central & Greater Northern New Jersey.

The investigation included a tour of the grounds and facility, review of facility documentation, and staff interview.

After evaluating this information, the surveyor was unable to identify a citable deficient practice related to your concerns.

The results of this investigation were presented to and reviewed with administrative staff for continued monitoring of patient care.

Thank you for forwarding your concerns to this office.

Sincerely,

Teresa Graham RN, BSN

Teresa Graham RN, BSN
Health Care Service Evaluator/Nurse
Assessment and Survey

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

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CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

April 7, 2015

Nicholas Campanella, MD
Pilgrim Medical Center, Inc
393 Bloomfield Avenue
Montclair, NJ 07042

Dear Dr. Campanella:

Thank you for your courtesy and cooperation extended during the State Relicensure Survey conducted on January 7, 2015, January 9, 2015, and January 13, 2015 by surveyors from the New Jersey Department of Health.

Enclosed is the statement of deficiencies; please reply to each deficiency on an item-by-item basis with your Plan of Correction (PoC).

The PoC must include:

1. How you will correct the specific findings cited for each deficiency.

2. What systemic changes will be implemented to ensure that each deficient practice does not recur.

3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The plan must identify the individual responsible for monitoring, how and when the monitoring will be conducted, and to whom the results will be reported.

4. The date on which each item addressed on the PoC will be corrected.

5. Do not reference and/or include attachments with your PoC.

6. Do not include names of individuals in the PoC. Use of titles is acceptable, such as, Administrator, Director of Nursing, Infection Control Practitioner, etc.

Please be advised that the PoC will not be accepted for review by this office and will be returned to you if it contains reference to and/or attachments and/or names of individuals.

All responses should be numbered to correspond with the number of your deficiency statements. Please sign and date the first page of the deficiency statement with your plan of correction. Return these forms to this office within ten (10) business days of receipt of this letter, to my attention. Any delay or lack of response may jeopardize the licensure of your facility.

Please be advised that some or all of the deficiencies cited in the enclosed survey report may be referred to the Office of Program Compliance ("OPC") for imposition of enforcement remedies, including civil penalties. OPC will advise you, at a later date and under separate cover, of any enforcement actions and your appeal rights.

Please do not hesitate to contact me, if you have any questions regarding the deficiencies at (609) 292-9900.

Sincerely,

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse

Encl.

Americans United for Life

PRINTED: 06/02/2016

Statement of Deficiencies
Citation Summary Sheet

For: PILGRIM MEDICAL CENTER, INC (70789 / NJ70789)

Survey Event: 239U11, Exit Date 01/13/2015

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
State	Z7BQ	8.00	00	0000	INITIAL COMMENTS	
State	Z7BQ	8.00	00	4183	INFEC PREV & CONTROL: INFEC PREV MEASURES	
State	Z7BQ	8.00	00	4190	INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS	
State	Z7BQ	8.00	00	4286	INFEC PREV & CTRL: MAINT STRL PRCSNG ENVRNMNT	
State	Z7BQ	8.00	00	4702	HOSKEEPING-SANITATN-SAFTY:HOSKPING PATNT SERV	
State	Z7BQ	8.00	00	4733	HOSKEEPING-SANITATN-SAFTY:HOSKPING PATNT SERV	
State	Z7BQ	8.00	00	4797	HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SERV	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70789	A. BUILDING: _____ B. WING _____	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	8:43A INITIAL COMMENTS This was a State Re-licensure survey that resulted in deficiencies. Medical Records reviewed: 20 Staff interviews/ Staff files reviewed: 20	A 000		
A4183	8:43A-14.3(a)(5) INFEC PREV & CONTROL: INFEC PREV MEASURES Infection prevention activities shall be based on Centers for Disease Control and Prevention Guidelines, and Hospital Infection Control Practices Advisory Committee (that is, HICPAC) recommendations. An exception to the adoption of the following guideline shall be allowed providing that there is a sound infection control rationale based upon scientific research or epidemiologic data. The following published guideline is incorporated herein by reference, as amended and supplemented: Guideline for Hand Hygiene in Health-Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16), published by the Coordinating Center for Health Information and Service, available at <http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf> and at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm>	A4183		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70789	A. BUILDING: _____ B. WING _____	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4183	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview on 1/9/15, it was determined that the facility failed to ensure that recommended infection control guidelines were adhered to by staff. Findings include: Reference #1: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee and the ICA/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16). Recommendations: 1. Indications for Hand washing and Hand antisepsis... J. Decontaminate hands after removing gloves. Reference #2: Facility policy titled, "Hand Hygiene" states, "...Use an alcohol based hand rub or alternately wash hands with antimicrobial soap during patient care...8. After removing gloves..." 1. At 10:45 AM, in the Laboratory area, Staff #16 was observed changing gloves several times without using an alcohol based hand rub or washing his/her hands with antimicrobial soap during patient care. 2. At 11:50 AM, in the Operating Room, Staff #19 was observed changing gloves without using an alcohol based hand rub or washing his/her hands with antimicrobial soap. 3. At 11:55 AM, in the Operating Room, the following was observed:	A4183		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70789	A. BUILDING: _____ B. WING _____	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4183	Continued From page 2 a. While wearing gloves, Staff #19 picked up paper from the floor and threw it in the garbage. He/She then picked up a package of sterile gloves and handed them to the physician. b. Staff #19 did not remove the contaminated gloves and use an alcohol based hand rub or wash his/her hands with antimicrobial soap. 4. These findings were confirmed by Staff #1.	A4183		
A4190	8:43A-14.4(a)(1) INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS Methods for processing reusable medical devices shall conform with the following or revised or later editions, if in effect, incorporated herein by reference: The Association for the Advancement of Medical Instrumentation (AAMI) requirements, "Good Hospital Practice: Steam Sterilization and Sterility Assurance," ST 46. This REQUIREMENT is not met as evidenced by: Based on direct observation, staff interviews and document review conducted on 1/7/15, it was determined that the facility failed ensure that it conforms with the Association for the	A4190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A4190	Continued From page 3 Advancement of Medical Instrumentation (AAMI) guidelines, "Comprehensive guide to steam sterilization and sterility assurance in health care facilities" ST79. (ST79 replaces and supersedes ST 46 by consolidating ST 46 with 4 other AAMI standards [ST 33, ST 37, ST 42, and ST 35] approved 7/10/2009). Findings include: Reference #1: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2014 edition, ST 79 section 8.9.2 states, "Sterile items should be stored in a manner that reduces the potential for contamination." 1. In the Sterilization Room at 12:10 PM, nine sterile instrument trays were stacked on a multi-tiered transport table stored in front of the HVAC (Heating, Ventilating and Air Conditioning) unit. a. The HVAC unit was wrapped in torn insulating material, exposing pink insulating fibers. The HVAC insulation was coated with a layer of dust and white debris. b. The air conditioner unit, located behind the HVAC unit, was blowing air towards the sterile instruments. c. Dust, debris and insulation fibers from the HVAC unit can compromise the integrity of the sterile instrument trays. 2. Staff #2 was immediately made aware of the situation at 12:15 PM. 3. At 12:25 PM, the nine sterile trays were	A4190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A4190	Continued From page 4 removed from the Sterilization Room. 4. Upon interview, Staff #2 confirmed that the instruments were brought to the Operating Room for use.	A4190		
A4286	8:43A-14.6(a)(3) INFEC PREV & CTRL: MAINT STRL PRCSNG ENVRNMNT The following environmental surface shall be maintained as follows in decontamination and clean processing areas: Ceilings, ventilation system vents, and sterilizer vents shall be clean and free from dust. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews conducted on 1/7/15, it was determined that the the facility failed ensure that it provides a clean and dust-free environment in its clean processing area. Findings include: 1. In the Sterilization Room at 11:40 AM, in the presence of Staff #3, the wall above the prep and pack counter contained exposed particulate material. This observation was cited on the 5/28/14 survey and remains uncorrected. a. The exposed particulate matter can generate loose fibers and dust and is not a cleanable surface. b. This finding was confirmed by Staff #1 and Staff #2.	A4286		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A4286	Continued From page 5 2. At 12:10 PM, sterile instrument trays were stored in front of the HVAC unit. a. The HVAC unit was wrapped in torn insulation, exposing some of the pink insulation material. The HVAC unit was coated with a layer of dust and white debris. b. Dust, debris and insulation fibers from the HVAC unit can compromise the integrity of the sterile trays. c. This finding was confirmed by Staff #1 and Staff #2.	A4286		
A4702	8:43A-17.3(d) HOSKEEPING-SANITATN-SAFTY:HOSKPING PATNT SERV Housekeeping and cleaning supplies shall be selected and approved by the Infection Control Committee. They shall be measured and used correctly according to the manufacturers' written instructions. This REQUIREMENT is not met as evidenced by: Based on documentation review, observation and staff interview conducted on 1/7/15, it was determined that the facility failed to ensure that cleaning supplies are selected and approved by the Infection Control Committee and used in accordance with the manufacturer's instructions for use (IFUs).	A4702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70789	A. BUILDING: _____ B. WING _____	01/13/2015

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PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

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A4702	Continued From page 6 Findings include: 1. During a tour of the Sterilization Room at 11:40 AM, two containers labeled with biohazard signs, one with "50% Vinegar" and another with "Alcohol," were stored on the shelf above the prep and pack counter. a. According to Staff #3, these solutions are used for cleaning and disinfecting environmental surfaces within the Sterilization Room. 2. Review of the facility's "Approved Antiseptics, Disinfecting, Cleaning, (sic) Agents" lists Alcohol 70% as an "antiseptic" used for "skin prep" and not as a cleaning agent. 3. Vinegar was not included on the approved list. 4. Upon request, Staff #2 and Staff #3 were unable to provide documented evidence that the facility Infection Control Committee has selected and approved the above cleaning solutions. 5. Upon request, Staff #2 and Staff #3 were unable to provide the manufacturer's IFUs the above cleaning solutions.	A4702		
A4733	8:43A-17.3(l) HOSKEEPING-SANITATN-SAFTY:HOSKPING PATNT SERV Effective and safe controls shall be used to minimize and eliminate the presence of rodents, flies, roaches and other vermin in the facility. The premises shall be kept in such condition as to prevent the breeding, harborage, or feeding of vermin. All openings to the outer air	A4733		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70789	A. BUILDING: _____ B. WING _____	01/13/2015

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A4733	Continued From page 7 shall be effectively protected against the entrance of insects. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview on 1/7/15, it was determined that the facility failed to ensure that all openings to the outside are maintained to protect against the entrance of insects or vermin. Findings include: 1. At 10:00 AM, in the presence of Staff #1, an open ended pipe section was visibly protruding from the ceiling in the lower level Storage Room. 2. At 11:15 AM, in the presence of Staff #1, an air-gap to the outside was visible underneath the rear entrance exterior door. 3. These findings were confirmed by Staff #1.	A4733		
A4797	8:43A-17.4(a)(15) HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SERV The following environmental condition shall be met: All equipment and environmental surfaces shall be kept clean to sight and touch. This REQUIREMENT is not met as evidenced by:	A4797		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	70789	A. BUILDING: _____ B. WING _____	01/13/2015

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A4797	Continued From page 8 Based on observation and staff interview on 1/7/15, it was determined the facility failed to ensure that all interior surfaces are maintained clean to sight and touch. Findings include: 1. At 9:45 AM, in the presence of Staff #1, the flooring in the Sterilizer Room and Processing Area was found to have surface damage and to have un-cleanable gaps where the floor base had separated from the wall. 2. At 10:15 AM, in the presence of Staff #1, the floor located in the lower level Staff Kitchen, was in disrepair, visibly worn with curled edges and had open seams which would preclude proper cleaning. 3. At 11:30 AM, in the presence of Staff #1, the Post Anesthesia Care Unit (PACU), located on the second floor, had several areas of wall damage and monolithic floor surface defects and openings. 4. At 11:50 AM, in the presence of Staff #1, three stained ceiling tiles were found located in the Medication Storage Room. 5. These findings were confirmed by Staff #1.	A4797		

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

July 31, 2015

Nicholas Campanella
Pilgrim Medical Center, Inc
393 Bloomfield Avenue
Montclair, NJ 07042

Dear Dr. Campanella:

Thank you for providing the Survey and Certification Program with a Plan of Correction (PoC) for the deficiencies found during the State Relicensure Survey at your facility on January 13, 2015.

Your Plan of Correction and addendum has been reviewed, found to be complete and approved by this office. Enclosed is a form indicating that all deficiencies have been corrected. Continued compliance with State Licensure will be required by your facility.

You are advised that this letter does not preclude a revisit from Assessment and Survey staff at a later date, to ensure that all elements of the PoC have been implemented.

Should you have further concerns regarding this survey, please direct them to me at (609) 292-9900.

Sincerely,

Louise A. Steska, MSN, RN
Health Care Services
Survey and

Evaluator/Nurse
Certification
Encl.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
70789 Y1	A. Building B. Wing Y2	7/15/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A4183	Correction	ID Prefix A4190	Correction	ID Prefix A4286	Correction
Reg. # 8:43A-14.3(a)(5)	Completed	Reg. # 8:43A-14.4(a)(1)	Completed	Reg. # 8:43A-14.6(a)(3)	Completed
LSC	07/15/2015	LSC	07/15/2015	LSC	07/15/2015
ID Prefix A4702	Correction	ID Prefix A4733	Correction	ID Prefix A4797	Correction
Reg. # 8:43A-17.3(d)	Completed	Reg. # 8:43A-17.3(l)	Completed	Reg. # 8:43A-17.4(a)(15)	Completed
LSC	07/15/2015	LSC	07/15/2015	LSC	07/15/2015
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
1/13/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

State PoC Addendum

RESPONSE TO STATEMENT OF DEFICIENCIES

- **A4183 8:43A-14.3(a)(5)**

This deficiency has been corrected on January 15, 2015 at which time Staff #16 and Staff #19 were re-trained in proper hand hygiene. Staff #19 was also retrained in appropriate operating room hygiene required by infection control. Pilgrim supplies alcohol based hand rub and sinks with antibacterial soap in all required areas.

Pilgrim will ensure that this deficiency does not recur by continuing its regular observation of hand hygiene as conducted by the Director of Nursing. All findings are reported to the Infection Control Committee for remedy as necessary.

- **A4190 8:43A-14.4(a)(1)**

As a preliminary matter, the unit in question was not a heating and air conditioning unit; it was, in fact, the boiler for the two sterilizer units. At no time has Pilgrim ever placed or considered placing any sterile instruments directly in front of any heating or air conditioning units due to the dust that clearly accumulates on such units. The boiler was wrapped in a pink insulation material which has since been removed and will be replaced with appropriately sealed insulation on or before June 1, 2015. Once again, the unit in question was the boiler unit used for the functioning of the sterilizers and the air conditioning unit had properly cleaned filters, which are cleaned on a weekly basis. Pilgrim accepts the fact that dust, debris and insulation fibers can compromise the integrity of sterile trays. However, it was due to an OSHA recommendation that this extremely hot unit was initially covered with insulation. The instruments in question, as Staff #2 recalls, were re-sterilized immediately at the recommendation of the surveyor who observed their location. To the best of Staff #2's recollection, the resolution of immediate jeopardy was, in fact, the immediate re-sterilization of these nine packs. That said, this deficiency has been corrected as of January 15, 2015 at which time the sterilization team was instructed that no sterile packs are to be placed in this location to ensure sterility.

OK

AM 6/4/15

Please also be advised that the sterilization area is serviced by two separate intake/outtake ventilation systems and a separate independent exhaust system which maintains negative pressure throughout. There are no fans or portable air conditioning units of any kind in the sterilization area. The unit in question is the latest model of ductless air conditioning units which is used extensively in hospitals and, in accordance with the owner's manual, utilizes an intake/outtake system with rate of air exchange of up to 11.4 cubic meters per minute. The system is a Daikin model # EDUS041501 and the owner's manual, the Engineering Data Manual" can be found at http://www.daikinac.com/content/assets/DOC/Engineering Manuals/EDUS041501.pdf. The owner's manual includes detailed diagrams of the intake/outtake system and the filtration system on pages 81-84.

Pilgrim will ensure that this deficiency does not recur by observing, on a daily basis, that these packs are in a clean area void of dust and kept away from any potential heat or air conditioning vents. The Medical Director and/or the Alternate Medical Director will be responsible for this daily observation and they will report all findings, including any deficiency, to the Infection Control Committee for re-training and remedy as needed. The facility will remain in compliance with functional and sanitary environmental conditions and in compliance with infection control through staff in-services and continued environmental rounds monitoring as indicated herein.

- **A4286 8:43A-14.6(a)(3)**

With regard to the exposed particulate material observed on the wall in the sterilization room as of January 15, 2015, this wall has been thoroughly cleaned and repaired and the Alternative Medical Director checks this area daily to make sure that there are no further defects in the material and that there is no particulate matter or any other debris present.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by

the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

As a preliminary matter, the unit in question was not a heating and air conditioning unit; it was, in fact, the boiler for the two sterilizer units. At no time has Pilgrim ever placed or considered placing any sterile instruments directly in front of any heating or air conditioning units due to the dust that clearly accumulates on such units. The boiler was wrapped in a pink insulation material which has since been removed and will be replaced with appropriately sealed insulation on or before June 1, 2015. Once again, the unit in question was the boiler unit used for the functioning of the sterilizers and the air conditioning unit had properly cleaned filters, which are cleaned on a weekly basis. Pilgrim accepts the fact that dust, debris and insulation fibers can compromise the integrity of sterile trays. However, it was due to an OSHA recommendation that this extremely hot unit was initially covered with insulation. The instruments in question, as Staff #2 recalls, were re-sterilized immediately at the recommendation of the surveyor who observed their location. To the best of Staff #2's recollection, the resolution of immediate jeopardy was, in fact, the immediate re-sterilization of these nine packs. That said, this deficiency has been corrected as of January 15, 2015 at which time the sterilization team was instructed that no sterile packs are to be placed in this location to ensure stability.

OK. Ann 6/4/15

Please also be advised that the sterilization area is serviced by two separate intake/outtake ventilation systems and a separate independent exhaust system which maintains negative pressure throughout. There are no fans or portable air conditioning units of any kind in the sterilization area. The unit in question is the latest model of ductless air conditioning units which is used extensively in hospitals and, in accordance with the owner's manual, utilizes an intake/outtake system with rate of air exchange of up to 11.4 cubic meters per minute. The system is a Daikin model # EDUS041501 and the owner's manual, the Engineering Data Manual" can be found at http://www.daikinac.com/content/assets/DOC/Engineering Manuals/EDUS041501.pdf. The owner's manual includes

detailed diagrams of the intake/outtake system and the filtration system on pages 81-84.

Pilgrim will ensure that this deficiency does not recur by observing, on a daily basis, that these packs are in a clean area void of dust and kept away from any potential heat or air conditioning vents. The Medical Director and/or the Alternate Medical Director will be responsible for this daily observation and they will report all findings, including any deficiency, to the Infection Control Committee for re-training and remedy as needed. The facility will remain in compliance with functional and sanitary environmental conditions and in compliance with infection control through staff in-services and continued environmental rounds monitoring as indicated herein.

OK
AM 6/4/15

- **A4702 8:43A-17.3(d)**

At no time has Pilgrim, its Governing Body, its Medical Director, Alternate Medical Director of Director of Nursing approved the use of 50% Vinegar or alcohol in cleaning any environmental surface. In fact, Pilgrim only uses a 10% Bleach Solution for non-corrosive surfaces and a biological agent, from Ruhof Corporation, which comes in pre-packaged spray bottles. Upon questioning Staff #2 and Staff #3 the Medical Director learned that these bottles had been present for years and the staff did not know what they were to be used for and neither had ever used them. This deficiency has been corrected on January 15, 2015 at which time they were disposed of and the staff was advised that no unacceptable cleaning supplies are to kept anywhere in the facility.

OK
AM 6/4/15

Pilgrim will ensure that this deficiency does not recur by observing on a daily basis that no unacceptable cleaning supplies are kept anywhere on the premises. The Medical Director and/or Alternate Medical Director will be responsible for all daily observations and they will report all findings including any deficiencies to the Infection Control Committee for remedy as needed. Any modification to the list of acceptable and approved cleaning materials will be reviewed and approved by the Infection Control Committee prior to implementation.

The facility will remain in compliance with functional sanitary and environmental conditions, and in compliance with infection control, through staff in services and continuing environmental rounds monitoring.

- **A4733 8:43A-17.3(I)**

This deficiency has been corrected as of April 10, 2015, at which time the door in question, wherein an air gap was visible, was replaced and is now airtight. The open end pipe protruding from the ceiling in the lower level storage room was sealed and a non-porous cover was placed to ensure closure.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

- **A4797 8:43A-17.4(a)(15)**

This deficiency will be corrected on or before June 1, 2015. The floor in the sterilization area and the processing area is in the process of being replaced and we anticipate that the entire project will be completed by June 1st. An acrylic seal will be placed on the floor itself to eliminate any gaps or cracks. The floor base has been reattached to the wall.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

The floor located in the lower level staff kitchen was replaced and on or before May 1, 2015, it will be sealed with an acrylic sealant to eliminate any gaps that would prevent proper cleaning.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and

observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

The wall damage in the PACU has been repaired as of April 1, 2015 and the monolithic floor has been repaired and will be sealed using an acrylic sealer on or before May 1, 2015.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

The stained ceiling tiles in the medication storage room were replaced, as of January 15, 2015.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

CONCLUSION

Pilgrim submits this Plan of Correction for consideration by the Department and awaits the Department's determination.

Very truly yours,

PILGRIM MEDICAL CENTER INC.

[redacted]

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

April 7, 2015

Nicholas Campanella, MD
Pilgrim Medical Center, Inc
393 Bloomfield Avenue
Montclair, NJ 07042

Dear Dr. Campanella:

Thank you for the courtesy and cooperation extended during the Federal Recertification Survey of your facility on January 7, 2015, January 9, 2015, and January 13, 2015 by surveyors from the New Jersey Department of Health.

As a result of observation and evaluation certain Federal deficiencies were evident. The deficiencies identified during this visit have resulted in the determination that your facility is not in compliance with the following Medicare Condition for Coverage:

416.41 Govering Body and Management
416.51 Infection Control

A complete listing of the specific deficiencies identified by the surveyors is enclosed. These Federal deficiencies were discussed with you and/or your staff during the visit and are listed on the left side of the enclosed CMS-2567 form. Please reply to each deficiency, on an item by item basis, with your Plan of Correction (PoC) and the date you expect the correction to be completed.

You may write your PoC on the deficiency report in the space provided, or it can be written on a separate document and submitted along with the signature page (page 1 of the deficiency report). Please number your response to correspond to the number of each deficiency statement.

The PoC for each deficiency must contain the following elements:

1. How the specific findings cited for each deficiency will be corrected.

2. The systemic changes put into place for each deficiency.

3. The measures that will be put into place to monitor each corrective action to ensure that the plan of correction is effective and that compliance is maintained.

4. The title of the person responsible for implementing the plan of correction.

5. The date on which each item addressed on the PoC will be corrected.

6. Do not reference and/or include attachments with your PoC.

7. Do not include names of individuals in the PoC. Use of titles is acceptable, such as, Administrator, Director of Nursing, Infection Control Practitioner, etc.

Please be advised that the PoC will not be accepted for review by this office and will be returned to you if it contains reference to and/or attachments and/or names of individuals.

Sign and date the first page of the CMS-2567 form and return the form with your PoC. Please retain a copy of each page for your records. All responses must be returned within 10 calendar days of receipt of this letter to my attention, New Jersey Department of Health, Health Facility and Field Operations, PO Box 367, Trenton, NJ 08625-0367.

It is important to return the completed forms promptly. Any delay or lack of response may jeopardize the certification status of your facility. If you have any questions concerning this report, please contact me, at (609) 292-9900.

Sincerely,

Louise A. Steska, MSN, RN
Health Care Services

Evaluator/Nurse

Survey and Certification

Americans United for Life

Encl.

Americans
United
for Life

PRINTED: 06/02/2016

Statement of Deficiencies
Citation Summary Sheet

For: PILGRIM MEDICAL CENTER, INC (31C0001229 / NJ70789)
Survey Event: MOGT11, Exit Date 01/13/2015

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	FQ08	08.02	00	0000	INITIAL COMMENTS	
Federal	FQ08	08.02	00	0040	GOVERNING BODY AND MANAGEMENT	
Federal	FQ08	08.02	00	0101	PHYSICIAL ENVIRONMENT	
Federal	FQ08	08.02	00	0240	INFECTION CONTROL	
Federal	FQ08	08.02	00	0241	SANITARY ENVIRONMENT	
Federal	FQ08	08.02	00	0242	INFECTION CONTROL PROGRAM	
Federal	FQ08	08.02	00	9999	FINAL OBSERVATIONS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001229	A. BUILDING _____ B. WING _____	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS This was a Federal Recertification survey that resulted in the Condition for Coverage of Governing Body and Managment and Infection Control being out of compliance. Medical Records reviewed: 20 Staff interviews/ Staff files reviewed: 20	Q 000		
Q 040	416.41 GOVERNING BODY AND MANAGEMENT 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 observation, review of medical records, review of policies and procedures, and staff interview, it was determined that the governing body failed to demonstrate that it is effective in carrying out the operation and management of the facility. The necessary oversight and leadership was not provided as evidenced by the lack of compliance with 416.51 Condition for Coverage: Infection Control.	Q 040		
Q 101	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary	Q 101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/13/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001229	A. BUILDING _____ B. WING _____	01/13/2015

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Q 101	Continued From page 1 environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that a safe environment is maintained for patients, staff, and the general public. Findings include: 1. On 1/7/15 at approximately 9:30 AM, in the presence of Staff #1, it was noted that the wooden exit stairway leading from the lower level was structurally deficient and in need of repair. 2. This finding was confirmed by Staff #1.	Q 101		
Q 240	416.51 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, staff interview, and document review conducted on 1/7/15, it was determined that the facility failed to ensure that there is an ongoing program to prevent, control and investigate infections, and communicable diseases. The infection control program had not implemented the nationally recognized infection control guidelines that the facility has selected. Findings include:	Q 240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001229	A. BUILDING _____ B. WING _____	01/13/2015

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PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

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Q 240	Continued From page 2 1. The facility failed to ensure that a functional and sanitary environment for the provision of surgical services is provided in accordance with the professionally acceptable standards of practice. (Cross refer to Tag Q 0241) 2. The facility failed to ensure compliance with its Infection Control policies and procedures, and that the AAMI (Association for the Advancement of Medical Instrumentation) guidelines that it has selected for its Infection Control program is implemented and monitored. (Cross refer to Tag Q 242)	Q 240		
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation and staff interviews conducted on 1/7/15, it was determined that the facility failed to ensure that a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice is provided and maintained. Findings include: Reference #1: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2014 edition ST 79 section 3.3.7.4 states, "...sterilizers should be located in a restricted-access area. Sterilizers should not be located in high traffic areas or near	Q 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001229	A. BUILDING _____ B. WING _____	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

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Q 241	Continued From page 3 any potential sources of contamination, ..." 1. In the Sterilization Room at 11:40 AM, the wall above the prep and pack counter contained exposed particulate material. This observation was cited on the 5/28/14 survey and remains uncorrected. a. The exposed particulate matter can generate loose fibers and dust, and is not a cleanable surface. b. This finding was confirmed by Staff #1 and Staff #2. 2. At 11:42 AM, two quart-size plastic containers were stored on the prep and pack counter. a. The two containers were cracked, and contained tape and other residues. b. At 11:43 AM, Staff #3 stated that the containers are "used to keep the towels from sliding." 3. At 11:45 AM, a Prepzyme enzymatic foam spray was stored on a shelf above the prep and pack counter in the Sterilization Room. a. Staff #3 stated that the spray is used in the Decontamination Room for soiled instruments but is stored in the Sterilization Room. 4. The facility failed to provide a functional and sanitary environment for the reprocessing of its surgical instruments. Reference #2: AAMI (Association for the Advancement of Medical Instrumentation)	Q 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

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Q 241	Continued From page 4 Sterilization in Health Care Facilities, 2014 edition ST 79 section 8.9.2 states, "Sterile items should be stored in a manner that reduces the potential for contamination." 1. In the Sterilization Room at 12:10 PM, sterile instrument trays were stored in front of the HVAC (Heating, Ventilating and Air Conditioning) unit. a. The HVAC unit was wrapped in torn insulation, exposing some of the pink insulation material. The HVAC unit was coated with a layer of dust and white debris. b. Dust, debris and insulation fibers from the HVAC unit can compromise the integrity of the sterile trays. 2. The facility failed to provide a functional and sanitary environment for the storage of its sterile instruments.	Q 241		
Q 242	416.51(b) INFECTION CONTROL PROGRAM 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: A. Based on direct observation, staff interviews and document review conducted on 1/7/15, it was determined that the facility failed to ensure that an ongoing infection control program that adheres	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Q 242	Continued From page 5 to its policies and procedures and to the nationally recognized infection control guidelines that it had selected , i.e., AAMI [Association for the Advancement of Medical Instrumentation], is implemented and maintained. Findings include: Reference #1: Facility document titled, "Designation Of Time Related Or Event Related Shelf Life" states, "Procedure: ... 1. Sterile items may be used as long as the integrity of the packaging is not compromised, i.e. (sic) torn, wet, punctured or otherwise suspected of being contaminated through improper storage of handling." ...Storage Conditions: 10. Sterile storage is not permitted near a running water source, non-medical fluids, windows, doors or directly under or adjacent to vents." Reference #2: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2014 edition section 8.9.2 states, "Sterile items should be stored in a manner that reduces the potential for contamination." 1. In the Sterilization Room at 12:10 PM, nine sterile instrument trays were stacked on a multi-tiered transport table and stored in front of the HVAC (Heating, Ventilating Air Conditioning) unit. a. The HVAC unit was wrapped in torn insulation, exposing some of the pink insulation material. The HVAC unit was coated with a layer of dust and white debris. b. An air conditioner unit located behind the	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Q 242	Continued From page 6 HVAC unit, was blowing air towards the sterile instruments. c. Dust, debris, and insulation fibers from the HVAC unit can compromise the integrity of the sterile trays. 2. Staff #2 was immediately made aware of the situation at 12:15 PM. 3. At 12:25 PM, the nine sterile trays were removed from the Sterilization Room. 4. Upon interview, Staff #2 confirmed that the instruments were brought to the Operating Room for use. These findings resulted in an Immediate Jeopardy which immediately curtailed this practice. The Immediate Jeopardy was removed on 1/7/15, upon receipt of an acceptable plan of correction. B. Based on observation and staff interview on 1/9/15, it was determined that the facility failed to ensure that recommended infection control guidelines were adhered to by staff. Findings include: Reference #1: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee and the ICA/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16). Recommendations: 1. Indications for Hand washing and Hand	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

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Q 242	Continued From page 7 antisepsis... J. Decontaminate hands after removing gloves." Reference #2: Facility policy titled, "Hand Hygiene" states, "...Use an alcohol based hand rub or alternately wash hands with antimicrobial soap during patient care...8. After removing gloves..." 1. At 10:45 AM, in the Laboratory area, Staff #16 was observed changing gloves several times without using an alcohol based hand rub or washing his/her hands with antimicrobial soap during patient care. 2. At 11:50 AM, in the Operating Room, Staff #19 was observed changing gloves without using an alcohol based hand rub or washing his/her hands with antimicrobial soap. 3. At 11:55 AM, in the Operating Room, the following was observed: a. While wearing gloves, Staff #19 picked up paper from the floor and threw it in the garbage. He/She then picked up a package of sterile gloves and handed them to the physician. b. Staff #19 failed to remove the contaminated gloves and use an alcohol based hand rub or wash his/her hands with antimicrobial soap. 4. These findings were confirmed by Staff #1.	Q 242		
Q9999	FINAL OBSERVATIONS 1/7/2014 - During the tour of the sterile processing room, sterilized instruments were observed drying on a shelving unit. Above this	Q9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001229	A. BUILDING _____ B. WING _____	01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Q9999	Continued From page 8 unit is an HVAC unit. The unit was covered with dust and debris and had exposed insulation on the side. This unit was blowing the dust onto the cooling instruments. Staff discussed this with the physician and the surgical tech, who indicated understanding and said this practice would stop. About 30 minutes later, the surveyor returned to ascertain the disposition of the instruments, to find out that they were sent to the OR for use, instead of re-cleaning and reprocessing the instruments. At this time an IJ was called and a Plan of Correction was requested.	Q9999		

State of New Jersey
DEPARTMENT OF HEALTH

PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

July 31, 2015

Nicholas Campanella, MD
Pilgrim Medical Center, Inc
393 Bloomfield Avenue
Montclair, NJ 07042

Dear Dr. Campanella:

Thank you for the courtesy and cooperation extended during the Federal revisit survey of your facility on July 15, 2015 by a surveyor from the New Jersey Department of Health.

Enclosed is the CMS-2567B form which indicates that the Federal deficiencies, identified during the survey of January 13, 2015 were corrected.

Should you have questions, please do not hesitate to contact me at (609) 292-9900.

Sincerely,

Louise A, Steska, MSN, RN
Health Care Services Evaluator/Nurse
Survey and Certification

Encl.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
31C0001229 Y1	A. Building B. Wing Y2	7/15/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM MEDICAL CENTER, INC	393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Q0040	Correction	ID Prefix Q0101	Correction	ID Prefix Q0240	Correction
Reg. # 416.41	Completed	Reg. # 416.44(a)(1)	Completed	Reg. # 416.51	Completed
LSC	07/15/2015	LSC	07/15/2015	LSC	07/15/2015
ID Prefix Q0241	Correction	ID Prefix Q0242	Correction	ID Prefix	Correction
Reg. # 416.51(a)	Completed	Reg. # 416.51(b)	Completed	Reg. #	Completed
LSC	07/15/2015	LSC	07/15/2015	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
1/13/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

RESPONSE TO STATEMENT OF DEFICIENCIES

- **Q040 416.41**

This deficiency was corrected on January 15, 2015 at which time the Governing Body of Pilgrim, consisting of the Medical Director, the Alternate Medical Director, the Administrator and the Director of Nursing met and reviewed their responsibilities with regard to oversight, with respect to the general day-to-day operations as well as compliance with CMS conditions of coverage specifically including infection control. The Governing Body reviewed its responsibilities for oversight and accountability for the quality assessment and performance improvement program and ensuring that the facilities policies and programs are administered so as to provide quality healthcare in a safe environment. The Governing Body also appointed an Assistant Director of Nursing to assist the Director of Nursing with implementation, administration and enforcement of the inflation control program.

Pilgrim will ensure that this does not recur by holding semi-annual meetings of the Governing Body, at which time all policies and procedures will be reviewed for compliance and proper oversight. Moreover, the Medical Director will directly oversee the implementation and administration of the infection control program by the Director of Nursing and the Assistant Director of Nursing. The Medical Director will be responsible for scheduling meetings to review observation and oversight on a monthly basis. Any deficiencies discovered as a result of such meetings shall be reported to the quality assurance committee for remedy. In the event the Governing Body determines at any such meeting that the policies require revision there will be an in-service or all employees within 7 days of any such change. The Director of Nursing shall be responsible for scheduling these in-services and the attendance and result of same shall be reported to the patient care policy committee.

- **Q101 416.44(a)(1)**

This deficiency has been corrected as of April 15, 2015 at which time the stairway in question was

repaired and reconstructed to eliminate any structural deficiency.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

OK mm 5-21-2015

- **Q240 416.51**

Please see responses to Tag Q 0241 and Q 242.

- **Q 241 416.241(a)**

With regard to the exposed particulate material observed on the wall in the sterilization room as of January 15, 2015, this wall has been thoroughly cleaned and repaired and the Alternative Medical Director checks this area daily to make sure that there are no further defects in the material and that there is no particulate matter or any other debris present.

OK. Acm 6/4/15

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

The two quart sized plastic containers were removed and disposed of and this deficiency was corrected on January 15, 2015 and the staff has been instructed that no such items should ever be used as weights in the future.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

The Prepzyme Enzymatic foam spray was removed from the sterilization area and returned to the

decontamination room on January 15, 2015 at which time this deficiency was corrected. Staff has been instructed that the Prepzyme enzymatic foam spray must remain in the decontamination room and should never inadvertently be moved to the prep and pack or sterilization area.

Pilgrim will ensure that this deficiency does not recur by observing, on a daily basis, that Prepzyme enzymatic foam spray is contained in the decontamination area. The Medical Director and/or the Alternate Medical Director will be responsible for this daily observation and they will report all findings, including any deficiency, to the Infection Control Committee for re-training and remedy as needed. The facility will remain in compliance with functional and sanitary environmental conditions and in compliance with infection control through staff in-services and continued environmental rounds monitoring as indicated herein.

OK
ACM
6/4/15

As a preliminary matter, the unit in question was not a heating and air conditioning unit; it was, in fact, the boiler for the two sterilizer units. At no time has Pilgrim ever placed or considered placing any sterile instruments directly in front of any heating or air conditioning units due to the dust that clearly accumulates on such units. The boiler was wrapped in a pink insulation material which has since been removed and will be replaced with appropriately sealed insulation on or before June 1, 2015. Once again, the unit in question was the boiler unit used for the functioning of the sterilizers and the air conditioning unit had properly cleaned filters, which are cleaned on a weekly basis. Pilgrim accepts the fact that dust, debris and insulation fibers can compromise the integrity of sterile trays. However, it was due to an OSHA recommendation that this extremely hot unit was initially covered with insulation. The instruments in question, as Staff #2 recalls, were re-sterilized immediately at the recommendation of the surveyor who observed their location. To the best of Staff #2's recollection, the resolution of immediate jeopardy was, in fact, the immediate re-sterilization of these nine packs. That said, this deficiency has been corrected as of January 15, 2015 at which time the sterilization team was

instructed that no sterile packs are to be placed in this location to ensure stability.

Please also be advised that the sterilization area is serviced by two separate intake/outtake ventilation systems and a separate independent exhaust system which maintains negative pressure throughout. There are no fans or portable air conditioning units of any kind in the sterilization area. The unit in question is the latest model of ductless air conditioning units which is used extensively in hospitals and, in accordance with the owner's manual, utilizes an intake/outtake system with rate of air exchange of up to 11.4 cubic meters per minute. The system is a Daikin model # EDUS041501 and the owner's manual, the Engineering Data Manual" can be found at http://www.daikinac.com/content/assets/DOC/EngineeringManuals/EDUS041501.pdf. The owner's manual includes detailed diagrams of the intake/outtake system and the filtration system on pages 81-84.

OK

ACM 6/4/15

Pilgrim will ensure that this deficiency does not recur by observing, on a daily basis, that these packs are in a clean area void of dust and kept away from any potential heat or air conditioning vents. The Medical Director and/or the Alternate Medical Director will be responsible for this daily observation and they will report all findings, including any deficiency, to the Infection Control Committee for re-training and remedy as needed. The facility will remain in compliance with functional and sanitary environmental conditions and in compliance with infection control through staff in-services and continued environmental rounds monitoring as indicated herein.

- **Q242 416.51 (b)**

As a preliminary matter, the unit in question was not a heating and air conditioning unit; it was, in fact, the boiler for the two sterilizer units. At no time has Pilgrim ever placed or considered placing any sterile instruments directly in front of any heating or air conditioning units due to the dust that clearly accumulates on such units. The boiler was wrapped in a pink insulation material which has since been removed and will be replaced with appropriately sealed insulation on or before June 1, 2015. Once again, the

OK ACM 6/4/15

unit in question was the boiler unit used for the functioning of the sterilizers and the air conditioning unit had properly cleaned filters, which are cleaned on a weekly basis. Pilgrim accepts the fact that dust, debris and insulation fibers can compromise the integrity of sterile trays. However, it was due to an OSHA recommendation that this extremely hot unit was initially covered with insulation. The instruments in question, as Staff #2 recalls, were re-sterilized immediately at the recommendation of the surveyor who observed their location. To the best of Staff #2's recollection, the resolution of immediate jeopardy was, in fact, the immediate re-sterilization of these nine packs. That said, this deficiency has been corrected as of January 15, 2015 at which time the sterilization team was instructed that no sterile packs are to be placed in this location to ensure stability.

OK 6/4/15

Please also be advised that the sterilization area is serviced by two separate intake/outtake ventilation systems and a separate independent exhaust system which maintains negative pressure throughout. There are no fans or portable air conditioning units of any kind in the sterilization area. The unit in question is the latest model of ductless air conditioning units which is used extensively in hospitals and, in accordance with the owner's manual, utilizes an intake/outtake system with rate of air exchange of up to 11.4 cubic meters per minute. The system is a Daikin model # EDUS041501 and the owner's manual, the Engineering Data Manual" can be found at http://www.daikinac.com/content/assets/DOC/EngineeringManuals/EDUS041501.pdf. The owner's manual includes detailed diagrams of the intake/outtake system and the filtration system on pages 81-84.

Pilgrim will ensure that this deficiency does not recur by observing, on a daily basis, that these packs are in a clean area void of dust and kept away from any potential heat or air conditioning vents. The Medical Director and/or the Alternate Medical Director will be responsible for this daily observation and they will report all findings, including any deficiency, to the Infection Control Committee for re-training and remedy as needed. The facility will remain in compliance with functional and sanitary environmental conditions and in compliance with

infection control through staff in-services and continued environmental rounds monitoring as indicated herein.

This deficiency has also been corrected on January 15, 2015 at which time Staff #16 and Staff #19 were re-trained in proper hand hygiene. Staff #19 was also retrained in appropriate operating room hygiene required by infection control. Pilgrim supplies alcohol based hand rub and sinks with antibacterial soap in all required areas.

Pilgrim will ensure that this deficiency does not recur by continuing its regular observation of hand hygiene as conducted by the Director of Nursing. All findings are reported to the Infection Control Committee for remedy as necessary.

OK ACM 6/4/15

- **K 115 416.44(b)(1)**

This deficiency has been corrected on or about February 1, 2015 at which time the opening in the wall above the door to the lower level storage room was repaired using ½" sheet rock in order to prevent the travel of smoke from one room to another in the event of fire.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

OK mm 5-21-2015

The smoke doors separating the reception area and the patient exam rooms are in the process of being replaced with new, air tight, doors in order to prevent the transference of smoke from one area to another. Pilgrim anticipates installation will be completed on or before May 1, 2015. A number of attempts have been made to make this correction sooner; however, the prior manufacturer never delivered the items as promised. A new contractor has been hired and has already proven to be much more reliable.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and

observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

CONCLUSION

Pilgrim submits this Plan of Correction for consideration by the Department and awaits the Department's determination.

Very truly yours,

PILGRIM MEDICAL CENTER INC.

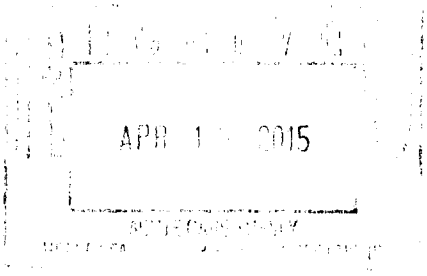
By: Nicholas V. Campanella, MD

Nicholas v. Campanella, MD, FACOG
Medical Director, C.E.O.

Americans United for Life

393 Bloomfield Avenue
Montclair, New Jersey 07042
Toll Free in New Jersey: (800) 772-2174
Other Areas: (201) 746-1500

Federal



Pilgrim
Medical Center, Inc.

April 13, 2015

VIA FEDERAL EXPRESS

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse
Survey and Certification
New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation & Licensing
120 South Stockton Street
Trenton, New Jersey 08611

Re: Pilgrim Medical Center, Inc.
Facility ID No.: 70789

Dear Ms. Steska,

Surveyors from the State of New Jersey Department of Health and Senior Services (hereinafter referred to as the "Department") inspected Pilgrim Medical Center, Inc.'s facility (hereinafter referred to as "Pilgrim") on January 7, 2015, January 9, 2015 and January 13, 2015. As the State Form does not provide sufficient space for Pilgrim to provide a Plan of Correction to the Statement of Deficiencies, this letter shall constitute the "Plan of Correction" and Pilgrim's response which is expressly incorporated into the State Form and made part thereof.

Americans United for Life

Federal PoC

RESPONSE TO STATEMENT OF DEFICIENCIES

- **Q040 416.41**

This deficiency was corrected on January 15, 2015 at which time the Governing Body of Pilgrim, consisting of the Medical Director, the Alternate Medical Director, the Administrator and the Director of Nursing met and reviewed their responsibilities with regard to oversight, with respect to the general day-to-day operations as well as compliance with CMS conditions of coverage specifically including infection control. The Governing Body reviewed its responsibilities for oversight and accountability for the quality assessment and performance improvement program and ensuring that the facilities policies and programs are administered so as to provide quality healthcare in a safe environment. The Governing Body also appointed an Assistant Director of Nursing to assist the Director of Nursing with implementation, administration and enforcement of the inflation control program.

Pilgrim will ensure that this does not recur by holding semi-annual meetings of the Governing Body, at which time all policies and procedures will be reviewed for compliance and proper oversight. Moreover, the Medical Director will directly oversee the implementation and administration of the infection control program by the Director of Nursing and the Assistant Director of Nursing. The Medical Director will be responsible for scheduling meetings to review observation and oversight on a monthly basis. Any deficiencies discovered as a result of such meetings shall be reported to the quality assurance committee for remedy. In the event the Governing Body determines at any such meeting that the policies require revision there will be an in-service or all employees within 7 days of any such change. The Director of Nursing shall be responsible for scheduling these in-services and the attendance and result of same shall be reported to the patient care policy committee.

OK
KM
6/5/15

- **Q101 416.44(a)(1)**

This deficiency has been corrected as of April 1, 2015 at which time the stairway in question was

repaired and reconstructed to eliminate any structural deficiency.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

- **Q240 416.51**

Please see responses to Tag Q 0241 and Q 242.

- **Q 241 416.241(a)**

With regard to the exposed particulate material observed o the wall in the sterilization room as of January 15, 2015, this wall has been thoroughly cleaned and repaired and the Alternative Medical Director checks this area daily to make sure that there are no further defects in the material and that there is no particulate matter or any other debris present.

The two quart sized plastic containers were removed and disposed of and this deficiency was corrected on January 15, 2015 and the staff has been instructed that no such items should ever be used as weights in the future.

NOT ok

ACM

1/6/15

The Prepzyme Enzymatic foam spray was removed from the sterilization area and returned to the decontamination room on January 15, 2015 at which time this deficiency was corrected. Staff has been instructed that the Prepzyme enzymatic foam spray must remain in the decontamination room and should never inadvertently be moved to the prep and pack or sterilization area.

As a preliminary matter the unit in question was not a heating and air conditioning unit, it was in fact the boiler for the two sterilizer units. At no time has Pilgrim ever placed or considered placing any sterile instruments directly in front of any heating or air conditioning unity due to the dust that clearly accumulates on such units. The boiler was wrapped in a pink insulation material which has since been removed so that the boiler can be more

efficiently cleaned and maintained. Once again, the unit in question was the boiler unity used for the functioning of the sterilizers and the air conditioning unit had properly cleaned filters which are cleaned on a weekly basis. Pilgrim accepts the fact that dust, debris and insulation fibers can compromise the integrity of sterile trays; however, it was due to an OSHA recommendation that this extremely hot unit was initially covered with insulation. The instruments in questions, as Staff #2 recalls, were re-sterilized immediately at the recommendation of the surveyor who observed their location. To the best of Staff #2's recollection, the resolution of immediate jeopardy was, in fact, the immediate re-sterilization of these 9 packs. That said, this deficiency has been corrected as of January 15, 2015, at which time the sterilization team was instructed that no sterile packs are to be placed into his location to ensure sterility.

NOT OK

ACM 5/5/15

Pilgrim will ensure that these deficiencies do not recur by observing on a daily basis that these items are in a clean, appropriate area and no inappropriate items are stored anywhere they should not be. The Medical Director and/or Alternate Medical Director will be responsible for all daily observations and they will report all findings including any deficiencies to the Infection Control Committee for retraining and remedy as needed.

The facility will remain in compliance with functional sanitary and environmental conditions, and in compliance with infection control, through staff in services and continuing environmental rounds monitoring.

- **Q242 416.51 (b)**

As a preliminary matter the unit in question was not a heating and air conditioning unit, it was in fact the boiler for the two sterilizer units. At no time has Pilgrim ever placed or considered placing any sterile instruments directly in front of any heating or air conditioning unity due to the dust that clearly accumulates on such units. The boiler was wrapped in a pink insulation material which has since been removed so that the boiler can be more efficiently cleaned and maintained. Once again, the unit in question was the boiler unity used for the

NOT OK

ACM 5/5/15

functioning of the sterilizers and the air conditioning unit had properly cleaned filters which are cleaned on a weekly basis. Pilgrim accepts the fact that dust, debris and insulation fibers can compromise the integrity of sterile trays; however, it was due to an OSHA recommendation that this extremely hot unit was initially covered with insulation. The instruments in questions, as Staff #2 recalls, were re-sterilized immediately at the recommendation of the surveyor who observed their location. To the best of Staff #2's recollection, the resolution of immediate jeopardy was, in fact, the immediate re-sterilization of these 9 packs. That said, this deficiency has been corrected as of January 15, 2015, at which time the sterilization team was instructed that no sterile packs are to be placed into his location to ensure sterility.

Pilgrim will ensure that this deficiency does not recur by observing on a daily basis that these packs are in a clean area void of dust and kept away from any potential heat or air conditioning vents. The Medical Director and/or Alternate Medical Director will be responsible for all daily observations and they will report all findings including any deficiencies to the Infection Control Committee for retraining and remedy as needed.

The facility will remain in compliance with functional sanitary and environmental conditions, and in compliance with infection control, through staff in services and continuing environmental rounds monitoring.

This deficiency has also been corrected on January 15, 2015 at which time Staff #16 and Staff #19 were re-trained in proper hand hygiene. Staff #19 was also retrained in appropriate operating room hygiene required by infection control. Pilgrim supplies alcohol based hand rub and sinks with antibacterial soap in all required areas.

Pilgrim will ensure that this deficiency does not recur by continuing its regular observation of hand hygiene as conducted by the Director of Nursing. All findings are reported to the Infection Control Committee for remedy as necessary.

- **K 115 416.44(b)(1)**

This deficiency has been corrected on or about February 1, 2015 at which time the opening in the wall above the door to the lower level storage room was repaired using ½" sheet rock in order to prevent the travel of smoke from one room to another in the event of fire.

The smoke doors separating the reception area and the patient exam rooms are in the process of being replaced with new, air tight, doors in order to prevent the transference of smoke from one area to another. Pilgrim anticipates installation will be completed on or before May 1, 2015. A number of attempts have been made to make this correction sooner; however, the prior manufacturer never delivered the items as promised. A new contractor has been hired and has already proven to be much more reliable.

Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using a monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All findings will be reported to the building and maintenance committee for remedy as needed.

CONCLUSION

Pilgrim submits this Plan of Correction for consideration by the Department and awaits the Department's determination.

Very truly yours,

PILGRIM MEDICAL CENTER INC.

[redacted]

PRINTED: 02/11/2019

Statement of Deficiencies
Citation Summary Sheet

For: CHERRY HILL WOMENS CENTER (22445 / NJ310001113)

Survey Event: 9LOL11, Exit Date 12/08/2017

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
State	3B6I	9.00	00	0000	INITIAL COMMENTS	
State	3B6I	9.00	00	1185	GEN REQUIREMENTS: PERSONNEL	
State	3B6I	9.00	00	1297	GEN REQUIREMENTS: EMPLOYEE HEALTH	
State	3B6I	9.00	00	2376	PHARMACEUTICAL SVCS: ADMIN OF MEDS	
State	3B6I	9.00	00	2432	PHARMACEUTICAL SVCS: STORAGE OF DRUGS	
State	3B6I	9.00	00	3945	MEDICAL RECORDS: REQUIREMNTS FOR ENTRIES	
State	3B6I	9.00	00	4071	INFEC PREV & CONTROL: POL & PROCEDURES	
State	3B6I	9.00	00	4098	INFEC PREV & CONTROL: POL & PROCEDURES	
State	3B6I	9.00	00	4112	INFEC PREV & CONTROL: POL & PROCEDURES	
State	3B6I	9.00	00	4183	INFEC PREV & CONTROL: INFEC PREV MEASURES	
State	3B6I	9.00	00	4215	INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS	
State	3B6I	9.00	00	4674	HOUSKEEPING-SANITATN-SAFETY: HOUSKEEPING P&Ps	
State	3B6I	9.00	00	4797	HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SERV	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	INITIAL COMMENTS This was a State Re-Licensure survey conducted on 12/7/2018 and 12/8/2017. Medical records reviewed: 20 Personnel files reviewed/staff interviews: 23	A 000		
A1185	8:43A-3.5(d)(1) GEN REQUIREMENTS: PERSONNEL All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency plans and procedures, the infection prevention and control program, universal precautions, policies and procedures concerning patient rights, and, if appropriate, given the patient population of the facility, identification of cases of child abuse and/or elder abuse. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview conducted on 12/8/2017, it was determined that the facility failed to ensure that all personnel receive orientation at the time of employment and at least an annual in-service education regarding, at a minimum, emergency plans and procedures, the infection prevention and control program, universal precautions, policies and procedures concerning patient rights, and identification of elder abuse. Findings include: 1. A review of (11) eleven out of (11) eleven	A1185		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1185	Continued From page 1 employee files (#1, #2, #4, #5, #8, #9, #13, #20, #21, #22 and #23), lacked evidence of annual education regarding emergency plans and procedures, infection prevention and control, universal precautions, patient rights, and elder abuse. 2. The above findings were confirmed by Staff #1.	A1185		
A1297	8:43A-3.7(a) GEN REQUIREMENTS: EMPLOYEE HEALTH The policy and procedures manual of the facility shall include policies and procedures to ensure that physical examinations of employees are performed upon employment and subsequently and shall specify the circumstances under which other persons providing direct patient care services shall receive a physical examination and the content and the frequency of the examinations for employees and other persons providing direct patient care services. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview conducted on 12/8/2017, it was determined that the facility failed to have a policy to ensure that physical examinations are performed on employees, subsequent to the physical examination performed upon employment, including the frequency and content of the examinations.	A1297		

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A1297	Continued From page 2 Findings include: 1. A review of twelve (12) out of twelve (12) employee files (#1, #2, #3 #4, #8, #9, #13, #15, #20, #21, #22 and #23), lacked evidence of a history and physical examination upon hire and subsequently. 2. The above findings were confirmed with Staff #1.	A1297		
A2376	8:43A-9.4(a) PHARMACEUTICAL SVCS: ADMIN OF MEDS All medications administered shall be prescribed in writing. Each written order shall specify the name of the drug, dose, frequency, and route of administration and shall be signed and dated by the prescriber. This REQUIREMENT is not met as evidenced by: A. Based on document review and staff interview conducted on 12/8/17, it was determined that the facility failed to ensure that medications administered are prescribed in writing. Findings include: 1. The administration of Morphine 4 mg IVP, on 9/29/17 at 11:17 AM, was recorded in Medical Record #13. a. There was no evidence of a physician's order for Morphine.	A2376		

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A2432	Continued From page 3	A2432		
A2432	8:43A-9.5(b) PHARMACEUTICAL SVCS: STORAGE OF DRUGS All drugs shall be stored under proper conditions, as indicated by the United States Pharmacopoeia, product labeling, and/or package inserts. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of facility policy, it was determined that the facility failed to ensure safe injection practices are followed in accordance with its policies. Findings include: Reference #1: Facility policy titled, Medication - Administration; Control and Storage of states, "Procedure ... 7. Multi use vials must be used within 28 days of opening. Do not use expiration date when discarding." Reference #2: United States Pharmacopia (USP) General Chapter 797 [16] states, "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial." 1. During an observation in the Post Anesthesia Care Unit (PACU) on 12/7/17, at approximately 12:35 PM, Staff #18 obtained a multidose vial of Nubain from an open box. Staff #18 withdrew the medication from the vial and confirmed that it was	A2432		

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A2432	Continued From page 4 ready to be administered to the patient. a. During an interview, Staff #18 confirmed that the medication vial had been accessed prior to the above medication preparation, and there was no date of opening on the medication vial label.	A2432		
A3945	8:43A-13.4(a) MEDICAL RECORDS: REQUIREMNTS FOR ENTRIES All orders for patient care shall be prescribed in writing and signed and dated by the prescriber, in accordance with the laws of the State of New Jersey. All orders, including verbal orders, shall be verified or countersigned in writing within seven days. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview conducted on 12/8/17, it was determined that the facility failed to ensure the development of policies and procedures addressing the signing of verbal orders by the prescriber. Findings include: 1. Facility policy titled, "Verbal Orders" fails to address the procedure for the signing of verbal orders by the prescriber, including that the order must be signed within seven (7) days. 2. This finding was confirmed by Staff #1.	A3945		
A4071	8:43A-14.2(b) INFEC PREV & CONTROL: POL & PROCEDURES	A4071		

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A4071	Continued From page 5 The infection control committee, with assistance from each service in the facility, shall develop, implement, and review, every three years or more frequently as necessary, written policies and procedures regarding infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy on 12/7/2017, it was determined that the facility failed to ensure that staff followed the policy regarding Operating Room (OR) attire. Findings include: Reference: Facility policy titled, "OR Attire" states, "...Surgical caps must be worn at all times in all areas of the operating room ... 3. All surfaces must be covered." 1. During an observation in the operating room, at approximately 11:55 AM, Staff #15 and Staff #16 failed to contain all their head hair beneath the surgical cap.	A4071		
A4098	8:43A-14.2(b)(4) INFEC PREV & CONTROL: POL & PROCEDURES	A4098		

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A4098	Continued From page 6 The infection control committee, with assistance from each service in the facility, shall develop, implement, and review, every three years or more frequently as necessary, written policies and procedures regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following: Infection control practices, including universal precautions, in accordance with the Occupational Safety and Health Administration (OSHA) rule 29 CFR Part 1910.1030, Occupational Exposure to Bloodborne Pathogens, incorporated herein by reference. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility policies and procedures, and review of nationally recognized guidelines and regulations, it was determined that the facility failed to ensure that Infection Control practices are implemented in accordance with OSHA regulations. Findings include: Reference #1: OSHA 29 CFR part 1910.1030(d)(3)(i) states, "Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective	A4098		

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A4098	Continued From page 7 equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used." 1. On 12/7/17 at 9:40 AM during the entrance conference, Staff #2 confirmed that the facility's Infection Control program is based on Center for Disease Control (CDC), OSHA, and Association for the Advancement of Medical Instrumentation (AAMI), guidelines and recommendations. 2. On 12/7/17 at 10:40 AM, in the Decontamination area, Staff #8 was observed manually cleaning and disinfecting a Dilation and Evacuation (D&E) tray. a. Staff #8 was observed pouring products of conception from a glass jar into a Styrofoam cup. (i) Staff #8 was donned in a blue Eclipse surgical gown. (ii) The Eclipse gown packaging indicates the gown is a Level 2 permeable gown. (iii) On 12/8/17, Staff #7 confirmed the gowns were level 2 permeable gowns. b. The facility failed to ensure staff in the Decontamination area wear impervious gowns. Reference #2: OSHA 29 CFR part 1910.1030(d)(2)(xiii) states, "Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during	A4098		

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A4098	Continued From page 8 collection, handling, processing, storage, transport, or shipping." Reference #3: Facility policy titled, "Laboratory Specimens" states, "Policy: ...2. ...Once the procedure is finished the specimen is kept in the suction bottle and taken into the Decontamination Room in preparation for the transfer to the Laboratory. ...1. Decontamination personnel will transfer the specimen into a Styrofoam cup with lid. The patients name is written on the cup...The cup is placed in the designated holders in the transport container. Be careful not to overload container. 3. The sterilization technician will see that the specimen transport container is taken to the outside door of the PACU (Post Anesthesia Care Unit) closet to the laboratory. 4. The laboratory technician, will take the transport container and drop it off at the laboratory." 1. On 12/7/17 at 10:40 AM, in the Decontamination area, Staff #8 was manually cleaning and disinfecting a Dilation and Evacuation (D&E) tray. a. Staff #8 was pouring products of conception from a glass jar into a Styrofoam cup and covered it with a lid. (i) Staff #8 placed, on the outside of the Styrofoam cup, a yellow "Post-it" sticker with the patient's first name and last initial written on it. (ii) Staff #8 then placed the cup into a red cooler and transported the specimen to the laboratory. (iii) The Styrofoam cup can be easily punctured, therefore it is not a container which prevents leakage.	A4098		

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A4112	Continued From page 9	A4112		
A4112	8:43A-14.2(b)(6) INFEC PREV & CONTROL: POL & PROCEDURES The infection control committee, with assistance from each service in the facility, shall develop, implement, and review, every three years or more frequently as necessary, written policies and procedures regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following: Aseptic technique, employee health in accordance with N.J.A.C 8:43A-3.7, and staff training in regard to infection control. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview conducted on 12/8/17, it was determined that the facility failed to ensure that medications are prepared in a clean, dry work space. Findings include: Reference #1: CDC-HICPAC Guidelines for Environmental Infection Control in Health-Care Facilities (2003) Last update: February 15, 2017 https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines.pdf page 39 of 240 states, "Construction design and function considerations for environmental infection control ... Appropriate location of medicine preparations areas (e.g., >3 ft. from a sink)" Reference #2: APIC Position Paper, Safe	A4112		

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A4112	Continued From page 10 Injection, Infusion, and Medication Vial Practices in Health Care (2016) states, " ... Preparation of parenteral medications must be performed in a clean, dry work space that is free of clutter and obvious contamination sources (e.g., water, sinks)." 1. During a tour of the facility, Staff #2 confirmed that the facility's medication preparation area, for the preparation of medications from multi-dose vials, was the area adjacent to the sink in the Anesthesia Workroom. 2. Upon request, Staff #1 and #2 were unable to provide a policy and procedure addressing the preparation of parenteral medications at least three (3) feet from a sink.	A4112		
A4183	8:43A-14.3(a)(5) INFEC PREV & CONTROL: INFEC PREV MEASURES Infection prevention activities shall be based on Centers for Disease Control and Prevention Guidelines, and Hospital Infection Control Practices Advisory Committee (that is, HICPAC) recommendations. An exception to the adoption of the following guideline shall be allowed providing that there is a sound infection control rationale based upon scientific research or epidemiologic data. The following published guideline is incorporated herein by reference, as amended and supplemented: Guideline for Hand Hygiene in Health-Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16), published by the Coordinating Center for Health	A4183		

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A4183	Continued From page 11 Information and Service, available at http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf and at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm. This REQUIREMENT is not met as evidenced by: A. Based on observation, staff interview, and review of nationally recognized guidelines, it was determined that the facility failed to ensure a functional and sanitary environment for the provision of surgical services by adhering to CDC (Centers for Disease Control and Prevention) -HICPAC (Healthcare Infection Control Practices Advisory Committee) guidelines on hand hygiene. Findings include: Reference #1: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee[HICPAC] and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the CDC (Centers for Disease Control and Prevention) Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16) page 32 states, "Recommendations: 1. Indications for Handwashing and Hand antisepsis...B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items	A4183		

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A4183	Continued From page 12 1C-J... Alternatively, wash hands with an antimicrobial soap and water in all clinical situations described in items... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled... J. Decontaminate hands after removing gloves..." 1. On 12/7/17 at 9:40 AM during the entrance conference, Staff #2 confirmed that the facility's Infection Control program is based on Center for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), Association for the Advancement of Medical Instrumentation (AAMI), guidelines and recommendations. 2. On 12/7/17 at 10:45 AM, in the decontamination room, Staff #8 was cleaning and disinfecting a D&E tray. a. After cleaning and disinfecting the D&E tray, Staff #8 removed his/her gloves and failed to perform hand hygiene prior to exiting the decontamination room. (i) The hand washing sink in the decontamination area was filled with chux pads and the alcohol-based hand rub was not readily accessible. (ii) When asked how he/she washes his/her hands, Staff #10 replied, "Sometimes I use the sink out there," and pointed to the OR corridor. (iii) When asked if he/she uses alcohol-based hand rub, Staff #10 replied by pointing to a bottle of hand sanitizer that was up high on a shelf in the decontamination room. 3. At 11:16 AM, during an observation of cleaning	A4183		

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A4183	Continued From page 13 and disinfecting of Operating Room (OR) #1, between patients, the following was revealed: a. Staff #10 was observed using Opti-cide spray and a green towel to clean and disinfect the OR. (i) Staff #10 then failed to remove his/her gloves, prior to exiting the OR, to obtain a green watering can and mop. (ii) After obtaining the watering can and mop, Staff #10 returned to the OR, with the same gloves on, mopped the floor, and failed to remove his/her gloves prior to exiting the OR to return the watering can and mop. (iii) Staff #10 then removed his/her gloves and failed to perform hand hygiene, prior to obtaining the next case cart and returning to OR #1. B. Based on observation and review of facility policy, it was determined that the facility failed to ensure that facility policy and CDC (Centers for Disease Control) guidelines for hand hygiene are implemented. Findings include: Reference #1: Facility policy titled Handwashing, states, "CHWC [Cherry Hill Women's Center] employees are required to wash hands frequently, including between care of each patient ... It is important that you wash your hands and change your gloves between patients." Reference #2: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee[HICPAC] and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task	A4183		

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A4183	Continued From page 14 Force, published in the CDC (Centers for Disease Control and Prevention) Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16) states, "Recommendations: 1. Indications for Handwashing and Hand antisepsis... C. Decontaminate hands before having direct contact with patients... F. Decontaminate hands after contact with a patient's intact skin... J. Decontaminate hands after removing gloves." 1. During an observation on 12/7/17, the following was revealed: a. In the Ultrasound room at 10:26 AM, Staff #12 donned his/her gloves, failed to perform hand hygiene, and then touched Patient #1. i. At 10:30 AM, Staff #12 doffed his/her gloves, failed to perform hand hygiene, and then escorted Patient #1 to the Lab Room. b. In the Consult Room at 11:00 AM, Staff #14 failed to perform hand hygiene before performing a physical assessment of Patient #1. c. In the Post Anesthesia Care Unit (PACU) at 12:25 PM, Staff #18 entered the PACU from the Operating Room (OR) Suite already wearing gloves. Staff #18 then doffed his/her gloves, failed to perform hand hygiene, and obtained medications from the PACU medication storage area.	A4183		
A4215	8:43A-14.4(g) INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS The manufacturer's instructions for cleaning, testing, disassembly, and sterilization of equipment shall be readily available and followed	A4215		

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A4215	Continued From page 15 by employees. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of facility documents and nationally recognized guidelines, it was determined that the facility failed to ensure manufacturer's Instructions for Use (IFU) are readily available and followed for cleaning and sterilization of Dilation and Evacuation (D&E) instruments. Findings include: Reference #1: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2015 edition states in ST 79 section 7.2.2 Manufacturers' written IFU, states, "The written IFU of the device manufacturer should always be followed." 1. On 12/7/17 at 9:40 AM during the entrance conference, Staff #2 confirmed that the facility's Infection Control program is based on Center for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), and Association for the Advancement of Medical Instrumentation (AAMI), guidelines and recommendations. 2. On 12/7/17 at 10:13 AM, a tour was conducted of the reprocessing area and the following was revealed: a. A soiled D&E tray was being reprocessed, Staff	A4215		

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A4215	Continued From page 16 #9 confirmed the D&E tray consist's of the following instruments: - 8 Cervical dilators - 2 Allis Clamps - 1 Tenaculum - 1 Sponge forcep - 2 Curettes - 1 Speculum - 1 small basin (i) The manufacturer's IFU were requested. (ii) At 10:34 AM Staff #9 confirmed there were no IFU's available for the D&E instruments. (iii) Staff #9 confirmed he/she uses the signage posted on the outside of the sterilizer, as his/her reference for sterilization parameters. (iv) At 11:55 AM Staff #7 confirmed he/she remembers printing the IFU's for the D&E instruments, however he/she was unable to locate them at that time. The facility immediately curtailed the practice of not following IFU's for instruments. An acceptable plan of correction was received by the facility on 12/8/17. Reference #2: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2015 edition states in ST 79 section 7.5.2 Cleaning agents, states, "...The cleaning agent manufacturer's written IFU should be followed." Reference #3: Ergo-Logistics One Cleaner Enzyme Detergent label Directions for Use states, "Soaking: Add 1/4 to 1/2 oz. ...One	A4215		

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A4215	Continued From page 17 cleaner per 1 gallon...of diluent (tepid warm water). Manual Cleaning: Add 1/4 ounce ...One cleaner per 1 gallon...diluents(tepid to elevated temperature water). 1. On 12/7/17 at 10:45 AM, a tour was conducted of the decontamination area and the following was revealed: a. Staff #8 was observed using Ergo-Logistics One Cleaner Enzyme Detergent to clean and disinfect a soiled D&E tray. (i) Staff #8 was observed using several pumps of enzyme detergent, when mixing the enzyme detergent and water. (ii) Staff #8 confirmed he/she uses approximately twelve (12) pumps of enzyme detergent to one-half (1/2) to one (1) gallon of water." (iii) Staff #8, when asked how he/she measures out one (1) gallon of water, pointed to half-way up the sink and replied "I usually fill the water to about here." (iv) Staff #8 confirmed there is no marking in the sink nor is the water measured to exactly one gallon. (v) Staff #8 was observed using a measuring cup and dispensed One Cleaner Enzyme Detergent into the measuring cup and poured it into the sink of water. (vi) Staff #8 confirmed that the measuring cup was a one-half (1/2) cup. (vii) Staff #8 was neither measuring the water nor the enzyme solution correctly.	A4215		

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A4215	Continued From page 18 2. The above finding was confirmed with Staff #2.	A4215		
A4674	8:43A-17.1(e) HOUSKEEPING-SANITATN-SAFETY: HOUSKEEPING P&Ps All cleaning and disinfecting agents shall be correctly labeled with the name of the product and its use, as specified by the manufacturer, including agents that have been repackaged from a bulk source. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure all cleaning and disinfecting agents are labeled with the name of the product and its use, as specified by the manufacturer. Findings include: Reference #1: CDC [Centers for Disease Control and Prevention] Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 page 84 states, "... By law, all applicable label instructions on EPA-registered products must be followed. If the user selects exposure conditions that differ from those on the EPA-registered product label, the user assumes liability from any injuries resulting from the off-label use and is potentially subject to enforcement action under FIFRA."	A4674		

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A4674	Continued From page 19 Reference #2: Cetylcide II Concentrate manufacturer's Instructions for Use (IFU) states, "...Bactericidal Stability of Use-Dilution: ...Always use clean, properly labeled dry containers when diluting the product. ..." 1. On 12/7/17 at 9:40 AM during the entrance conference, Staff #2 confirmed that the facility's Infection Control program is based on Center for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), Association for the Advancement of Medical Instrumentation (AAMI), guidelines and recommendations. 2. During observation of a room turnover cleaning in Operating Room (OR) #1 at 11:10 AM, Staff #10 was observed using a green garden Watering Can, to clean the OR floor. a. Upon interview, Staff #10 confirmed the Watering Can contained diluted Cetylcide-II cleaning solution, however was unsure of who mixed the solution. (i) Staff #11 confirmed he/she dilutes the solution in the morning, and uses two (2) oz. (ounces) of Cetylcide -II solution to one (1) gallon of water. (ii) The Watering Can was unlabeled and failed to contain the name of the product and its use, as specified by the manufacturer.	A4674		
A4797	8:43A-17.4(a)(15) HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SERV The following environmental condition shall be met: All equipment and environmental surfaces	A4797		

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A4797	Continued From page 20 shall be kept clean to sight and touch. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview conducted on 12/08/17, it was determined the facility failed to ensure that all environmental surfaces are maintained clean to sight and touch. Findings include: 1. During a tour conducted at approximately 10:30 AM, in the presence of Staff #7, the following were noted: a. Uncleanable tape residue was identified on cabinetry surfaces located within the clean utility room. b. The cabinet base located inside the decontamination room was damaged which would preclude cleaning. c. Trim surrounding the pass-thru window in the sterilization room exhibited uncleanable wood-like base material. d. The base on the procedure table being used within OR #1 appeared grimy and had a rust-like residue on its surface. e. Uncleanable surface damage and open parted seams were found on the monolithic flooring located in the following locations:	A4797		

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A4797	Continued From page 21 (i) The integral floor base within OR #1. (ii) In the hallway adjacent to OR #2. 2. These findings were confirmed by Staff #7.	A4797		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
22445 Y1	A. Building B. Wing Y2	4/17/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1185	Correction	ID Prefix A1297	Correction	ID Prefix A2376	Correction
Reg. # 8:43A-3.5(d)(1)	Completed	Reg. # 8:43A-3.7(a)	Completed	Reg. # 8:43A-9.4(a)	Completed
LSC	04/17/2018	LSC	04/17/2018	LSC	04/17/2018
ID Prefix A2432	Correction	ID Prefix A3945	Correction	ID Prefix A4071	Correction
Reg. # 8:43A-9.5(b)	Completed	Reg. # 8:43A-13.4(a)	Completed	Reg. # 8:43A-14.2(b)	Completed
LSC	04/17/2018	LSC	04/17/2018	LSC	04/17/2018
ID Prefix A4098	Correction	ID Prefix A4112	Correction	ID Prefix A4183	Correction
Reg. # 8:43A-14.2(b)(4)	Completed	Reg. # 8:43A-14.2(b)(6)	Completed	Reg. # 8:43A-14.3(a)(5)	Completed
LSC	04/17/2018	LSC	04/17/2018	LSC	04/17/2018
ID Prefix A4215	Correction	ID Prefix A4674	Correction	ID Prefix A4797	Correction
Reg. # 8:43A-14.4(g)	Completed	Reg. # 8:43A-17.1(e)	Completed	Reg. # 8:43A-17.4(a)(15)	Completed
LSC	04/17/2018	LSC	04/17/2018	LSC	04/17/2018
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

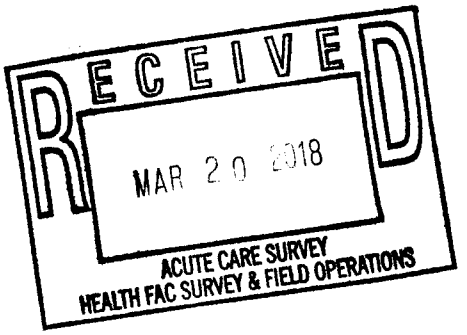
FOLLOWUP TO SURVEY COMPLETED ON
12/8/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

CHERRY HILL WOMEN'S CENTER, INC

502 Kings Highway North ◆ Cherry Hill NJ 08034
(856) 667-5910 ◆ (800) 877-6331
Fax: (856) 667-8304

March 15, 2018



Shilpa Rathore, MS, RD.
Public Health Consultant 1
Nutrition Survey and Certification
State of New Jersey
Department of Public Health
PO Box 367
Trenton, NJ 08625-0367

Dear Ms. Rathore:

Enclosed please find the proposed Plan of Corrections for Cherry Hill Women's Center following the State Survey conducted on 12/7/17 and 12/8/18.

Please do not hesitate to contact me if you have any questions regarding this plan at (856) 675-1375.

Sincerely,

Susan Sperry
Deputy Director
Cherry Hill Women's Center

Americans United for Life

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22445	A. BUILDING: _____ B. WING _____	12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

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A 000	INITIAL COMMENTS This was a State Re-Licensure survey conducted on 12/7/2018 and 12/8/2017. Medical records reviewed: 20 Personnel files reviewed/staff interviews: 23	A 000	PoC Accepted 4/6/18	
A1185	8:43A-3.5(d)(1) GEN REQUIREMENTS: PERSONNEL All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency plans and procedures, the infection prevention and control program, universal precautions, policies and procedures concerning patient rights, and, if appropriate, given the patient population of the facility, identification of cases of child abuse and/or elder abuse. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview conducted on 12/8/2017, it was determined that the facility failed to ensure that all personnel receive orientation at the time of employment and at least an annual in-service education regarding, at a minimum, emergency plans and procedures, the infection prevention and control program, universal precautions, policies and procedures concerning patient rights, and identification of elder abuse. Findings include: 1. A review of (11) eleven out of (11) eleven	A1185		

A1185

843A-5 (d)(1) GEN REQUIREMENTS PERSONNEL

1. The deficiency will be corrected as it relates to the individual by conducting a training for all staff regarding emergency plans and procedures, infection prevention and control program, universal precautions, and patients' rights.
2. Systemically, these in-service/training topics will be added to the annual calendar of trainings scheduled for the center.
3. To ensure that compliance is maintained, required trainings will be imbedded into the center's Quality Improvement Plan and will be reviewed to ensure completion at quarterly QI meetings.
4. The person responsible for ensuring implementation of this plan is the facility's Deputy Director.
5. The corrective action will be completed by April 13, 2018

A129

8:43A-3.7(a) GEN REQUIREMENTS: EMPLOYEE HEALTH

1. The deficiency will be corrected as it relates to the individual by complying with Cherry Hill Women's Center *Employee Health Exam Policy.* All applicants for employment shall undergo a health screening/physical examination following a conditional offer of employment and annually thereafter undergo an annual health screening/physical examination. In accordance with the Americans with Disabilities Act, this screening/examination shall be limited to assessing whether the applicant has a health condition that would prevent performance of the essential functions of the job or would pose a direct threat to the applicant or others, even with a reasonable accommodation.
2. Systemically, employee records will be reviewed within three months of hire and annually thereafter to ensure compliance.
3. To ensure that compliance is maintained, "Employee Health Exam" will be added to the facility's internal annual checklist for Employee Record maintenance/assurance.
4. The person responsible for ensuring compliance is maintained is the Director of Nursing
5. The corrective action will be completed by April 13, 2018.

A2376

8:43a-9.4(a) PHARMACEUTICAL SVCS:ADMIN OF MEDS

1. The deficiency will be corrected as it relates to the individual by updating the facility's policy regarding verbal orders to include the requirement that the order must be documented and signed by the ordering physician in a timely manner.
2. Systemically, the facility's Deputy Administrator (DA) will re-train all physicians regarding the updated policy.
3. To ensure that compliance is maintained, the facility's Deputy Administrator will audit ten charts for each physician on a monthly basis for twelve months.
4. The facility's Deputy Administrator is responsible for implementing the plan of correction.
5. This corrective action will be completed by April 13, 2018.

A2432

8:43-9.5(B) PHARMACEUTICAL SVCS: STORAGE OF DRUGS

1. The deficiency will be corrected as it relates to the individual by ensuring that all multi-use vials are labeled individually in addition to the boxes they are kept in.
2. Systemically, the Director of Nursing will retrain all nursing staff on proper multi-use vial labeling.
3. To ensure that compliance is maintained, the Director of Nursing will routinely spot check multi-use vials to ensure they are labeled appropriately.
4. The Director of Nursing is responsible for ensuring the PoC is adhered to.
5. This corrective action will be completed by 4.13.2018

A3945

8:43A-13.4(a) MEDICAL RECORDS: REQUIREMENTS FOR ENTRIES

1. The deficiency will be corrected as it relates to the individual by updating the facility's policy regarding verbal orders to include the requirement that the order must be documented and signed by the ordering physician in a timely manner.
2. Systemically, the facility's Deputy Administrator (DA) will re-train all physicians regarding the updated policy.
3. To ensure that compliance is maintained, the facility's Deputy Administrator will audit ten charts for each physician on a monthly basis for twelve months.
4. The facility's Deputy Administrator is responsible for implementing the plan of correction.
5. This corrective action will be completed by April 13, 2018.

A4071

8:43a-14.2(b) INFEC PREV& CONTROL: POL & PROCEDURES

1. The deficiency will be corrected as it relates to the individual by ensuring that all staff are securing all of their head hair beneath the surgical cap.
2. Systemically, the Director of Nursing will retrain all medical staff on proper use of surgical caps.
3. To ensure that compliance is maintained, the Director of Nursing will routinely spot check surgical attire to ensure proper use.
4. The Director of Nursing is responsible for ensuring the PoC is adhered to.
5. This corrective action will be completed on 4.13.18.

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A4098

8:43-14.2(b)(4) INFEC PREV & CONTROL: POL & PROCEDURES

1. The deficiency will be corrected as it relates to the individual by:
   - Updating the facility's Infection Control Plan to reflect that fact that the facility has selected and implemented guidelines from Association for the Advancement of Medical Instrumentation (AAMI), Occupational Safety and Health Administration (OSHA), and Centers for Disease Control and Prevention (CDC).
   - Ensuring that staff in the Decontamination area wear adequate Personal Protective Equipment (PPE), including a Level 4 (impermeable) gown.
   - Removing from the Decontamination area any containers which could be easily punctured, and by updating the facility's policy regarding laboratory specimens. The updated policy will reflect that specimens will be transported from the Decontamination area to the laboratory in a container which prevents leakage.
2. The systemic changes put into place for each deficiency are as follows:
   - The facility's Deputy Administrator will provide an in-service for all personnel to educate them regarding the updated Infection Control Plan.
   - The facility's Deputy Administrator will update the facility's PPE policy to reflect this change and will provide staff education for all personnel regarding this update.
   - The facility's Deputy Administrator will provide education to the facility's personnel impacted by this change in policy, namely all personnel working in Decontamination and the laboratory.
3. To ensure that compliance is maintained:
   - The Infection Control Plan will be reviewed on an annual basis by the Quality Improvement Committee to ensure that the plan accurately reflects the chosen standards of the facility's program.
   - The Level 4 gown requirement will be included in the facility's existing Hand Hygiene/ PPE QI monitoring audits which occur on a monthly basis.
   - The facility's Deputy Administrator will add this to the staff annual competencies and routinely spot check staff use of PPE and transport containers to ensure compliance.
4. The person responsible for implementing these plans is the facility's Deputy Administrator.
5. These corrective actions will be completed by April 13, 2018.

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A4112

8:43A-14.2(b)(6) INFEC PREV & CONTROL: POL & PROCEDURES

1. The deficiency will be corrected as it relates to the individual in that the facility will purchase and install a splash guard, further protecting the medication preparation area.
2. Systemically, the Director of Nursing will explain the barrier to all Anesthesiologists and Nurses ensuring that the barrier remains in place as she conducts her daily rounds of the center.
3. To ensure compliance is maintained, the facility's Director of Nursing will ensure the barrier is in place as she conducts her daily rounds of the center.
4. The Director of Nursing is responsible for ensuring this plan of correction is implemented and adhered to.
5. This corrective action will be completed by April 13,2018

A4183

8:43A-14.3(a)(5) INFEC PREV & CONTROL: INFEC PREV MEASURES

1. The deficiency will be corrected as it relates to the individual by ensuring that all handwashing sinks are free of debris. Additionally, alcohol based cleaners will be made available and within arm's reach in every clinical area of the ASC.
2. Systemically, the Director of Nursing will retrain all staff on proper hand hygiene techniques,
3. To ensure that compliance is maintained, the Director of Nursing will assess staff ability to adhere to policy by performing monthly surprise hand hygiene audits.
4. The Director of Nursing is responsible for ensuring the PoC is adhered to.
5. This corrective action will be completed on 4.13.18.

A4215

8:43A-14.4(g) INFEC PREV & CONTROL: STRILIZATN PT CARE ITEMS

1. The deficiency will be corrected as it relates to the individual by purchasing a water mark to ensure proper labeling of the sink.
2. Systemically, the center's Director of Nursing will retrain all sterilization staff to utilize the water marking in the sink along with the measuring cup as per manufacturer's recommendations.
3. To ensure compliance is maintained, the Director of Nursing will assess staff ability to adhere to IFU when completing annual competency.
4. The Director of Nursing is responsible for ensuring this PoC is maintained.
5. This corrective action will be completed on 4.13.18.

Americans United for Life

A4674

8:43A-17.1(e) HOUSEKEEPING-SANITATN-SAFETY: HOUSEKEEPING P&PS

1. The deficiency will be corrected as it relates to the individual by purchasing a transparent container that demarks measurements of liquids diluted and allows for proper labeling of said container.
2. Systemically, the center's Director of Nursing will retrain all clinical support staff to properly dilute chemicals using properly labeled container.
3. To ensure compliance is maintained, the Director of Nursing will asses staff ability to adhere to PoC when completing annual competency (formally) and on daily rounds (informally).
4. The Director of Nursing is responsible for ensuring this PoC is maintained.
5. This corrective action will be completed on 4.13.18.

A4797

8:43a-17.4(a)(15) HOUSEKEEPING-SANI & SAFETY: ENVIRNMNTL PT CARE SERV

1. The deficiency will be corrected as it relates to the individual in that the facility will;
   - Remove all tape residue from the cabinetry surfaces in the clean utility room.
   - Replace the cabinetry base in the decontamination room.
   - Re-trim the pass-thru window ensuring ability to clean.
   - Remove residue from base of OR#1 procedure table and repaint
   - Replace/repair monolithic flooring in OR #1 and hallway adjacent to OR #2
2. Systemically the Director of Nursing will retrain medical staff via a staff in-service to ensure that a sanitary environment is maintained at all times.
3. To ensure compliance is maintained, the facility's Director of Nursing will ensure the sanitary environment is maintained by conducting a monthly walkthrough of the ASC, alerting Director of needed repairs.
4. The Director of Nursing is responsible for ensuring this plan of correction.
5. The corrective action will be completed by 5.1.18

Americans United for Life

PRINTED: 02/27/2019

Statement of Deficiencies
Citation Summary Sheet

For: CHERRY HILL WOMENS CENTER (31C0001113 / NJ310001113)

Survey Event: NNPM11, Exit Date 12/08/2017

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	EP01	1.01	00	0000	Initial Comments	
Federal	FQ09	09.00	00	0000	INITIAL COMMENTS	
Federal	FQ09	09.00	00	0081	PROGRAM SCOPE; PROGRAM ACTIVITIES	
Federal	FQ09	09.00	00	0083	PERFORMANCE IMPROVEMENT PROJECTS	
Federal	FQ09	09.00	00	0181	ADMINISTRATION OF DRUGS	
Federal	FQ09	09.00	00	0184	VERBAL ORDERS	
Federal	FQ09	09.00	00	0240	INFECTION CONTROL	
Federal	FQ09	09.00	00	0241	SANITARY ENVIRONMENT	
Federal	FQ09	09.00	00	0242	INFECTION CONTROL PROGRAM	

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	31C0001113	A. BUILDING _____ B. WING _____	12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments This was a Federal Recertification Survey conducted on 12/7/2017 and 12/8/2017. The facility is in substantial compliance with Emergency Preparedness Regulation CFR 416.54. The facility is not in compliance with the requirements of of 42 CFR Part 416, Subpart C requirements for Ambulatory Surgical Centers.	E 000		
Q 000	INITIAL COMMENTS An Immediate Jeopardy (IJ) was identified on 12/7/2017. The facility failed to ensure that manufacturers' Instructions For Use (IFUs) are followed for reprocessing Dilation and Evacuation (D&E) instruments. The IJ was removed on 12/8/2017 upon receipt of an acceptable plan of correction. The following Condition for Coverage was found to be out of compliance: 416.51 Infection Control	Q 000		
Q 081	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,	Q 081		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001113	A. BUILDING _____ B. WING _____	12/08/2017

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Q 081	Continued From page 1 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 review of facility documents and staff interview on 12/8/2017, it was determined that the facility failed to establish an ongoing program that measures the total operation and ensures patient safety in the facility. Findings include: Reference #1: The facility document titled, 'Quality Improvement Plan", states, "...The members of the Quality improvement Committee (QIC) are responsible for: Assuring that the review functions outlined in this plan are completed; Prioritizing issues referred to the QIC for review; Assuring that the data obtained through QI activities are analyzed, recommendations made, and appropriate follow up of a problem resolution done; ....Reporting on ongoing findings, studies, recommendations, and trends to the Governing Body quarterly and to the Medical Staff a minimum of six (6) times per year as appropriate. ...."	Q 081		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001113	A. BUILDING _____ B. WING _____	12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Q 081	Continued From page 2 1. Staff #2 provided evidence of quality improvement Activities Schedule for performance improvement activities as outlined in the above referenced document. The schedule outlined which staff member collected data for the different QI indicators. 2. The quality assurance (QA) meeting minutes from 2/26/16 to 8/10/2017 provided by Staff #2, did not include evidence of how the data was collected and tracked. 3. During interview, Staff #2 was unable to explain what the facility did with the collected data. 4. The facility was unable to provide evidence of data analysis, recommendations and follow up of the data collected, as per the above referenced document.	Q 081		
Q 083	PERFORMANCE IMPROVEMENT PROJECTS CFR(s): 416.43(d) (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results This STANDARD is not met as evidenced by: Based on staff interview and document review, it	Q 083		

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Q 083	Continued From page 3 was determined that the facility failed to ensure that a specific annual quality improvement project was conducted. Findings include: 1. Upon interview on 12/8/2017, Staff #2 and Staff #3 indicated that they had not undertaken a specific annual quality improvement project for the year 2017.	Q 083		
Q 181	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: A. Based on document review and staff interview conducted on 12/8/17, it was determined that the facility failed to ensure that medications administered are prescribed in writing. Findings include: 1. The administration of Morphine 4 mg IVP, on 9/29/17 at 11:17 AM, is recorded in Medical Record #13. a. There was no evidence of a physician's order for Morphine.	Q 181		
Q 184	VERBAL ORDERS CFR(s): 416.48(a)(3)	Q 184		

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Q 184	Continued From page 4 Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. This STANDARD is not met as evidenced by: Based on document review and staff interview conducted on 12/8/17, it was determined that the facility failed to ensure the development of policies and procedures addressing the signing of verbal orders by the prescriber. Findings include: 1. Facility policy titled, "Verbal Orders" fails to address the procedure for signing of verbal orders by the prescriber. 2. This finding was confirmed by Staff #1.	Q 184		
Q 240	INFECTION CONTROL CFR(s): 416.51 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, document review, and staff interview, it was determined that the facility failed to maintain an infection control program that seeks to minimize infections and communicable diseases. Findings include: 1. The facility failed to ensure that medications are prepared following aseptic technique. Refer to	Q 240		

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Q 240	Continued From page 5 Tag Q 241. 2. The facility failed to ensure that a safe and sanitary environment is maintained for patients, staff, and the general public. Refer to Tag Q 241. 3. The facility failed to ensure that manufacturers' instructions for use are followed. Refer to Tag Q 241. 4. The facility failed to ensure adherence to CDC guidelines on hand hygiene. Refer to Tag Q 241. 5. The facility failed to ensure implementation of policies and procedures addressing safe injection practices. Refer to Tag Q 241. 6. The facility failed to ensure implementation of policies and procedures addressing OR attire. Refer to Tag Q 241. 7. The facility failed to ensure that its Infection Control program included that the facility followed AAMI guidelines. Refer to Tag Q 242. 8. The facility failed to ensure the implementation of an Infection Control program that adhered to OSHA regulations. Refer to Tag Q 242.	Q 240		
Q 241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by:	Q 241		

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	31C0001113	A. BUILDING _____ B. WING _____	12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 241	Continued From page 6 A. Based on observation and staff interview conducted on 12/8/17, it was determined that the facility failed to ensure that medications are prepared following aseptic technique. Findings include: Reference #1: CDC-HICPAC Guidelines for Environmental Infection Control in Health-Care Facilities (2003) Last update: February 15, 2017 https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines.pdf page 39 of 240 states, "Construction design and function considerations for environmental infection control ... Appropriate location of medicine preparations areas (e.g., >3 ft. from a sink)" Reference #2: APIC Position Paper, Safe Injection, Infusion, and Medication Vial Practices in Health Care (2016) states, " ... Preparation of parenteral medications must be performed in a clean, dry work space that is free of clutter and obvious contamination sources (e.g., water, sinks)." 1. During a tour of the facility, Staff #2 confirmed that the facility's medication preparation area, for the preparation of medications from multi-dose vials, was the area adjacent to the sink in the Anesthesia Workroom. 2. Upon request, Staff #1 and #2 were unable to provide a policy and procedure addressing the preparation of parenteral medications at least three (3) feet from a sink. B. Based on observation and staff interview on 12/08/17, it was determined the facility failed to ensure that a safe and sanitary environment is	Q 241		

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Q 241	Continued From page 7 maintained for patients, staff and the general public. Findings include: 1. During a tour conducted at 10:30 AM, in the presence of Staff #7, the following were noted: a. Uncleanable tape residue was identified on cabinetry surfaces located within the clean utility room. b. The cabinet base located inside the decontamination room was damaged which would preclude cleaning. c. Trim surrounding the pass-thru window in the sterilization room exhibited uncleanable wood-like base material. d. The base on the procedure table being used within OR #1 appeared grimy and had a rust-colored residue on its surface. e. Uncleanable surface damage and open parted seams were found on the monolithic flooring located in the following locations: (i) The integral floor base within OR #1 (ii) In the hallway adjacent to OR #2 2. These findings were confirmed by Staff #7. C. Based on observation, staff interview, and review of facility documents, and nationally recognized guidelines, it was determined that the facility failed to ensure manufacturer's	Q 241		

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Q 241	Continued From page 8 Instructions For Use (IFU) are followed for reprocessing Dilation and Evacuation (D&E) instruments. Findings include: Reference #1: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2015 edition states in ST 79 section 7.2.2 Manufacturers' written IFU, states, "The written IFU of the device manufacturer should always be followed." 1. On 12/7/17 at 9:40 AM during the entrance conference, Staff #2 confirmed that the facility's Infection Control program is based on Center for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), and Association for the Advancement of Medical Instrumentation (AAMI), guidelines and recommendations. 2. On 12/7/17 at 10:13 AM, a tour was conducted of the reprocessing area and the following was revealed: a. A soiled D&E tray was being reprocessed. Staff #9 confirmed the D&E tray consist's of the following instruments: - 8 Cervical dilators - 2 Allis Clamps - 1 Tenaculum - 1 Sponge forcep - 2 Curettes - 1 Speculum - 1 small basin (i) The manufacturer's IFU were requested.	Q 241		

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Q 241	Continued From page 9 (ii) At 10:34 AM Staff #9 confirmed there were no IFU's for the D&E instruments, available for use in the sterilization room. (iii) Staff #9 confirmed he/she uses the signage posted on the outside of the sterilizer, as his/her reference for sterilization parameters. (iv) At 11:55 AM Staff #7 confirmed he/she remembers printing the IFU's for the D&E instruments, however he/she is unable to locate them at this time. The above finding resulted in an Immediate Jeopardy which curtailed this practice. The Immediate Jeopardy was removed on 12/8/17, upon receipt of an acceptable plan of correction. Reference #2: AAMI (Association for the Advancement of Medical Instrumentation) Sterilization in Health Care Facilities, 2015 edition states in ST 79 section 7.5.2 Cleaning agents, states, "...The cleaning agent manufacturer's written IFU should be followed." Reference #3: Ergo-Logistics One Cleaner Enzyme Detergent label Directions for Use states, "Soaking: Add 1/4 to 1/2 oz. ...One cleaner per 1 gallon...of diluent (tepid warm water). Manual Cleaning: Add 1/4 ounce ...One cleaner per 1 gallon...diluents(tepid to elevated temperature water). 1. On 12/7/17 at 10:45 AM, a tour was conducted of the decontamination area and the following was revealed: a. Staff #8 was observed using Ergo-Logistics One Cleaner Enzyme Detergent to clean and	Q 241		

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Q 241	Continued From page 10 disinfect a soiled D&E tray. (i) Staff #8 was observed using several pumps of enzymatic, when mixing the enzyme detergent and water. (ii) Staff #8 confirmed he/she uses approximately twelve (12) pumps of enzyme detergent to one-half (1/2) to one (1) gallon of water." (iii) Staff #8, when asked how he/she measures out one (1) gallon of water, pointed to half-way up the sink and replied "I usually fill the water to about here." (iv) Staff #8 confirmed there is no marking in the sink nor is the water measured to exactly one gallon. (v) Staff #8 was observed using a measuring cup and dispensed One Cleaner Enzyme Detergent into the measuring cup and poured it into the sink of water. (vi) Staff #8 confirmed that the measuring cup was a one-half (1/2) cup. (vii) Staff #8 was neither measuring the water nor the enzyme detergent correctly. 2. The above finding was confirmed with Staff #2. D. Based on observation, staff interview, and review of nationally recognized guidelines, it was determined that the facility failed to ensure a functional and sanitary environment for the provision of surgical services by adhering to CDC (Centers for Disease Control and Prevention)	Q 241		

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Q 241	Continued From page 11 -HICPAC (Healthcare Infection Control Practices Advisory Committee) guidelines on hand hygiene. Findings include: Reference #1: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee[HICPAC] and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the CDC (Centers for Disease Control and Prevention) Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16) page 32 states, "Recommendations: 1. Indications for Handwashing and Hand antisepsis...B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations described in items 1C-J... Alternatively, wash hands with an antimicrobial soap and water in all clinical situations described in items... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled... J. Decontaminate hands after removing gloves..." 1. On 12/7/17 at 9:40 AM during the entrance conference, Staff #2 confirmed that the facility's Infection Control program is based on Center for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), Association for the Advancement of Medical Instrumentation (AAMI), guidelines and recommendations. 2. On 12/7/17 at 10:45 AM, in the decontamination room, Staff #8 was cleaning and disinfecting a D&E tray.	Q 241		

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Q 241	Continued From page 12 a. After cleaning and disinfecting the D&E tray, Staff #8 removed his/her gloves and failed to perform hand hygiene prior to exiting the decontamination room. (i) The hand washing sink in the decontamination area was filled with chux pads and the alcohol-based hand rub was not readily accessible. (ii) When asked how he/she washes his/her hands, Staff #10 replied, "Sometimes I use the sink out there" and pointed to the OR corridor. (iii) When asked if he/she uses alcohol-based hand rub, Staff #10 replied by pointing to a bottle of hand sanitizer that was up high on a shelf in the decontamination room. 3. At 11:16 AM, during an observation of cleaning and disinfecting of Operating Room (OR) #1, between patients, the following was revealed: a. Staff #10 was using Opti-cide spray and a green towel to clean and disinfect the OR. (i) Staff #10 then failed to remove his/her gloves, prior to exiting the OR to obtain a green watering can and mop. (ii) After obtaining the watering can and mop, Staff #10 returned to the OR, with the same gloves on, mopped the floor, and failed to remove his/her gloves prior to exiting the OR to return the watering can and mop. (iii) Staff #10 then removed his/her gloves and failed to perform hand hygiene, prior to obtaining the next case cart and returning to OR #1.	Q 241		

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Q 241	Continued From page 13 E. Based of observation and review of facility policy, it was determined that the facility failed to ensure that facility policy and CDC (Centers for Disease Control) guidelines for hand hygiene were followed. Findings include: Reference #1: Facility policy titled Handwashing, states, "CHWC [Cherry Hill Women's Center] employees are required to wash hands frequently, including between care of each patient ... It is important that you wash your hands and change your gloves between patients." Reference #2: Guideline for Hand Hygiene in Health Care Settings: Recommendation of the Healthcare Infection Control Practices Advisory Committee[HICPAC] and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, published in the CDC (Centers for Disease Control and Prevention) Morbidity and Mortality Weekly Report at MMWR 2002; 51 (No. RR-16) states, "Recommendations: 1. Indications for Handwashing and Hand antisepsis... C. Decontaminate hands before having direct contact with patients... F. Decontaminate hands after contact with a patient's intact skin... J. Decontaminate hands after removing gloves." 1. During an observation on 12/7/17, the following was revealed: a. In the Ultrasound room at 10:26 AM, Staff #12 donned his/her gloves, failed to perform hand hygiene, and then touched Patient #1.	Q 241		

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Q 241	Continued From page 14 i. At 10:30 AM, Staff #12 doffed his/her gloves, failed to perform hand hygiene, and then escorted Patient #1 to the Lab Room. b. In the Consult Room at 11:00 AM, Staff #14 failed to perform hand hygiene before performing a physical assessment on Patient #1. c. In the Post Anesthesia Care Unit (PACU) at 12:25 PM, Staff #18 entered the PACU from the Operating Room (OR) Suite already wearing gloves. Staff #18 then doffed his/her gloves, failed to perform hand hygiene, and obtained medications from the PACU medication storage area. F. Based on observation, staff interview, and review of facility policy, it was determined that the facility failed to ensure safe injection practices were followed in accordance with its policies. Findings include: Reference #1: Facility policy titled, Medication - Administration; Control and Storage of states, "Procedure ... 7. Multi use vials must be used within 28 days of opening. Do not use expiration date when discarding." Reference #2: United States Pharmacopeia (USP) General Chapter 797 [16] states, "If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial." 1. During an observation in the Post Anesthesia Care Unit (PACU) on 12/7/17, at approximately	Q 241		

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Q 241	Continued From page 15 12:35 PM, Staff #18 obtained a multidose vial of Nubian from an open box. Staff #18 withdrew the medication from the vial and confirmed that it was ready to be administered to the patient. a. During an interview, Staff #18 confirmed that the medication vial had been accessed prior to the above medication preparation, and there was no date of opening on the medication vial label. G. Based on observation and review of facility policy, it was determined that the facility failed to ensure that staff followed the policy regarding Operating Room (OR) attire. Findings include: Reference: Facility policy titled, OR Attire states, "Surgical caps must be worn at all times in all areas of the operating room ... 3. All surfaces must be covered." In the operating room, on 12/7/17, at approximately 11:55 AM, Staff #15 and Staff #16 failed to contain all their head hair beneath the surgical cap.	Q 241		
Q 242	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.	Q 242		

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Q 242	Continued From page 16 This STANDARD is not met as evidenced by: A. Based on staff interview and document review, it was determined that the facility failed to ensure that the selected and implemented nationally recognized guidelines for infection control are documented. Findings include: Reference #1: Facility document titled, "Infection Prevention and Control Program" states, "...In addition, as a result of consideration and selection by Cherry Hill Women's Center's Infection Control Committee, the Infection Control and Prevention Program in this facility has been designed and implemented according to CDC (Center for Disease Control and Prevention) guidelines, ...Procedure: ...R. The exposure Control Plan shall remain in compliance with OSHA (Occupational Safety and Health Administration) Bloodborne Pathogen Standard and shall be evaluated by the Governing body on a yearly basis." 1. Upon entrance, a request was made for documentation of the nationally recognized Infection Control guidelines that the facility considered, selected and implemented. a. Staff #2 confirmed that the facility has selected and implemented the following guidelines: - Association for the Advancement of Medical Instrumentation (AAMI) - Occupational Safety and Health Administration (OSHA) regulations - Centers for Disease Control and Prevention (CDC)	Q 242		

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Q 242	Continued From page 17 b. The facility's Infection Control Program was provided and reviewed. Although CDC and OSHA guidelines were selected, there was no documented evidence that AAMI guidelines were selected by the facility. 2. The above finding was confirmed by Staff #2. B. Based on observation, staff interview, review of facility policies and procedures, and nationally recognized guidelines and regulations, it was determined that the facility failed to ensure an ongoing Infection Control program that adheres to OSHA regulations are implemented. Findings include: Reference #2: OSHA 29 CFR part 1910.1030(d)(3)(i) states, "Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used." 1. On 12/7/17 at 9:40 AM, during the entrance conference, Staff #2 confirmed that the facility's Infection Control program is based on Center for	Q 242		

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Q 242	Continued From page 18 Disease Control (CDC), OSHA, and Association for the Advancement of Medical Instrumentation (AAMI), guidelines and recommendations. 2. On 12/7/17 at 10:40 AM, in the Decontamination area, Staff #8 was observed manually cleaning and disinfecting a Dilation and Evacuation (D&E) tray. a. Staff #8 was observed pouring products of conception from a glass jar into a Styrofoam cup. (i) Staff #8 was donned in a blue surgical gown. (ii) The Eclipse gown packaging indicates the gown is a Level 2 permeable gown. (iii) On 12/8/17, Staff #7 confirmed the gowns were level 2 permeable gowns. b. The facility failed to ensure staff in the Decontamination area wear impervious gowns. Reference #3: OSHA 29 CFR part 1910.1030(d)(2)(xiii) states, "Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping." Reference #4: Facility policy titled, "Laboratory Specimens" states, "Policy: ...2. ...Once the procedure is finished the specimen is kept in the suction bottle and taken into the Decontamination Room in preparation for the transfer to the Laboratory. ...1. Decontamination personnel will transfer the specimen into a Styrofoam cup with lid. The patients name is written on the cup...The cup is placed in the designated holders in the	Q 242		

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Q 242	Continued From page 19 transport container. Be careful not to overload container. 3. The sterilization technician will see that the specimen transport container is taken to the outside door of the PACU (Post Anesthesia Care Unit) closet to the laboratory. 4. The laboratory technician, will take the transport container and drop it off at the laboratory." 1. On 12/7/17 at 10:40 AM, in the Decontamination area, Staff #8 was observed manually cleaning and disinfecting a Dilation and Evacuation (D&E) tray. a. Staff #8 was observed pouring products of conception from a glass jar into a Styrofoam cup with a lid. (i) Staff #8 placed on the outside of the Styrofoam cup, a yellow Post-it sticker with the patients first name and last initial written on it. (ii) Staff #8 then placed the cup into a red cooler and transported the specimen to the laboratory. (iii) The Styrofoam cup can be easily punctured, therefore it is not a container which prevents leakage.	Q 242		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
31C0001113 Y1	A. Building B. Wing Y2	4/17/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Q0081	Correction	ID Prefix Q0083	Correction	ID Prefix Q0181	Correction
Reg. # 416.43(a), 416.43(c)(1)	Completed	Reg. # 416.43(d)	Completed	Reg. # 416.48(a)	Completed
LSC	04/17/2018	LSC	04/17/2018	LSC	04/17/2018
ID Prefix Q0184	Correction	ID Prefix Q0240	Correction	ID Prefix Q0241	Correction
Reg. # 416.48(a)(3)	Completed	Reg. # 416.51	Completed	Reg. # 416.51(a)	Completed
LSC	04/17/2018	LSC	04/17/2018	LSC	04/17/2018
ID Prefix Q0242	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 416.51(b)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/17/2018	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
12/8/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

PRINTED: 02/27/2019

Statement of Deficiencies
Citation Summary Sheet

For: CHERRY HILL WOMENS CENTER (31C0001113 / NJ310001113)
Survey Event: NNPM21, Exit Date 12/08/2017

Citations Cited This Visit

Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	K309	03.02	01	0000	INITIAL COMMENTS	
Federal	K309	03.02	01	0321	Hazardous Areas - Enclosure	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001113	A. BUILDING **01** B. WING _____	**12/08/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	**502 KINGS HIGHWAY NORTH** **CHERRY HILL, NJ 08034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This was a Federal Recertification Survey conducted on 12/08/17. This facility is not in substantial compliance with the National Fire Protection Association's 2012 Life Safety Code for this Federal Recertification Survey.	K 000		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas must meet one of the following: *Contain 1 hour rated enclosure when non-sprinklered *Sprinkler protected with smoke resistive separation *Severe Hazard locations contain sprinkler protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7 This STANDARD is not met as evidenced by: Based on observation and staff interview on 12/08/17, it was determined the facility failed to ensure that a fire safe environment is maintained for patients, staff and the general public. Findings include: 1. During a tour conducted at 10:30 AM, in the presence of Staff #7, the ceiling installed within the basement was found in disrepair, with damaged and missing tiles. This would allow the passage of smoke from one area to another inside the building. 2. This finding was confirmed by Staff #7.	K 321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/12/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001113	A. BUILDING **01** B. WING _____	**12/08/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY HILL WOMENS CENTER	**502 KINGS HIGHWAY NORTH** **CHERRY HILL, NJ 08034**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

CHERRY HILL WOMEN'S CENTER
502 Kings Highway North ◆ Cherry Hill NJ 08034
(856) 667-5910 ◆ (800) 87[illegible]-6331
Fax: (856) 667-8304

Received 4/6/2018
POC Accepted

April 2, 2018

Shilpa Rathore, MS, RD
New Jersey Department of Health
Health Facility and Field Operations
PO Box 367
Trenton NJ 08625-0367

Dear Ms. Rathore,

Attached, please find the additional information requested related to the Federal Recertification Audit Plan of Correction submitted 3/12/18.
If you have any questions or concerns about this plan, please do not hesitate to reach out to me.

Sincerely,

Jenifer Groves, MEd, MBA
Administrator
Cherry Hill Women's Center

Americans United for Life

POC Accepted 4/6/2018 SR

Tag 083: *Specify staff education and participation regarding annual QA project.*

1. The deficiency will be corrected as it relates to the individual by immediately choosing and implementing a performance improvement project for 2018. Staff to be educated in relation to chosen projects and their participation via staff meeting.
2. Systemically, annual performance improvement projects will also be addressed on the facility's Quality Improvement Plan and communicated to staff via staff meeting.
3. To ensure that compliance is maintained, implemented projects will be discussed during the quarterly QI committee meetings, and said discussions will be documented in the meeting minutes accordingly.
4. The facility's Director of Nursing is responsible for implementing the plan of correction. ✓
5. The corrective action will be completed by April 13, 1018. ✓

Tag 184: *Specify the timeframe for the MD signature.*

1. The deficiency will be corrected as it relates to the individual by updating the facility's policy regarding verbal orders to include the requirement that the order must be documented and signed by the ordering physicians within 3 business days. →
2. Systemically, the facility's Deputy Administrator (DA) will re-train all physicians regarding updated policy.
3. To ensure that compliance is maintained, the facility's Deputy Administrator will audit ten (10) charts for each physician on a monthly basis for six (6) months. ✓ from 12 to 6 mos ? why but OK
4. The facility's Deputy Administrator is responsible for implementing this plan of correction.
5. The corrective action will be completed by April 13, 2018.

Tag 241: *C, D, E, F, G: Specify how and when the monitoring will be conducted and to whom the results will be reported to.*

C. (From approved IJ PoC 12.7.17)

1. The corrective action was accomplished by ensuring that all IFU sheets were reprinted and made accessible to sterilization staff.
2. All patients within the facility would potentially be affected (surgical services curtailed until approval received from DoH staff onsite).
3. Instruments on site were re-sterilized as per IFU.
4. The systemic changes set in place so the deficiency does not reoccur;
    a. Binder created and located in sterilization area
    b. Documented medical staff in-service and discussions individually with each sterilization staff member.

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5. The method by which this deficiency will be monitored to ensure this does not recur will be the Director of Nursing confirming the presence of the manual on a quarterly basis to ensure manual is present, accessible and up to date. The results of the DoN quarterly spot check will be reported quarterly to the QI committee and documented in the meeting minutes.
6. This corrective action was completed on 12/7/17.

1. The deficiency will be corrected as it relates to the individual by purchasing a water mark to ensure proper labeling of the sink.
2. Systemically the center's Director of Nursing will retrain all sterilization staff to utilize the water mark in the sink along with the measuring cup as per manufacturer's recommendations.
3. To ensure compliance is maintained, the Director of Nursing will assess staff ability to adhere to the IFU when completing staff annual competency. Completed annual competencies are reviewed by the facility's Deputy Director annually prior to becoming part of the staff person's employee record.
4. The Director of Nursing is responsible for ensuring this PoC is maintained.
5. This corrective action will be completed by 4.13.18.

D

1. The deficiency will be corrected as it relates to the individual by ensuring that all handwashing sinks are free of debris. Additionally alcohol based cleaners will be made available and within arms reach in every clinical area of the ASC.

2. Systemically, the Director of Nursing will retrain all staff on proper hand hygiene techniques.

3. To ensure that compliance is maintained, the Director of Nursing will assess staff ability to adhere to policy by performing monthly unannounced hand hygiene audits. The results of these monthly audits will be reported to the QI team on a quarterly basis and documented in both the QI meeting minutes and in the staff employee file.

4. The Director of Nursing is responsible for ensuring the PoC is adhered to.

5. The corrective action will be completed on 4.13.18

E

1. The deficiency will be corrected as it relates to the individual by ensuring that all handwashing sinks are free of debris. Additionally alcohol based cleaners will be made available and within arms reach in every clinical area of the ASC.

2. Systemically, the Director of Nursing will retrain all staff on proper hand hygiene techniques.

3. To ensure that compliance is maintained, the Director of Nursing will assess staff ability to adhere to policy by performing monthly unannounced hand hygiene audits. The results of these monthly audits will be reported to the QI team on a quarterly basis and documented in both the QI meeting minutes and in the staff employee file.
4. The Director of Nursing is responsible for ensuring the PoC is adhered to.
5. The corrective action will be completed on 4.13.18

F

1. The deficiency will be corrected as it relates to the individual by ensuring that all multiuse vials are labeled individually in addition to the boxes they are kept in.
2. Systemically the Director of Nursing will retrain all nursing staff on proper multi-use vial labeling.
3. To ensure that compliance is maintained, The Director of Nursing or her designee will spot check multiuse vials weekly to ensure they are labeled appropriately. Report of these weekly checks will be reported to the QI team quarterly.
4. The Director of Nursing is responsible for ensuring that the PoC is adhered to.
5. The corrective action will be completed on 4.13.18

G

1. The deficiency will be corrected as it relates to the individual by ensuring that all staff are ensuring that all of their head hair is secured beneath the surgical cap.
2. Systemically, the Director of Nursing will retrain all medical staff on proper use of surgical caps.
3. To ensure that compliance is maintained, the Director of Nursing will add "donned surgical attire appropriately" on unannounced hand hygiene audits. The results of these monthly audits will be reported to the QI team on a quarterly basis and documented in both the QI meeting minutes and in the staff employee file.
4. The Director of Nursing is responsible for ensuring the PoC is adhered to.
5. The corrective action will be completed on 4.13.18

Tag 242: A, B: Who are the results of the monitoring being reported to?

1. The deficiency will be corrected as it relates to the individual by:
    a. Updating the facility's Infection Control Plan to reflect the fact that the facility has selected and implemented guidelines from Association for the Advancement of Medical Instrumentation (AAMI), Occupational Safety and Health Administration (OSHA), and Centers for Disease Control and Prevention (CDC).

b. Ensuring that staff in decontamination area wea s adequate Personal Protective Equipment (PPE), including a Level 4 (impermeat le) gown.
c. Removing from the decontamination area any containers which could be easily punctured, and by updating the facility's policy regarding laboratory specimens, The updated policy will reflect that specimens will be transported from the decontamination area to the laboratory in a container which prevents leakage.

2. The systemic changes put into place for each deficiency are as follows:
   a. The facility's Deputy Administrator will provide an in-service for all personnel to educate them regarding the updated Infection Control pla n.
   b. The facility's Deputy Administrator will update the facility's PPE policy to reflect this change and will provide staff with education for a ll personnel regarding this update.
   c. The facility's Deputy Administrator will provide e ducation to the facility's personnel impacted by this change in policy, namely all pers onnel working in decontamination and the laboratory.
3. To ensure that compliance is maintained:
   a. The Infection Control Plan will be reviewed on an annual basis by the Quality Improvement Committee to ensure that the plan accurately reflects the chosen standards of the facility's program.
   b. The Level 4 gown requirement will be included in the facility's existing Hand Hygiene/PPE QI monitoring audits which occur or a monthly basis. The results of these monthly audits are reported in the quarterly Quality Improvement committee meetings.
   c. The facility's Deputy Administrator will update staff annual competencies and routinely audit staff use of PPE and transport containers to ensure compliance
4. The person responsible for ensuring these plans is the facility's Deputy Administrator
5. These corrective actions will be completed by April 13, 2018

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