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 SER	V
State	J93T	02.08	00	1170	PAIN MGMT PROCDURS: PAIN ASSESSMENT PROCDUR	S



If continuation sheet 1 of 20

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED	
		10263	B. WING		11/	11/02/2016	
	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STATE			02/2016	
		40 E	ENGLE STREET	, 0002			
	LITAN SURGICAL ASS	ENC	GLEWOOD, NJ 07631				
X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
A 000	INITIAL COMMENTS	5	A 000				
		e survey was conducted on resulted in deficiencies.					
	Medical Instrumenta AORN= Association Nurses CDC=Centers for Dis Prevention CI=Chemical Indicat HICPAC=Hospital In Advisory Committee IDSA=Infectious Dis IFUs=Instructions for OPA=Ortho-Phthalal OR=Operating Room OSHA=Occupationa Administration PPE=Personal Prote	of periOperative Registered sease Control and or/Integrator fection Control Practices ease Society of America r Use I dehyde n I Safety and Health					
A1885	America TOP=Termination of 8:43A-6.4(a) PT CAI HISTORY & PHYS E	RE POL & SVCS: MED	A1885				
	procedures the circu patient's medical his contents of the medi of updating. The con past surgical proced	cify in its policies and mstances under which the tory will be obtained, the cal history, and the frequenc tents shall include at least ures and medical/health adverse reactions to drugs, ons.	y		Amer	Bican	
		/SUPPLIER REPRESENTATIVE'S SIG		TITLE	Uni		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	
		10263	B. WING	11/	11/02/2016	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		02/2010
ETROPO	DLITAN SURGICAL ASS	SOCIATES	E STREET			
		ENGLEV	WOOD, NJ 07631			
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A1885	Continued From pag	ge 1	A1885			
	by: Based on document was determined that that a complete med	T is not met as evidenced review and staff interview, it t the facility failed to ensure lical history is obtained prior cordance with its Medical ulation.				
	Findings include:					
	Regulation states, ". 2. Under no circums performed until the p	Medical Staff Rules and VII. Medical Records stances may an operation be patient's history, physical ecorded on the medical				
	lacked a complete n the physicians prior records have a Patie includes the patient' surgery/hospitalizati etc. which is comple As per Staff #7, this	ords of Patients #2 - #20 nedical history performed by to a procedure. The medical ent Information sheet that s medical history, past on, allergies, medications, ted and signed by the patient. form is reviewed and utilized by the physicians as a to the procedure.				
A2166	8:43A-8.4(a) NURSI RESPONSIBILITIES		A2166		C	
	care to patients in a New Jersey Nursing 45:11-23 et seq., as	rsonnel shall provide nursing ccordance with the State of Practice Act, N.J.S.A. interpreted by the New of Nursing, and written job es provided shall be			Amer	S ican
TE FORM			6899 DI	T711	for	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE : COMPI	
		10263	B. WING		11/02/2016	
AME OF PI	ROVIDER OR SUPPLIER	1	DDRESS, CITY, STATE	, ZIP CODE	1 11/	JZ/2010
FTROPO	LITAN SURGICAL ASS	OCIATES 40 ENGL	LE STREET			
		ENGLEV	WOOD, NJ 07631			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
A2166	Continued From pag	e 2	A2166			
	documented in the p	atient's medical record.				
		T is not met as evidenced				
	was determined that provide nursing care	cord review and interview, it nursing personnel did not in accordance with a of practice and its policy.				
	Findings include:					
		Nursing Practice Act for the states: "The practice of				
	defined as diagnosin responses to actual	ed professional nurse RN is g and treating human or potential physical and				
	as casefinding, healt	blems, through such services h teaching, health rision of care supportive to or				
	medical regimens as	l wellbeing, and executing prescribed by a licensed or horized physician or dentist."				
	Management at MM patient's recovery af	ity policy "Perioperative Pain A" states, " To make the ter surgery and anesthesia te PACU nurse is advised to				
	do a pain assessme	nt based on a scale of 0-10, s absolutely unbearable"			<u>ر</u> ۲۸	2
	the patient underwer The PACU (post ane	rd of Patient #7 revealed that a procedure on 10/8/16. sthesia care unit) Post statistication that at 1:20			E S	P
	PM, the patient met	sheet indicated that at 4:30 discharge criteria. One harge Criteria is "Pain score <			Ameri I Ini	ican
E FORM			⁶⁸⁹⁹ D.	T711	for	

		ey Department of Hea TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
APPCILIES BUGLE STREET ENGLEWOD. IN DRAM Main Summary statement or performance no preprint PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION MUST are PRECEDED BY PLU). no preprint PROVIDER'S PLAN OF CORRECTION correction <thcorection< th=""> correction <thcorrec< th=""><th></th><th></th><th>10263</th><th>B. WING</th><th></th><th colspan="2">11/02/2016</th></thcorrec<></thcorection<>			10263	B. WING		11/02/2016	
Image: Control of Patient #5 indicated in the patient's pain was assessed prior to the p	NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
Image: TAG IEAH: DEFICIENCY MUST BE PRECEDED BY FULL REGULTIONY OR LISCIDENTIFYING INFORMATION) PREFIX TAG CEAH: ORGENTIE APPROPRIATE COMPLET DEFICIENCY COMPLET <deficiency< td=""> COMPLET<deficiency< td=""> COMPLET<deficiencent<deficiencent< td=""> COMPLET<deficiencencent< td=""> <td< th=""><th>IETROPO</th><th>DLITAN SURGICAL ASS</th><th>OCIATES</th><th></th><th></th><th></th><th></th></td<></deficiencencent<></deficiencent<deficiencent<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<></deficiency<>	IETROPO	DLITAN SURGICAL ASS	OCIATES				
 (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 Operative Admission sheet indicated that at 12:15 PM the patient met discharge Criteria is "Pain score < (less) 3." There was no evidence in the medical record that the patient are cord that the patient underwent a procedure on 10/25/16. The the patient cord is the patient of the Discharge Criteria is "Pain score < (less) 3." There was no evidence in the medical record of the Discharge Criteria is "Pain score < (less) 3." There was no evidence in 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 pain was assessed prior to 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) pm (as needed) cramping x1." Although the patient did not require any medication for craning 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 (milliter) per hour. There was no evidence in the Post Operative Orders of an intravenous fluid 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETE DATE
5. The medical record of Patients #4 indicated	A2166	 (less) 3." There was record that the patient throughout the PACU 2. The medical record the patient underwern The PACU Post Operindicated that at 12:1 discharge criteria. O Criteria is "Pain score evidence in the medi pain was assessed in discharge. 3. The medical record the patient underwern Post procedure there patient's pain was assessed in the patient's pain was assessed in the Patient's Informat that the patient was a lbuprofen. The Post 10/14/16 contained a mg (milligram) po (by cramping x1." Althour require any medicatio operatively, there was staff consulted with the or discontinuation of 4. The medical record that post-operative order of the patient of the patient was a staff consulted with the or discontinuation of 4. The medical record that post-operative order order. 	no evidence in the medical ht's pain was assessed J stay and prior to discharge. rd of Patient #6 revealed that it a procedure on 10/25/16. rative Admission sheet 5 PM the patient met ne indicator of the Discharge e < (less) 3." There was no cal record that the patient's n PACU and prior to rd of Patient #2 revealed that it a procedure on 12/30/15. was no evidence that the sessed prior to the patient's rd of Patient #5 indicated in tion Medical History sheet allergic to Dapro and Operative Orders dated in order for "Ibuprofen 800 v mouth) prn (as needed) ugh the patient did not on for cramping post s no evidence that nursing he physician for clarification the order. rd of Patient #7 indicated on beratively, the patient was red Ringers at 125 ml There was no evidence in the rs of an intravenous fluid	A2166		Ameri	S

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
		10263	B. WING		11/02/2016	
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	. ZIP CODE	I 11/0	JZ/ZU16
IETROPC	LITAN SURGICAL ASS	OCIATES 40 ENGI	LE STREET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		NOOD, NJ 07631	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
A2166	maintained on Lactat hour with 20 units of evidence in the Post- intravenous fluid order 6. The medical reco- indicated that these p post operatively to a medical records faile	on 8/3/16, the patient was ted Ringers at 125 ml per Pitocin. There was no Operative Orders of an	A2166			
A2285	POLICIES & PROCE The facility's policies administration, contro- medications shall inco- policies and procedu storage, safeguardin disposition of drugs, Jersey State Board of 13:39, and the Contro- Acts and amendmen services provided thr shall be provided by New Jersey State Board individual patient ma	and procedures for the ol, and storage of dude, but not be limited to, res for the purchase, g, accountability, use, and in accordance with the New of Pharmacy Rules, N.J.A.C. olled Dangerous Substances ts thereto. Pharmaceutical rough written agreement a pharmacy licensed by the oard of Pharmacy. An y choose to obtain wharmacy which is not	A2285		Ş	3
	This REQUIREMEN by: Based on observatio	Γ is not met as evidenced n and staff interview			Ameri Uni	can Can
ATE FORM			6899 DJ	T711	for	ationChect 5

TATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL		
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AME OF PF	ROVIDER OR SUPPLIER		TADDRESS, CITY, STATE, ZIP CODE				
IETROPC	LITAN SURGICAL ASS	OCIATES	LE STREET VOOD, NJ 07631				
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A2285	facility failed to ensure acceptable standards preparation. Findings include: Reference: Institute Practices (ISMP) Sat Adult IV Push Medica 3.5 Do NOT withdraw commercially availab into another syringes 1. Carpuject prefilled Labetalol were found Operating Room #4. 2. Upon interview, S	6, it was determined that the re the implementation of s of practice for medication for Safe Medication fe Practice guidelines for ations, Appendix A, states, " v IV push medications from ble, cartridge-type syringes for administration." syringe cartridges of I in the anesthesia cart of that ff # 4 stated that the facility ation using a syringe and did	A2285				
A4098	8:43A-14.2(b)(4) INF POL & PROCEDURE The infection control from each service in implement, and revie frequently as necess procedures regarding control, including, bu procedures regarding control practices, inc in accordance with th Health Administration 1910.1030, Occupati	committee, with assistance the facility, shall develop, ew, every three years or more ary, written policies and g infection prevention and t not limited to, policies and g the following: Infection luding universal precautions, ne Occupational Safety and n (OSHA) rule 29 CFR Part onal Exposure to	A4098		Amer	Sican	
TE FORM	Bloodborne Pathoge	ns, incorporated herein by	6899 DJ	T711	Uni for	tec	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
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AME OF PF	ROVIDER OR SUPPLIER	1	DDRESS, CITY, STATE	, ZIP CODE		
ETROPC	LITAN SURGICAL ASS	OCIATES				
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A4098	Continued From pag	e 6	A4098			
	reference.					
		T is not met as evidenced				
	by:					
	Based on observatio	n and staff interview 6, it was determined that the				
	facility failed to ensu	re compliance to OSHA				
	regulations.					
	Findings include:					
	Reference: OSHA (Occupational Safety and				
		n) 29 CFR part 1910.1030(d) he employer shall ensure				
	that the employee us	ses appropriate personal				
		t unless the employer shows mporarily and briefly declined				
		ective equipment when,				
		ordinary circumstances, it				
	the specific instance	professional judgment that in its use would have				
	-	ry of health care or public				
	safety services or wo increased hazard to	the safety of the worker or				
	co-worker. When the	employee makes this				
	judgement, the circu investigated and doc					
	determine whether c	hanges can be instituted to			-C(
	prevent such occurre	ences in the future."			S	K
		side OR #2, in the presence			S.	\mathcal{V}
		was observed exiting OR #2 g a container of soiled			Amer	can
	instruments without t	the benefit of protective				Lail
	gloves.				Uni	tec
E FORM			6899 DJ	T711	for	ation hear 7

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	
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NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
METROPO	DLITAN SURGICAL ASS	OCIATES	LE STREET NOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
A4098	Continued From pag	e 7	A4098			
	a. The container wa biohazard warning la	s observed to contain a bel.				
		to ensure implementation of ice to OSHA regulations.				
	3. This finding was o	confirmed by Staff #2.				
A4112	8:43A-14.2(b)(6) INF POL & PROCEDURI	EC PREV & CONTROL: ES	A4112			
	from each service in implement, and revie frequently as necess procedures regarding control, including, bu procedures regarding technique, employee	committee, with assistance the facility, shall develop, ew, every three years or more ary, written policies and g infection prevention and t not limited to, policies and g the following: Aseptic thealth in accordance with and staff training in regard to				
	by: Based on document interview, it was dete	T is not met as evidenced review, observation and ermined that the facility failed shniques are implemented in policy.			Š	202
		policy titled Safe Medication			Amer	j ⁻ ican
	Administration Guide	lines states, " [bullet] Use			Uni	tor
TE FORM			6899 D.I	T711	for	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
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IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	•	
IETROPC	LITAN SURGICAL ASS	OCIATES	LE STREET WOOD, NJ 07631			
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A4112	 aseptic technique to sterile injection equip vials will be used as They will be puncture single use [bullet] / syringe and needle t [bullet] Do not re-use cannulae [bullet] S pad prior to drawing use vials." 1. During an observ 11/1/16, Staff #4 re-us syringe used previou draw up an additional 2. Staff #4 did not d with alcohol prior to p 	avoid contamination of oment [bullet] Multi-dose single dose vials at all times. ed once and discarded after Always use a new sterile o draw up medications e needles, syringes or wab all vials with an alcohol up medication even single ation of Patient #1 on used the same needle and usly to administer propofol, to al dose of propofol.	A4112			
A4154	Measures Infection prevention the Centers for Dise Guidelines, and Hos	Prev & Control: Infec Prev activities shall be based on ase Control and Prevention pital Infection Control committee (that is, HICPAC)	A4154		Ameri	S can
					Uni	tec
TE FORM			6899 DJ	T711	for	ation Cheer 9

New Jers	sey Department of Hea	lth				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		10263	B. WING		11/0	2/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
METROPO	OLITAN SURGICAL ASSO	40 ENGL	E STREET			
		ENGLEV	VOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
A4154	Continued From page	9	A4154			
A4183	by: Based on observation and procedures, revie guidelines, and staff i that the facility failed according to establish Findings include: Reference #: CDC, C of Intravascular Catho 2011, pg. 55 states, " must be used to prev microbes through con studies have shown t devices with chlorhex appears to be most e colonization [195, 196 1. On 11/1/16, Staff # follows CDC guideling practices. 2. During an observa 11/1/16, Staff #4 adm numerous times to Pa disinfecting his/her IV 3. Staff #1 and Staff findings.	Guidelines for the Prevention eter-Related Infections, ' Appropriate disinfectants ent transmission of unectors [357]. Some hat disinfection of the idine/alcohol solutions ffective in reducing 6]" #1 indicated that the facility es for its infection control tion of Patient #1 on inistered IV medication atient #1 without first port with alcohol. #7 confirmed the above EC PREV & CONTROL:	A4183		Ameri	Scans
					Uni	ted
STATE FORM			⁶⁸⁹⁹ C	DJT711	If continuat	ion speet 10 of 20
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STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMPI	
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
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A4183	Centers for Disease Guidelines, and Hosp Practices Advisory C recommendations. A of the following guide providing that there is rationale based upor epidemiologic data. guideline is incorpora amended and supple Hygiene in Health-Ca Recommendation of Control Practices Ad HICPAC/SHEA/APIC Force, published in th Weekly Report at MM published by the Coc Information and Serv http://www.cdc.gov/n at	activities shall be based on Control and Prevention pital Infection Control ommittee (that is, HICPAC) n exception to the adoption eline shall be allowed s a sound infection control n scientific research or The following published ated herein by reference, as emented: Guideline for Hand are Settings: the Healthcare Infection visory Committee and the C/IDSA Hand Hygiene Task he Morbidity and Mortality MWR 2002; 51 (No. RR-16), ordinating Center for Health	A4183			
	by: Based on observatio policy review conduct determined that the f and sanitary environ surgical services by a	T is not met as evidenced n, staff interview and facility ted on 11/1/16, it was facility failed to ensure a safe ment for the provision of adhering to hand hygiene dance with CDC-HICPAC <i>r</i> n policy.			Amer	Bicans
ATE FORM			6899 DJ	T711	for	tion speet 1 of

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
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A4183	Continued From page	je 11	A4183			
	Findings include:					
	titled, "Hand Hygien states, " A. Indicat Handwashing may a decontaminating has situations: After re	ity policy and procedure e Policy and Procedure" ions for Handwashing3. Ilso be used for routinely nds in the following clinical emoving gloves B. rubbing After removing				
	Health Care Settings Healthcare Infection Committee[HICPAC] HICPAC/SHEA/APIC Force, published in t Control and Prevent Weekly Report at MI page 32 states, " Recommendations	C/IDSA Hand Hygiene Task the CDC (Centers for Disease ion) Morbidity and Mortality MWR 2002; 51 (No. RR-16)				
	 C. Decontaminate h contact with patients	nands before having direct				
	invasive devices F. Decontaminate h patient's intact skin	l vascular catheters, or other ands after contact with a nands after contact with a			Ś	ŝ
	inanimate objectsi patient.	ands after contact with n the immediate vicinity of the ands after removing gloves."			Ameri) ican
TE FORM			6899 DJ	T711	for	tion speet 12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMPI	
		10263	B. WING		11/	02/2016
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE	•	
IETROPO	DLITAN SURGICAL ASS	OCIATES	LE STREET WOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
A4183	Continued From pag	e 12	A4183			
	presence of Staff #2 removing his/her so his/her mask and ey sanitizing his/her har a. This finding was	DR #2 at 12:20 PM, in the , Staff #8 was observed iled gloves and touching eglasses without first nds. confirmed by Staff #2 and				
	of Staff #2, Staff #3	ne SPD area, in the presence was observed removing and opening a door, without r hands.				
	a. The above finding and Staff #3.	g were confirmed by Staff #2				
	environment by impl	to ensure a safe and sanitary ementing hand hygiene in C-HICPAC guidelines and its I policy.				
	a procedure, Staff #8	erating Room (OR) #2 during 3 donned and doffed his/her s without hand sanitizing ges.				
	a. With gloved hands wrappers down insid	s, Staff #8 pushed discarded e a trash can.				
		g the same gloves, Staff #8 closing cabinet doors in			S.	ß
	b. At 12:46 PM, Sta and left the OR to re	ff #8 doffed his/her gloves trieve supplies.			Amer	ican
	(i) When Staff #8 re	turned to the OR, he/she did			Ini	tor
TE FORM			6899 DJ	Γ711	for	tion speet 18

	D PLAN OF CORRECTION IDENTIFICATION NUMBER:	1				
		10263	B. WING		11/0	2/2016
AME OF PROV	/IDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
IETROPOLIT	TAN SURGICAL ASS	DCIATES				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLET DATE
A4190 8:- CO	Reference #3: AORI rerioperative Practica tates, " Chipped a emoved prior to entri- ne perioperative envi- nat is chipped may h umbers Chipped emoved to prevent p nvironment or the pa- hould not be worn b he perioperative envi- nhancement or resir onsidered artificial. ps, gels and acrylic crylic fingernails cor- ngernails " . The following obse 1/1/16 in the PACU . Staff #15 confirme el nails. . Staff #14 was wea isibly chipped on bo . Staff #10 was wea isibly chipped on bo . Staff #1 and Staff ndings. :43A-14.4(a)(1) INF CONTROL:STRILIZA	or to donning gloves. N, Guidelines for e, 2016 Edition pg. 30 fingernail polish should be y into the restricted area of ironment. Fingernail polish harbor pathogens in large fingernail polish should be possible contamination of the atient Artificial fingernails y health care personnel in ironment. Any fingernail n bonding product is Fingernail extensions or overlays, resin wraps, or nstitute types of artificial ervations were made on area: ed that he/she was wearing aring nail polish that was th hands. aring nail polish that was th hands. #7 confirmed the above	A4183		Ameri	Scan

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMPI	
		10263	B. WING			02/2016
NAME OF PR	ROVIDER OR SUPPLIER	ł	DDRESS, CITY, STATE,	ZIP CODE		
METROPO	DLITAN SURGICAL ASS	OCIATES				
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A4190	of Medical Instrumer	ncorpated herein by ciation for the Advancement ntation (AAMI) requirements, tice: Steam Sterilization and	A4190			
	by: Based on observatio conducted on 11/1/1 facility failed to ensu Reprocessing adhen (ST 79 replaces and consolidating ST 46	6, it was determined that the				
	Facilities, 2014 edition Internal chemical ind should be used withi	I Sterilization in Health Care on, ST 79 section 10.5.2.2.2 licators states, "An internal CI n each package, tray, or rigid r system to be sterilized."			C	
	basement, in the pre #11, a sterile instrum	-			Amer	S ican
TE FORM			6899 DJ	T711	for	tion speet 15

BENDELE STREET ENGLEWOOD, NJ 0521 OWNOUS SURGELA SOCIATES PROVIDERS PLAN OF CORRECTION MOUDLE BE CACH CORRECTLA CONSIGNED AND TALL RECELLATEORY OR LSC DENTRYING INFORMATION) IPPOVIDERS PLAN OF CORRECTION MOUDLE BE CROSS REFERENCED TO THE APPORENT COMMENT CROSS REFERENCE TO THE APPORENT A1100 A1100 Not applicated to the SING CROSS REFERENCE TO THE APPORENT Not applicated to the SING CROSS REFERENCE TO THE APPORENT Not applicated to the APPORT TO THE APPORENT NOT APPORT TO THE APPORENT NOT APPORT TO THE APPORENT NOT APPORT TO THE APPORT		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
MALE OF PROVIDER OR SUPPLIEN STREET ADDRESS, CITY, STATE, 2P CODE BETROPOLITAN SURGICAL ASSOCIATES BENGLE STREET ENGLEWOOD, NJ 07631 INV SUMMARY STATEMENT OF DEFICIENCES ENGLEWOOD, NJ 07631 INV BECHT BERDINGY MUST BE PROCEEDED BY FLUX. ECONSERVEEMENCED TO THE SHOUND E CONSERVEEMENCED TO THE SHOUNDE CONSERVEEMENCED TO THE SHOUNDE CONSERVEEMENCED TO THE SHOUNDE DEFICIENCY 0 A4190 Continued From page 15 A4190 3. This finding was confirmed by Staff #3. A4190 Reference #2: AAMI Sterilization in Health Care Facilities, 2014 edition, ST 79, section 3.3.6.5.5 Temperature states, " The decontamination area should have a temperature controlled between 16 degrees C [Celsius] and 16 degrees F.). bacteria thrive a thigh temperatures; cool temperatures in the decontamination area amight help minimize bioburden." 1. During a review of SPD Temperature and Humidity' logs evidenced daily temperatures above 65 degrees F from 91/16 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." A4215 2. The facility failed to ensure temperature control is implemented in the Decontamination Area is between '60 degrees F and 65 degrees F." A4215 2. The sending were confirmed by Staff #2. A4215 A4215 CONTROL:STRILIZATIN PT CARE ITEMS The manufacturer's instructions for cleaning, testing, disassembly, and sterilization of A4215			10263	B. WING		11/02/2016	
Lett ROPOLITAN SURCICAL ASSOCIATES ENGLEWOOD, NJ 07831 (M) ID REFERX TAG SUMMARY SITEMENT OF DEPICIENCIES (EACH DEFICIENT WAIST BE RECENTION TO THE APPROPRIATE RESULTION OF DEPICIENCIES. ID RESULTION CONTRICTION SIGULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) COMPLET (BACH CONTROL SIGULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) COMPLET (BACH CONTROL SIGULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) COMPLET (CROSS-REFERENCE) CROSS-REFERENCE) CROSS-REFERENCE)<	AME OF PI	ROVIDER OR SUPPLIER	STREET		ZIP CODE	1 1	
Interface TAG (EACH DEFICIENCY WUST BE PRECEDED BY FULL RESULATORY OR LIS IDENTIFYING INFORMATION) PUERT TAG (EACH CORRECTIVE CATION BHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CONTINUE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A4190 Continued From page 15 A4190 A4190 A4190 The facility failed to ensure compliance with AAMI ST79 guidelines. A4190 A4190 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 [Collegies F] Farenheit] and 66 degrees F]. bacteria thrive at high temperatures; cool temperatures in the decontamination area might help minimize bloburden." Introl for temperature and Humidity' logs, the "Decontamination Area Documentation of Temperature and Humidity' logs evidenced daily temperatures above 65 degrees F and 65 degrees F." A4215 4.100 The set findings were confirmed by Staff #2. A4215 4.110 A4215 A4215	IETROPO	DLITAN SURGICAL ASS	OCIATES				
 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 F. (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 reso 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. 	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
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. A4215 8:43A-14.4(g) INFEC PREV & CONTROL:STRILIZATN PT CARE ITEMS The manufacturer's instructions for cleaning, testing, disassembly, and sterilization of	A4190	 2. The facility failed AAMI ST79 guideline 3. This finding was of Reference #2: AAMI Facilities, 2014 edition Temperature states, area should have a to between 16 degrees C (60 degrees F [Fail bacteria thrive at h temperatures in the of help minimize bioburn 1. During a review of Relative Humidity log Area Documentation Humidity" logs evide above 65 degrees F 	to ensure compliance with es. confirmed by Staff #3. Sterilization in Health Care on, ST 79, section 3.3.6.5 " The decontamination emperature controlled C [Celsius] and 18 degrees nrenheit] and 65 degrees F). high temperatures; cool decontamination area might den." f SPD Temperature and gs, the "Decontamination of Temperature and nced daily temperatures	A4190			
	A4215	temperature range in between "60 degrees 2. The facility failed control is implemente in the Decontaminati AAMI guidelines and 3. These findings we 8:43A-14.4(g) INFEC CONTROL:STRILIZA The manufacturer's i testing, disassembly.	the Decontamination Area is F and 65 degrees F." to ensure temperature ed on Area, in accordance with its own policy. ere confirmed by Staff #2. C PREV & ATN PT CARE ITEMS instructions for cleaning,	A4215		Amer	Sican

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
		10263	B. WING		11/02/2016	
	ROVIDER OR SUPPLIER	OCIATES 40 ENGL	DDRESS, CITY, STATE E STREET VOOD, NJ 07631	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
A4215	Continued From pag by employees.	e 16	A4215			
	by: Based on observatio of manufacturer's ins conducted on 11/1/1	T is not met as evidenced n, staff interview, and review structions for use (IFUs) 6, it was determined that the re that manufacturer's IFUs				
	Sterilization in Health states in ST 79 secti written IFU [Instruction	I (Association for the dical Instrumentation) n Care Facilities, 2014 edition on 7.2.2 Manufacturers' ons for Use], "The written IFU acturer should always be				
	Probe manufacturer' Disinfection Disinf (3) Dipping: Use d Disinfectant procedu accordance with disi instructions Table Active ingredient: Glu	adzu Ultrasonic Vaginal s IFU states, "High Level ect the probe after each use. lisinfectant, listed in Table 1. re should be executed in nfectant manufacture's (sic) e 1 Recommended Solution: utaraldehyde Solution: er: Johnson & Johnson"			S	33
	procedure at 1:05 PM using Cidex OPA (Or	on of a high-level disinfection M, Staff #3 was observed rtho-Phthalaldehyde) solution t a Shimadzu Ultrasonic			Ameri	can
TE FORM			6899 DJ	T711	for	tion speet 47

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMPL	
		10263	B. WING		11/	02/2016
NAME OF PR	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
IETROPC	LITAN SURGICAL ASS	OCIATES				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	NOOD, NJ 07631	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
A4215	Continued From page	e 17	A4215			
	Vaginal Probe.					
	a. Cidex OPA solution from Cidex glutaralde	on is a different disinfectant ehyde solution.				
		listed by the manufacturer as duct for disinfecting the				
	2. The facility failed manufacturer's IFUs.	to ensure adherence to the				
	3. This finding was o	confirmed by Staff #3.				
A4797	8:43A-17.4(a)(15) HOSKEEPING-SANI CARE SERV	&SAFTY:ENVIRNMNTL PT	A4797			
		nmental condition shall be nd environmental surfaces a sight and touch.				
	by: Based on observatio	Γ is not met as evidenced n, staff interview and facility ted on 11/1/16, it was				
	determined that the f and sanitary environ surgical services by a	acility failed to ensure a safe ment for the provision of adhering to the nationally s it has selected for its				3
	Findings include:				Amer	tor
TE FORM			6899 D.I	T711		
			D3	17.11	for	

TATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE S COMPL	
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		10263			11/0	02/2016
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, LE STREET	ZIP CODE		
IETROPC	DLITAN SURGICAL ASS	OCIATES	WOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
A4797	Continued From pag	e 18	A4797			
	Practice, 2016 editio Recommendation III. be reestablished after from the area III.C operating and proceed cleaned and disinfec invasive procedure if	Guidelines For Perioperative n states on pages 12-13, " A clean environment should er the patient is transferred C.5. The floors and walls of dure rooms should be ted after each surgical or soiled or potentially soiled." ce conference, Staff #1 and				
	Staff #2 stated that the AORN, CDC, and OS Infection Control properties termination of pregnation 2. During observation	ne facility follows AAMI, SHA guidelines for its gram. The facility performs ancy (TOP) procedures only. n of room turnover cleaning				
	was observed moppi the table to clean the					
		potentially soiled with blood to the type of procedures it				
	-	to ensure that the floors were ted between patients.				
	4. This finding was of Staff #10.	confirmed by Staff #2 and				
H1170	8:43E-6.4(b) PAIN M ASSESSMENT PRC	IGMT PROCDURS: PAIN OCDURS	H1170		22	5
	occur, at a minimum of a planned dischar	ient's/resident's pain shall , upon admission, on the day ge, and when warranted by s/resident's condition, and/or evidence of			Ameri	P ican
E FORM			6899 D I	[71]	for	

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPL	
		10263	B. WING		11/0	02/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
IETROPO	DLITAN SURGICAL ASS	OCIATES	LE STREET WOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
H1170	pain. In the case of in health care services, with a visit by staff of agency and assessm is not required if the to an inpatient or res	cative of the presence of ndividuals receiving home assessment shall coincide the home health service nent on the day of discharge individual has been admitted idential health care facility he home health service	H1170			
	by: Based on document determined that the f	T is not met as evidenced review and interview, it was facility failed to ensure that conducted upon admission				
	pain was assessed u 2. Medical Records	#2- #20 lacked evidence that ipon admission. #2, #3 and #5 through #21 pain was assessed post				
	3. The above was co	onfirmed by Staff #2.			Ameri	Sican
ATE FORM			6899 D.	JT711	for If continue	ion speet 20 o

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-		
IDENTIFICATION NUMBER	A. Building					
10263 _{Y1}	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 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).

ITEI	м	DATE	ITEM		DATE	ITEM	DATE
Y4		Y5	Y4		Y5	Y4	Y5
ID Prefix	H1170	Correction	ID Prefix		Correction	ID Prefix	Correction
Reg. #	8:43E-6.4(b)	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	
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	
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LSC			LSC _		_	LSC	Americans
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REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			forLife
FOLLOWI 11/2/2016	JP TO SURVEY Co ି	DMPLETED ON		FOR ANY UNCORRECT			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
10263	B. Wing		4/24/2018			
10263 Y1	B. Willig	Y2	4/24/2010	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
METROPOLITAN SURGICAL ASSOCIATES		40 ENGLE STREET				
		ENGLEWOOD, NJ 07631				

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ITEM		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	A1885 8:43A-6.4(a)	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	A2166 8:43A-8.4(a)	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	A2285 8:43A-9.3(b)(5)	Correction Completed 04/24/2018
ID Prefix Reg. # LSC	A4098 8:43A-14.2(b)(4)	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	A4112 8:43A-14.2(b)(6)	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	A4154 8:43A-14.3(a)	Correction Completed 04/24/2018
ID Prefix Reg. # LSC	A4183 8:43A-14.3(a)(5)	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	A4190 8:43A-14.4(a)(1)	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	A4215 8:43A-14.4(g)	Correction Completed 04/24/2018
ID Prefix Reg. # LSC	A4797 8:43A-17.4(a)(15)	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
REVIEWED BY STATE AGENCY REVIEWED BY (INITIALS) REVIEWED BY CMS RO REVIEWED BY (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON 11/2/2016				SIGNATURE OF S TITLE CK FOR ANY UNCORRECTI ORRECTED DEFICIENCIES	ED DEFICIENCIES		FOP TEL	ed ife

METROPOLITAN SURGICAL ASSOCIATES

40 Engle Street Englewood, NJ 07631 Tel: (201) 567-0522 Fax: (201) 816-9863 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,

auministrator



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. 2-	-18-17;01:82FM;			; 1114			
		1 10				APPROVED	
STATEMEN	Sey Department of H T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	UENTIFICATION NUMBER	A. BUILDING: _		0,0,0,0	COMPLETED	
		10263	B, WING		11/0	11/02/2016	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE, ZIP CODE			
METROP	OLITAN SURGICAL	ASSOCIATES	E STREET OOD, NJ 076	31			
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A 000	8:43A INITIAL COM	MENTS	A 000				
		re survey was conducted on ch resulted in deficiencies.					
	Medical Instrumen						
	Nurses	n of periOperative Registered Disease Control and					
	CI=Chemical Indic	Infection Control Practices					
	IDSA=Infectious D IFUs=Instructions OPA=Ortho-Phtha	isease Society of America for Use aldehyde					
	Administration	orn hal Safety and Health otective Equipment					
	SHEA=Society of I America TOP=Termination	Healthcare Epidemiology of of Pregnancy					
A1885	8:43A-6.4(a) PT C HISTORY & PHYS	ARE POL & SVCS: MED S EXAM	A1885				
	procedures the cir patient's medical h	pecify in its policies and cumstances under which the history will be obtained, the					
	of updating. The c past surgical proc	edical history, and the frequency ontents shall include at least adures and medical/health as, adverse reactions to drugs, ations.			S	B	
				A	Ameri	cans	
			•		Ini	ed	
l						(\\8) DATE	
ler.				······································	'l continua	allon sheet 1 of 20	

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 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 ericans 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 template 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.

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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.

AZ166 Reference Z/ 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 **bis fully** 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. Personal 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.

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 enter 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.

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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.

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 inservices. 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 QA so that further remediate steps are taken.

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

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.

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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 y

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.

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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.

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 <u>daily</u> temper log for the Decontamination area. In the event that the temperature is out of acceptable anse 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 me monthly reviews of the daily temperature log to make sure all readings have either been within

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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.

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 deficiency by the Site Survey Team on Nov. 2, 2016.

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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.

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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.

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.

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.

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.

Monitoring of this POC will occur via chart review. For the first month following the 3. 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.

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

A2166 Reference 2/4,5

Upon transfer from the OR to the PACU, the attending physician must perform a medication 1. 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.

The medical chart has been modified to assure systemic compliance with this corrective action. 2. 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.

Monitoring to assure against recurrences of this deficiency will occur by incorporating 3. 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 vill be responsible for ensuring full compliance with all rules and regulations.

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

A2166 Reference 2/6

Physicians transferring a patient from the Facility to the hospital will enter such an formed in the facility to the hospital will enter such an formed in the hospital will enter such an formed in the hospital will be an enter such as the hospital will be as the hospital will be an enter such as t 1. 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 of the Rounds. The ICO, or an appointed designee, shall also be responsible for providing immediate and the second s

remediation if non-compliance is later observed by conducting a mandatory in-service with noncomplying 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.

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 or 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 hard the real 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 to rear 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 insurveillance will be reported to the QAC in eight weeks' time.

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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 patalogue of medical equipment to ensure that it remains current. This corrective action should provide systemic term assurance that such an error does not recur.

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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. $NoV + f_{ij} \ge o_{ij} \otimes o_{ij}$

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.



A1885

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

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Revision of the medical chart provides a systemic change that will ensure that that this deficient 2. 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.

2017 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

The medical chart will now provide written documentation of patients' pain assessment by the 1. 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. m_{1} m_{2} m_{3} m_{2} m_{2} m_{3} m_{2} m_{3} m_{4} m_{4} 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.

The POC was fully implemented as of Nov 17, 2016, following the identification of this deficiency 4. 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 ha 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

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

Monitoring of this POC will occur via chart review. For the first month following the 3. 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.

Monitoring to assure against recurrences of this deficiency will occur by incorporating 3. 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 vill be responsible for ensuring full compliance with all rules and regulations.

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

A2166 Reference 2/6

Physicians transferring a patient from the Facility to the hospital will enter such an for hto Life 1. the patient's medical record.

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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.

OR

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 two-week period; if complete compliance is noted, it will then become part of the monthly Infection Cortrol III CO 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 noncomplying 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 ited 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 CC (mechanism to confirm the POC has been successfully implemented and will be complied with in the TC (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 **ife** 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 **Ited** Infection Control rounds. Shortcomings will be brought to the attention of the cleaning statt 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.

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 0 (2116) II/15/II6 as provides for will be held.
 This POC will monitor for effectiveness by auditing patient charts to assure ongoing compliance

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

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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.

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.



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	



DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		31C0001006	B. WING			11/	02/2016
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Q 000	INITIAL COMMENTS		Q	000			
	A Federal Re-certific on 11/1 and 11/2/16.	ation survey was conducted					
	Oxygen Concentrator	rdy regarding the use of an r in an Operating Room Il use in the home, was					
	The following Condition compliance:	ons for Coverage are out of					
	42 CFR 416.41 Gove Management	rning Body and					
	42 CFR 416.44 Envir	onment					
	42 CFR 416.51 Infect	tion Control					
	Medical Records Rev	riewed: 20					
	Staff Files Reviewed/	Interviews: 15					
	Nurses CDC=Centers for Dis Prevention	ion of periOperative Registered ease Control and					
	Advisory Committee IDSA=Infectious Dise IFUs=Instructions for	ection Control Practices ase Society of America Use				S	S
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	OR=Operating Room OSHA=Occupational				Ar	neri	cans
LABORATORY	 DIRECTOR'S OR PROVIDER/:	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE	ni	X6 DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is deter other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosa 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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	assumes full legal res implementing, and mo the ASC's total opera has oversight and acc assessment and perfe program, ensures tha programs are adminis quality health care in	a governing body that sponsibility for determining, initoring policies governing tion. The governing body countability for the quality ormance improvement t facility policies and stered so as to provide a safe environment, and ns a disaster preparedness					
Q 100	Based on document observation, it was de Body failed to demon carrying out the respon- management of the A (ASC). The Governin- necessary oversight a by the lack of complia Condition of Participa Infection Control. ENVIRONMENT CFR(s): 416.44 The ASC must have a environment, properly	onsibility of the operation and mbulatory Surgical Center g Body failed to provide and leadership as evidenced ince with the following tion: Environment and	Q	100	-	ي meri	
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: LCSI	L11	Facilit			
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Q 100	Continued From page patients.	2	Q 10				
	Based on observation 11/2/16, it was determ	not met as evidenced by: n and staff interview on nined that the facility failed to nment to protect the health the public.					
	Findings include:						
Q 104	Association's Life Safe (Cross refer to Tag Q	ational Fire Protection ety Code, 2012 edition. 104).	Q 104	4			
	the ASC must meet the Ambulatory Health Ca edition of the Life Safe Protection Association of patients served. The the Federal Register H 101® 2000 edition of January 14, 2000, for in accordance with 5 M part 51. A copy of the inspection at the CMS Center, 7500 Security and at the National Ar Administration (NARA availability of this mat 202-741-6030, or go the http://www.archives.g ederal-regulations/ibr Copies may be obtain	S Information Resource Y Boulevard, Baltimore, MD rchives and Records (). For information on the erial at NARA, call to ov/federalregister/code_of_f			An	s ieri	Scans

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Q 104	Quincy, MA 02269. If of the Code are incor will publish notice in t announce the change (2) In consideration o State survey agency, deemed appropriate, Life Safety Code whic result in unreasonable only if the waiver will health and safety of th (3) The provisions of apply in a State if CM code imposed by Stat patients in an ASC. (4) An ASC must be i 21.2.9.1, Emergency March 13, 2006. (5) Notwithstanding a edition of the Life Saf ASC may place alcoh dispensers in its facili (i) Use of alcohol-I does not conflict with prohibit or otherwise alcohol-based hand r facilities; (ii) The dispensers that minimizes leaks a falls; (iii) The dispensers	f any changes in this edition porated by reference, CMS he Federal Register to es. f a recommendation by the CMS may waive, for periods specific provisions of the ch, if rigidly applied, would e hardship upon an ASC, but not adversely affect the he patients. the Life Safety Code do not IS finds that a fire and safety te law adequately protects n compliance with Chapter Lighting, beginning on	Q 10			S	S
	access; and						cans
	(iv) the dispenser	s are installed in accordance			An	neri	cans

Event ID: LCSL11

Facility ID: NJ31C0001006



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Q 104	corridor, the corridor s of 6 ft (1.8m); (B) The maximum capacity shall be: (1) 0.3 gallor in rooms, corridors, an (2) 0.5 gallor in suites of rooms (C) The dispense horizontal spacing of other; (D) Not more tha gallons (37.8 liters) of use in a single smoke storage cabinet; (E) Storage of qu gallons (18.9 liters) in compartment shall me NFPA 30, Flammable Code; (F) The dispense over or directly adjace (G) In locations v	visions: nsers are installed in a shall have a minimum width m individual dispenser fluid as (1.2 liters) for dispensers and areas open to corridors as (2.0 liters) for dispensers ers shall have a minimum 4 feet (1.2m) from each an an aggregate of 10 ABHR solution shall be in a compartment outside of a uantities greater than 5 a single smoke bet the requirements of and Combustible Liquids ers shall not be installed ent to an ignition source; with carpeted floor a installed directly over all be permitted only in mpartments; and a re maintained in	Q	104			Si	S
	Based on observation	not met as evidenced by: n and staff interview, it was acility failed to comply with				An	neri	cans



DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ 31C0001006 B. WING 11/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 ENGLE STREET** METROPOLITAN SURGICAL ASSOCIATES ENGLEWOOD, NJ 07631 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Q 104 Continued From page 5 Q 104 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 141 ORGANIZATION AND STAFFING Q 141 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LCSL11

Facility ID: NJ31C0001006



PRINTED: 05/29/2018

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/29/2018 / APPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE	
		31C0001006	B. WING		_	11/	02/2016
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
METROPC	LITAN SURGICAL ASSO	DCIATES		0 ENGLE STREET			
			E	ENGLEWOOD, NJ 0763	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Q 141	Continued From page	9 6	Q 141				
	provide nursing care i recognized standard of	n accordance with a of practice and its policy.					
	Findings include:						
	State of New Jersey s nursing as a registered defined as diagnosing responses to actual o emotional health prob as casefinding, health counseling, and provi- restorative of life and medical regimens as otherwise legally auth Reference #2: Facilit Management at MMA patient's recovery after	r potential physical and lems, through such services teaching, health sion of care supportive to or wellbeing, and executing prescribed by a licensed or orized physician or dentist." y policy "Perioperative Pain " states, " To make the er surgery and anesthesia					
	do a pain assessment	PACU nurse is advised to t based on a scale of 0-10, absolutely unbearable"					
	the patient underwent The PACU (post anes Operative Admission PM, the patient met d indicator of the Discha (less) 3." There was record that the patient	d of Patient #7 revealed that a procedure on 10/8/16. thesia care unit) Post sheet indicated that at 4:30 ischarge criteria. One arge Criteria is "Pain score < no evidence in the medical t's pain was assessed stay and prior to discharge.					
	the patient underwent	d of Patient #6 revealed that a procedure on 10/25/16. ative Admission sheet				S.	ダ
	indicated that at 12:15				An	neri	cans

Event ID: LCSL11



		ND HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		31C0001006	B. WING			11/	/02/2016
NAME OF P	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE		
METROPO	DLITAN SURGICAL ASS	OCIATES			ENGLE STREET IGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 141	 evidence in the medii pain was assessed in discharge. 3. The medical record the patient underwein Post procedure there patient's pain was as transfer. 3. The medical record the Patient's Information that the patient was as lbuprofen. The Post 10/14/16 contained at mg (milligram) po (by cramping x1." Althour require any medication post-operatively, there nursing staff consulted clarification or discord 4. The medical record 10/22/16 that post-operatively, there maintained on Lactated (milliliter) per hour. The Post Operative Order order. 5. The medical record that post-operatively maintained on Lactated hour with 20 units of evidence in the Post- intravenous fluid order 6. The medical record 	e < (less) 3." There was no cal record that the patient's n PACU and prior to d of Patient #2 revealed that t a procedure on 12/30/15. was no evidence that the sessed prior to the patient's d of Patient #5 indicated in tion Medical History sheet allergic to Dapro and Operative Orders dated n order for "Ibuprofen 800 mouth) prn (as needed) ugh the patient did not on for cramping e was no evidence that ed with the physician for tinuation of the order. d of Patient #7 indicated on peratively the patient was ed Ringers at 125 ml There was no evidence in the rs of an intravenous fluid rd of Patients #4 indicated on 8/3/16, the patient was ed Ringers at 125 ml per Pitocin. There was no Operative Orders of an	Q	141		_	Scans
FORM CMS-256	57(02-99) Previous Versions Ob		L11	Facil	lity ID: NJ31C0001006 If cor	inuation she	et @ C ²⁶
					f	or I	Life



TATEMENT (OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		31C0001006	B. WING		11	/02/2016
NAME OF PI	ROVIDER OR SUPPLIER			FREET ADDRESS, CITY, STATE, ZIP CODE	E	
METROPO	DLITAN SURGICAL AS	SOCIATES) ENGLE STREET NGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
Q 141	medical records fai	ge 8 tively for evaluation. The led to include a transfer order. confirmed by Staff #2 and	Q 141			
Q 181	Staff #7. ADMINISTRATION CFR(s): 416.48(a)	OF DRUGS	Q 181			
		bared and administered ished policies and acceptable ce.				
	Based on observation observation conducted on 11/2/ facility failed to ens	s not met as evidenced by: tion and staff interview 16, it was determined that the ure the implementation of ds of practice for medication				
	Findings include:					
	Practices (ISMP) S Adult IV Push Medi "3.5 Do NOT withdu commercially availa	e for Safe Medication afe Practice guidelines for cations, Appendix A, states, raw IV push medications from able, cartridge-type syringes e for administration."				
	Labetalol were four Operating Room #4				Ś	ß
		Staff # 4 stated that the facility ication using a syringe and did olding devices			Amer	

Event ID: LCSL11

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DEPARTMENT OF HEAL CENTERS FOR MEDICA						FORM	APPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE			
		31C0001006	B. WING _			11/	02/2016		
NAME OF PROVIDER OR SUPPL	IER		•		TREET ADDRESS, CITY, STATE, ZIP CODE				
METROPOLITAN SURGICA	L ASSC	DCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631					
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
Q 181 Continued From	n page	9	Q 1	81					
	SICIA	re confirmed by Staff #2. N OWNERSHIP	Q 2	223					
420 of this sub provide a list of interest or own Disclosure of ir This STANDAF Based on revie interview, it wa to ensure that t	chapte f physio ership nforma RD is r ew of 4 s deten the pat arding	se, in accordance with Part r, and where applicable, cians who have financial in the ASC facility. tion must be in writing. not met as evidenced by: of 4 medical records and rmined that the facility failed ient is provided written the facility physician rgery.							
and #12 lacked regarding the p was provided to 2. The above of ADVANCED D CFR(s): 416.50 The ASC must requirements: (1) Provide the patient's represe concerning its	I recor I evide hysicia o the p was co IRECT 0(c)(1)(compl patien sentatio policies	nfirmed by Staff #1. IVES	Q2	224		Şx	CC.		
	s and,	if requested, official State			Δπ	V. neri	Cans		
FORM CMS-2567(02-99) Previous Vers		olete Event ID-LCSI			sility ID: NJ31C0001006				

Event ID: LCSL11

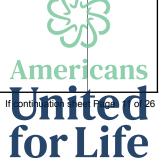
Facility ID: NJ31C0001006



	-	ID HUMAN SERVICES				FORM	MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		31C0001006	B. WING			11/	02/2016
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
METROPO	DLITAN SURGICAL ASSO	DCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Q 224	 patient's representative make informed decisic care. (3) Document in a procurrent medical recorrindividual has executed. This STANDARD is represent of the state of the patient's represent of the procedure, with policies on advance of patient, or as appropring representative of the informed decisions reand failed to document patient's current medicate individual has executed. Findings include: 1. The medical recorrindigues on advance of the individual has executed. This surrent medicate individual has executed the individual has executed the individual has executed. The medical recorring and #12 failed to individual has executed to facility policies on advance of the individual has executed to individual has executed the individual has executed to individual	or, as appropriate, the ve of the patient's rights to ons regarding the patient's ominent part of the patient's d, whether or not the ed an advance directive. not met as evidenced by: f 4 of 4 medical records, y, and interview of was determined that the le patients or, as appropriate native in advance of the date n information concerning its lirectives; failed to inform the	Q	224			
	2. The medical recor	ds of Patient #6, #8, and of an advance directive admission.				Sy	S
	3. Staff #1 confirmed	the above findings.			Ar	neri	cans

Event ID: LCSL11

Facility ID: NJ31C0001006



		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/29/2018 M APPROVED D. 0938-0391
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		31C0001006	B. WING		11/	/02/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
METROPO	DLITAN SURGICAL ASSO	DCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
Q 240	INFECTION CONTR CFR(s): 416.51	OL	Q 2	40		
		ain an infection control o minimize infections and ses.				
	Based on observation staff interview conduct it was determined that adequate Infection Co	not met as evidenced by: n, document review and cted on 11/1/16 and 11/2/16, at the facility failed to have an ontrol program that seeks to nd communicable diseases.				
	Findings include:					
	sanitary environment services by adhering	to provide a functional and for provision of surgical to professionally acceptable . (Cross refer to Tag Q				
Q 241	compliance with the i procedures and proto Control Plan and the guidelines that it has Control program. (Cro	o implement and monitor nfection control policies, bools of the facility's Infection nationally recognized selected for its Infection boss refer to Tag Q 0242). MMENT	Q 2	41		
					S.	3
		not met as evidenced by: ation, review of facility			Ameri	
FORM CMS-256	97(02-99) Previous Versions Obs	solete Event ID: LCS	L11	Facility ID: NJ31C0001006 If	for I	Life

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONS	TRUCTION	(X3) DATE	E SURVEY PLETED
		31C0001006	B. WING _			11/02/2016	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
METROPO	OLITAN SURGICAL ASSO	DCIATES			LE STREET EWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
Q 241	documentation, and s determined that the fa functional and sanitar provision of surgical s Findings include: 1. On 11/2/16 at 10:5 Staff #1, a Platinum 5 Oxygen Concentrator Operating Room #2 v performed. a. A review of the Ma Manual states, "Your intended for individua Select a location: Yo house The air intal located in a well vent pollutants and/or fum b. During interview, 9 oxygen concentrator procedures on 11/2/1 c. The Oxygen Conc accordance with Man This finding resulted which immediately cu Immediate Jeopardy day of survey, upon r of correction. B. Based on observa facility policy review of determined that the fa	staff interview, it was acility failed to ensure a ry environment for the services. 50 AM, in the presence of 6 HF model IRC5LX02 was being used in while procedures were being anufacture's Operator oxygen concentrator is al use in the home." u may select a room in your ke of the unit should be ilated area to avoid airborne es" Staff #1 confirmed the was functioning during	Q2	241		Sameri	Scans
FORM CMS-256	67(02-99) Previous Versions Obs		SL11	Facility ID:	NJ31C0001006 If c	ontinu ation shee	Page 13 of 26
							Life



FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 31C0001006 B. WING 11/02/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 ENGLE STREET METROPOLITAN SURGICAL ASSOCIATES** ENGLEWOOD, NJ 07631 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Q 241 Continued From page 13 Q 241 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: LCSL11

Facility ID: NJ31C0001006



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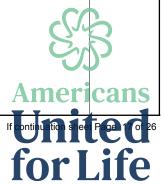
PRINTED: 05/29/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION	(X3) DATE	
		31C0001006	B. WING			11/02/2016	
NAME OF PI	ROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CODE		
METROPO	DLITAN SURGICAL ASSO	DCIATES			ENGLE STREET IGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 241	following clinical situa direct contact with pa with a patient's intact pulse or blood pressu [bullet] When moving site to a clean body s [bullet] After contact v (including medical eq vicinity of the patient. gloves 1. Artificial find not be worn if duties if patients 3. Remove before touching non- environmental surfact another patient" 1. During a tour of O presence of Staff #2, removing his/her soild his/her mask and eye sanitizing his/her han a. This finding was c Staff #8. 2. During a tour of th of Staff #2, Staff #3 w his/her soiled gloves first sanitizing his/her a. This finding was c Staff #3. 3. On 11/1/16 in Ope a procedure, Staff #8 gloves multiple times between glove chang	tions: [bullet] Before having tients [bullet] After contact skin (e.g., when taking a ire, and lifting a patient) from a contaminated body ite during patient care with inanimate objects uipment) in the immediate [bullet] After removing ingernails or extenders may nclude direct contact with e gloves promptly after use, contaminated items and es, and before caring for R #2 at 12:20 PM, in the Staff #8 was observed ed gloves and touching iglasses without first ds. onfirmed by Staff #2 and e SPD area, in the presence vas observed removing and opening a door, without hands. onfirmed by Staff #2 and erating Room (OR) #2 during donned and doffed his/her without hand sanitizing es.		241 Facil	-		
FURM CMS-256	or (02-99) Previous Versions Obs	solete Event ID: LCS	L11	Faci			
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Q 241 Continu wrappe (i) Whi	SUMMARY STA SUMMARY STA EACH DEFICIENCY EGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 40 ENGLE STREET ENGLEWOOD, NJ 07631 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	ECTION	02/2016
METROPOLITAN SI PREFIX TAG Q 241 (i) Whi	SUMMARY STA SUMMARY STA EACH DEFICIENCY EGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	40 ENGLE STREET ENGLEWOOD, NJ 07631 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI	ECTION	
(X4) ID PREFIX TAG Q 241 Continu wrappe (i) Whi	SUMMARY STA EACH DEFICIENCY EGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	ENGLEWOOD, NJ 07631 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI		
Q 241 Continu wrappe (i) Whi	EACH DEFICIENCY EGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SI		
wrappe (i) Whi				CROSS-REFERENCED TO THE AF DEFICIENCY)		(X5) COMPLETION DATE
 search c. At 12 and left (i) When not han 4. The environ accordation When not han 4. The environ accordation Finding C. Bas facility p determinant Finding 1. Duri Staff #2 AORN, Infectiont Referent Practication Should transfer 	e still wearing opening and cl of supplies. 2:46 PM, Staff the OR to retr en Staff #8 retu d sanitize prio facility failed to ment by imple ance with CDC ection Control ed on observa colicy review c ned that the fa- nitary environn l services by a zed guidelines n Control prog s include: ng the entrance stated that th CDC, and OS n Control prog tion of pregna nece: AORN Gr e, 2016 edition mendation III. be reestablish- red from the a	 a trash can. the same gloves, Staff #8 osing cabinet doors in #8 doffed his/her gloves ieve supplies. urned to the OR, he/she did r to donning gloves. o ensure a safe and sanitary menting hand hygiene in HICPAC guidelines and its policy. tion, staff interview and onducted on 11/1/16, it was acility failed to ensure a safe nent for the provision of dhering to the nationally is it has selected for its 	Q 24	11	Ameri	Scans

	-	ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES					<u>). 0938-0391</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE SURVEY COMPLETED		
		31C0001006	B. WING			11/	02/2016	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
METRODO				4	0 ENGLE STREET			
WEIROPC	POLITAN SURGICAL ASSOCIATES ENGLEWOOD, NJ 07631							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
Q 241	surgical or invasive protentially soiled. " 1. During observation in OR #2, in the preservation of the table to clean the table to clean the table to clean the a. The floors can be and bodily fluids due performs. 2. The facility failed the cleaned and disinfect and disinfect and disinfect and disinfect and policies and procedure recognized guidelines determined that the fasanitary environment professionally accepts Findings include: Reference #1: AORN Perioperative Practice states, " Chipped for removed prior to entry the perioperative environment or the perioperative environment or the perioperative environment or the perioperative processional for the perioperative environment or the perioperative environment or the perioperative perioperative perioperative environment or the perioperative periope	d disinfected after each rocedure if soiled or n of room turnover cleaning ence of Staff #2, Staff #10 ng the floors without moving floor underneath. potentially soiled with blood to the type of procedures it o ensure that the floors are ed between patients. onfirmed by Staff #2 and ation, review of facility res, review of nationally s, and staff interview, it was acility failed to provide a by adhering to able standards of practice. A, Guidelines for e, 2016 Edition pg. 30 fingernail polish should be y into the restricted area of irronment. Fingernail polish arbor pathogens in large fingernail polish should be ossible contamination of the atient Artificial fingernails y health care personnel in	Q2	241		S. neri	Scans	
	the perioperative envi	ironment. Any fingernail						



	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X3) DATE	
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NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
METROPO	LITAN SURGICAL ASSO	DCIATES			ENGLE STREET GLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
Q 241	tips, gels and acrylic of acrylic fingernails con- fingernails " 1. The following was PACU area: a. Staff #15 confirme gel nails. b. Staff #14 was wea visibly chipped on bot c. Staff #10 was wea visibly chipped on bot Reference #2: CDC, Prevention of Intravas Infections, 2011, pg. § disinfectants must be transmission of micro [357]. Some studies of the devices with ch appears to be most ef colonization [195, 196 1. During an observa 11/1/16, Staff #4 adm numerous times to Pa disinfecting the IV por 2. Staff #1 and Staff f findings. Reference #3: Facilit	 a bonding product is Fingernail extensions or overlays, resin wraps, or artificial observed on 11/1/16 in the d that he/she was wearing at the hands. Guidelines for the scular Catheter-Related 55 states, " Appropriate used to prevent bes through connectors have shown that disinfection lorhexidine/alcohol solutions ffective in reducing 6]" tion of Patient #1 on inistered IV medication atient #1 without first t with alcohol. #7 confirmed the above 	Q 2	241		S	Scans
	[bullet] Use aseptic te				All		La115

Event ID: LCSL11

Facility ID: NJ31C0001006



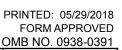
					APPROVED
RS FUR MEDICARE &	MEDICAID SERVICES			OMB NC	<u>). 0938-0391</u>
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			SURVEY LETED
	31C0001006	B. WING		11/	02/2016
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OLITAN SURGICAL ASSO	DCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
 contamination of steri [bullet] Multi-dose via dose vials at all times once and discarded a Always use a new ste draw up medications. needles, syringes or ovials with an alcohol p medication even sing 1. During an observation observation observation and the syringe used previous draw up an additional 2. Staff #4 did not dis with alcohol prior to p 3. Staff #1 and Staff findings. INFECTION CONTROL 	le injection equipment Is will be used as single a. They will be punctured ifter single use [bullet] erile syringe and needle to [bullet] Do not re-use cannulae [bullet] Swab all bad prior to drawing up le use vials." Attion of Patient #1 on sed the same needle and sly to administer propofol, to I dose of propofol. Sinfect the rubber septum iercing the vial. #7 confirmed the above				
The ASC must mainta designed to prevent, infections and commu addition, the infection program must include ASC has considered, nationally recognized This STANDARD is r A. Based on observa review of manufacture (IFUs) conducted on	control, and investigate unicable diseases. In control and prevent e documentation that the selected, and implemented infection control guidelines.			Ameri	Scans
	PROVIDER OR SUPPLIER OLITAN SURGICAL ASSO SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page contamination of steri [bullet] Multi-dose via dose vials at all times once and discarded a Always use a new ste draw up medications. needles, syringes or o vials with an alcohol p medication even sing 1. During an observa 11/1/16, Staff #4 re-u syringe used previous draw up an additional 2. Staff #4 did not dis with alcohol prior to p 3. Staff #1 and Staff findings. INFECTION CONTRe CFR(s): 416.51(b) The ASC must mainta designed to prevent, infections and commu addition, the infection program must include ASC has considered, nationally recognized	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 31C0001006 PROVIDER OR SUPPLIER POLITAN SURGICAL ASSOCIATES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. PROVIDER OF FORCE PROGRAM	OF DEFICIENCIES PECORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A BUILDING 31C0001006 B. WING	OPE DEFICIENCIES (X1) RROWDERSUPPLERCUAL (X2) MULTPLE CONSTRUCTION IF CORRECTION 31C0001006 INVIG PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE QUITAN SURGICAL ASSOCIATES STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES D (EACH DEFICIENCY MUST PRECEDED BOYLLL ID REGULATORY OR LSC IDENTIFYING INFORMATION) D Contamination of sterile injection equipment [Dullet] [Dullet] Multi-dose vials will be used as single O 2 241 Contamination of sterile injection equipment [Dullet] [Dullet] Multi-dose vials will be used as single O 2 241 Advance medications [Dullet] Do not re-use needles, syringes or camulae [Dullet] Do not re-use needles, syringes or camulae [Dullet] Swab all vials with an alcohol pad pior to drawing up medications medication even single use vials." O 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 Graw up medications 2. Staff #1 and Staff #7 confirmed the above findings. 1. INFECTION CONT	OPC BENCISS PCORRECTION (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BULING (X3) MULTIPLE CONSTRUCTIPLE PROPERENT A BULING (X3) MULTIPLE C

Event ID: LCSL11

Facility ID: NJ31C0001006



	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		31C0001006	B. WING			11/02/2016	
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
METROPO	DLITAN SURGICAL ASSO	DCIATES) ENGLE STREET NGLEWOOD, NJ 07631		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 242	manufacturer's IFUs a Findings include: Reference #1: AAMI Advancement of Med Sterilization in Health states in ST 79 sectio written IFU [Instruction of the device manufacturer's Disinfection Disinfe (3) Dipping: Use di Disinfectant procedur accordance with disir instructions Table Active ingredient: Glu Cidex Manufacturer 1. During observation procedure at 1:05 PM using Cidex OPA (Or solution to clean and Ultrasonic Vaginal Pro- a. Cidex OPA solution from Cidex glutaralder b. Cidex OPA is not I a recommended proc	(Association for the lical Instrumentation) Care Facilities, 2014 edition on 7.2.2 Manufacturers' ons for Use], "The written IFU cturer should always be adzu Ultrasonic Vaginal a IFU states, "High Level ect the probe after each use. sinfectant, listed in Table 1. re should be executed in offectant manufacture's (sic) 1 Recommended Solution: taraldehyde Solution: taraldehyde Solution: tranaldehyde Solution: tran	Q	242		Sameri	
FORM CMS-256	57(02-99) Previous Versions Obs	solete Event ID:LCS	L11	Fac	ility ID: NJ31C0001006 If conti	ustion shee	Page 2 of 26
							Life



	-	ID HUMAN SERVICES					APPROVED
STATEMENT C	S FOR MEDICARE & PF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G		(X3) DATE S COMPL	
		31C0001006	B. WING			11/0	2/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 40 ENGLE STREET	DDE		
METROPO	LITAN SURGICAL ASSO	DCIATES		ENGLEWOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC	ON SHOULD B		(X5) COMPLETION DATE
Q 242	 B. Based on observation conducted on 11/1/16 facility failed to ensure Reprocessing adhere AAMI is one of the national guidelines the facility Control program. Findings include: Reference #1: AAMI Facilities, 2014 edition Internal chemical indistructure should be used within sterilization container 1. During a tour of the basement, in the prese #11, a sterile instrume was opened and inspirate internal CI (chemical the package. 2. The facility failed to AAMI ST79 guideline 3. This finding was concepted and inspirate internal chemical indistructure #2: AAMI ST29 guideline 	ation and staff interview b, it was determined that the e its Instrument es to AAMI ST 79 guidelines. ationally recognized has selected for its Infection Sterilization in Health Care n, ST 79 section 10.5.2.2.2 cators states, "An internal CI n each package, tray, or rigid r system to be sterilized." e SPD area located in the sence of Staff #3 and Staff ent tray labeled "D&C set" ected. The tray lacked an indicator/integrator) within o ensure compliance with s. onfirmed by Staff #3. Sterilization in Health Care n, ST 79, section 3.3.6.5 ' The decontamination	Q 24		T)		
	area should have a te between 16 degrees C (60 degrees F [Fah bacteria thrive at h	emperature controlled C [Celsius] and 18 degrees irenheit] and 65 degrees F). igh temperatures; cool econtamination area might			An	neri	Scans

Facility ID: NJ31C0001006



PRINTED: 05/29/2018

		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY PLETED
		31C0001006	B. WING			11/	02/2016
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
METROPOLITAN SURGICAL ASSOCIATES			40 ENGLE STREET ENGLEWOOD, NJ 07631				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Q 242	 During a review of Relative Humidity log Area Documentation Humidity" logs eviden above 65 degrees F f 10/29/16. a. The log indicated f temperature range in between "60 degrees The facility failed t control in the Deconta accordance with AAM policy. These findings we Based on observation conducted on 11/1/16 facility failed to ensure that adhere to AORN Findings include: Reference #1: AORN periOperative Registed <https: 13<br="" november="" www.aorn.orgupdated="">"Perioperative team m attire that covers the a supplies. Wearing lon contain skin squames Opening sterile suppl without wearing a lon skin squames from th member's bare arms</https:> 	SPD Temperature and s, the "Decontamination of Temperature and ced daily temperatures rom 9/1/16 through that the facility's acceptable the Decontamination Area is F and 65 degrees F." o ensure temperature amination Area was in Il guidelines and its own re confirmed by Staff #2. Ation and staff interview 6, it was determined that the e perioperative practices guidelines. I [Association of ered Nurses] Clinical FAQs g/clinicalfaqs/attire/> 3, 2014 states, nembers should wear scrub arms when opening sterile ig-sleeved attire helps is shed from bare arms. ies onto the sterile field g-sleeved jacket may allow	Q	242		San	Scans

Facility ID: NJ31C0001006



PRINTED: 05/29/2018

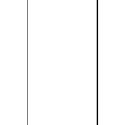
		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/29/2018 MAPPROVED D. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		31C0001006	B. WING		_	11/	02/2016	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
METROPO	LITAN SURGICAL ASSO	OCIATES		40 ENGLE STREET ENGLEWOOD, NJ 0763	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
Q 242	 page 100, "I.c. When nonscrubbed person" their arms with a long jacket." 1. AORN is one of th guidelines the facility Control program. 2. During observation procedure in OR #2, is Staff #8 was observed items onto the sterile long-sleeved attire. a. The lack of a long- squames that are she drop onto the sterile field. 3. The facility failed to personnel wear long-s restricted areas of the 4. The facility failed to of surgical items on the maintained. 5. These findings we Staff #8. D. Based on observation conducted on 11/1/16 facility failed to ensure regulations. 	I Guidelines For e, 2016 edition states on in the restricted areas, all nel should completely cover -sleeved scrub top or e nationally recognized has selected for its Infection n of room preparation for a n the presence of Staff #2, d opening sterile surgical field without wearing a esleeved attire allows skin ed from Staff #8's arms to ield and potentially o ensure all nonscrubbed sleeved attire while in the e facility.	Q 24	2	An	Saeri	Scans	
	Findings include:				AI	IGL	calls	

Event ID: LCSL11



	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 05/29/2018 MAPPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED
		31C0001006	B. WING		11	/02/2016
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
METROPC	LITAN SURGICAL ASSO	DCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
Q 242	Continued From page	23	Q 24	42		
	Health Administration (3)(ii) states, "Use. The that the employee use protective equipment that the employee ter to use personal prote under rare and extract was the employee's p the specific instance is prevented the deliver safety services or wo increased hazard to t co-worker. When the judgement, the circum investigated and doct determine whether ch prevent such occurre 1. During a tour outs of Staff #2, Staff #9 w at 12:10 PM, carrying	y of health care or public uld have posed an he safety of the worker or employee makes this instances shall be umented in order to hanges can be instituted to inces in the future." ide OR #2, in the presence ras observed exiting OR #2				
	biohazard warning lal					
		o ensure implementation of ce to OSHA regulations.				
Q 261	3. This finding was c ADMISSION ASSES CFR(s): 416.52(a)(1)	-	Q 26	61	S.	ß
	-	rs before the date of the ach patient must have a			Ameri	-
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:LCS	L11	Facility ID: NJ31C0001006 If	continuation she	P 0 2 0 26
]	forl	Life

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		DNSTRUCTION	(X3) DATE	E SURVEY PLETED
		31C0001006	B. WING			11	/02/2016
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
METROPO	DLITAN SURGICAL ASSO	DCIATES			NGLE STREET GLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 261	assessment complete in section 1861(r) of t practitioner in accord	e 24 cal history and physical ed by a physician (as defined he Act) or other qualified ance with applicable State s, standards or practice, and	Q	261			
	Based on document was determined that	not met as evidenced by: review and staff interview, it the facility failed to ensure cal history is obtained prior					
	Findings include:						
	Regulation states, " 2. Under no circums performed until the pa	Medical Staff Rules and VII. Medical Records cances may an operation be atient's history, physical corded on the medical					
Q9999	lacked a complete me the physicians prior to records contain a Pati includes the patient's surgery/hospitalizatio etc. which is complete	n, allergies, medications, ed and signed by the patient. orm is reviewed and utilized y the physicians as a to the procedure.	Q9	999		S.	Ś
		are on site today for a n survey and have identified dy. The survey team			A	meri), cans
FORM CMS-256	7(02-99) Previous Versions Obs	colete Event ID: LCS	 L11	Facility	y ID: NJ31C0001006 If cont	inuation she	Page 25 of 26
						JLI	Life



PRINTED: 05/29/2018 FORM APPROVED

	-	ID HUMAN SERVICES				FOR	MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		31C0001006	B. WING			11/	02/2016
	ROVIDER OR SUPPLIER	DCIATES		4	STREET ADDRESS, CITY, STATE, ZIP CODE 40 ENGLE STREET ENGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
Q9999	observed a Platinum Oxygen Concentrator Room during a proce- use indicate the follow "Your oxygen conce individual use in the h "Select a location: Y your house " " The air intake of in a well ventilated and pollutants and/or fumo The unit takes air from converts it to concent administers O2 via na exhausts air though th The facility was made immediate Plan of Co the survey team. The Condition tag tha Physical Environment 11/21/16-*An accepta	5 HF model IRC5LX02 being used in the Operating dure. The instructions for ving: ntrator is intended for nome " You may select a room in the unit should be located ea to avoid airborne es. " In the operating room, rated oxygen and asal cannulas and also he side. e aware of the IJ and an prection was requested by tt this will be cited under is	Q9	999		S. meri	Scans

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ31C0001006



POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT				
IDENTIFICATION NUMBER	A. Building						
31C0001006 _{Y1}	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).

ITEI	N		DATE	ITEM			DATE	ITEM		DATE
Y4			Y5	Y4			Y5	Y4		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
	00444		O a ma ati a m	ID Desfec	00101		O a mar ati a m			O
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	<u> </u>	Correction
Reg. #			Completed	Reg. #			Completed	Reg. #		Completed
LSC				LSC			-	LSC	-Americ	cans
REVIEWE		REVIEWE (INITIALS		DATE		SIGNATURE OF S	JRVEYOR		Unit	ed
REVIEWE CMS RO	D BY	REVIEWE (INITIALS		DATE		TITLE			for	ife
FOLLOWI 11/2/2016	JP TO SURVEY CO	OMPLETED	ON			ANY UNCORRECTE ED DEFICIENCIES				5 🗌 NO

LCSL12

Statement of Deficiencies Citation Summary Sheet

For: METROPOLITAN SURGICAL ASSOCIATES (31C0001006 / NJ31C0001006) Survey Event: LCSL21, Exit Date 11/02/2016

Citations Cited This Visit

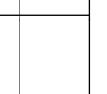
Regulation Type	Regulation ID	Regulation Version	Building Number	Tag Number	Tag Title	Scope/ Severity
Federal	K309	03.02	02	0000	INITIAL COMMENTS	
Federal	K309	03.02	02	0161	Building Construction Type and Height	
Federal	K309	03.02	02	0211	Means of Egress - General	
Federal	K309	03.02	02	0223	Doors with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



	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY PLETED
		31C0001006	B. WING			/02/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
METROPO	OLITAN SURGICAL ASSO	DCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION
K 000	INITIAL COMMENTS		K 00	00		
	This was a Federal F	Recertification Survey.				
	Fire Protection Assoc	compliance with the National ciation's 2012 Life Safety recertification survey only.				
K 161			K 16	51		
	Building Construction Building construction 20.1.6.1 or Table 21.7	type and stories meet Table				
	Construction Typ 1 I (442), I (3 number of stories II (111), III (211), non-sprinklered of V (111)	32), II (222), Any IV (2HH),				
	2 II (000), III (200), non-sprinklered					
	sprinklered	Any number of stories				
	be separated by Type Type V (111) construct following are met: 1. Such levels are un					
	ambulatory health ca 2. Hazardous spaces 8.7. Sprinklered stories m	are protected per section			S.	R
		vroved, supervised automatic				
	system in accordance	e with section 9.7. (See				
	20.3.5 or 21.3.5, resp	pectively)			Amer	Icans

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined has other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable to 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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 02	· · ·	E SURVEY PLETED
		31C0001006	B. WING			100/0040
AME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		/02/2016
IETROPC	DLITAN SURGICAL ASS	OCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
K 161	construction, the num basements, floors on location of smoke or approval. Complete s plan of the building a 20.1.6.1, 20.1.6.2, 2 This STANDARD is Based on observation facility failed to ensur that are two or more sprinklered througho supervised automation Findings include: 1. On 11/2/16 at 1:3 Staff #1, the building stories, constructed of unprotected combuss a. The building was	on, in REMARKS, of the nber of stories, including which patients are located, fire barriers and dates of sketch or attach small floor s appropriate. 1.1.6.1, 21.1.6.2 not met as evidenced by: on, it was determined that the re buildings of type III (200) stories in height, are ut by an approved	K 16			
K 211	exit locations, and ac with Chapter 7, and 1 continuously maintai full instant use in cas	eneral eneral s, corridors, exit discharges, ccesses are in accordance the means of egress is ned free of all obstructions to se of emergency, unless 2 through 20/21.2.11.	K 21	1	Amer	Bican
M CMS-256	7(02-99) Previous Versions Ob	solete Event ID:LCSL21	 F	acility ID: NJ31C0001006	If continuation si	eet Page 2
					for	



	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 02	(X3) DATE SURVEY COMPLETED
		31C0001006	B. WING		11/00/0010
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	11/02/2016
	NOVIDER OR SUIT LIER			40 ENGLE STREET	
IETROPO	DLITAN SURGICAL ASSO	DCIATES		ENGLEWOOD, NJ 07631	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETICIE APPROPRIATEDATE
K 211	Continued From page	2	K 2	11	
	Based on observatio facility failed to ensur	not met as evidenced by: n, it was determined that the e that exit enclosures otected path of travel to an			
	Findings include:				
		ety Code, 2012 edition, ide stairs serving as an exit , shall be enclosed in			
	"101:7.1.3.2.2, An ex	nal Fire Protection Tety Code, 2012 edition, it enclosure shall provide a path of travel to an exit			
K 223	Staff #1, fifty percent capacity for the Base was enclosed at the I discharged into the P and was not a protec Discharge. Doors with Self-Closi	re/Post Operative Care Unit ted path to an Exit	К 22	23	
	be held open by a rel 7.2.1.8.2 that automa	ng Devices self-closing are permitted to ease device complying with tically closes all such doors e compartment, entire			American



	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		SURVEY PLETED	
		31C0001006	B. WING		11	/02/2016	
AME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	02/2016	
ETROPC	DLITAN SURGICAL ASS	DCIATES		40 ENGLE STREET ENGLEWOOD, NJ 07631			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
K 223	smoke passing throu smoke detection syst * Automatic sprinkler * Loss of power 20.2.2.4, 20.2.2.5, 21 This STANDARD is Based on observation facility failed to ensur	nclosure doors upon re alarm system, and ors designed to detect gh the opening or a required em; and system, if installed; and .2.2.4, 21.2.2.5 not met as evidenced by: on, it was determined that the e that doors required to be d, unless held open by an	K 22	3			
K 311	1. On 11/2/16 at 11:0 Staff #1, a manual fo to the basement door Care Unit. This door open at the time of th Vertical Openings - E CFR(s): NFPA 101	nclosure	K 31	11			
	per 8.6, unless one of exist: 1. Unenclosed verti- permitted. 2. Unenclosed oper a required means of 3. Exit access stairs meet the following co- Two stories or less	all be enclosed or protected f the following conditions ical openings per 8.6.9.1 are nings which do not serve as egress are permitted. s may be unenclosed if they inditions:			Ameri	Sican	
/I CMS-256	7(02-99) Previous Versions Obs	solete Event ID: LCSL21	1	Facility ID: NJ31C0001006	If continuation s	ieer Page 4	
	· · ·				forl		

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION 2	(X3) DATE	D. 0938-0391 SURVEY PLETED
		31C0001006	B. WING			11/	02/2016
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10	
METROPO	DLITAN SURGICAL ASSO	DCIATES			0 ENGLE STREET INGLEWOOD, NJ 07631		
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K 311	supervised sprinkler s b. Total travel di exceed 100 feet. Three stories or le a. Occupant loa 15 people. b. Building is sp per 9.7.1.1(1). c. Building contr detection system per d. Activation of smoke detection syste the building. e. Total travel di exceed 100 feet. Floors that are below used for storage or an occupancy, shall not openings to the busin 21.3.1, 39.3.1.1, 39.3 This STANDARD is r Based on observatio facility to ensure that of the means of egres Findings include: 1. On 11/2/16 at 10:2 Staff #1, the required	system per 9.7.1.1(1). istance to outside does not ess id per story does not exceed winkler protected throughout ains an automatic smoke 9.6. the sprinkler system or em notifies all occupants of istance to outside does not the street level and are ny use other than a business have any unprotected tess occupancy floors. .1.2 not met as evidenced by: n, it was determined that the stairs used as a component as are enclosed.	K	311	Ar	San	B

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ31C0001006



POST-CERTIFICATION REVISIT REPORT

			DATE OF REVISIT		
	A. Building 02 - METROPOLITAN MEDICAL / B. Wing	2 - METROPOLITAN MEDICAL ASSOCIATES			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		•	
METROPOLITAN SURGICAL ASS	OCIATES	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).

ITE	м	DATE	ITEM		DATE	ITEM	DATE
Y4		Y5	Y4		Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0161	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	NFPA 101 K0211	Correction Completed 04/24/2018	ID Prefix Reg. # LSC	CorrectionNFPA 101CompletedK022304/24/2018
ID Prefix Reg. #	NFPA 101	Correction Completed	ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #	Correction
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 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	Completed Americans
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGNATURE C	OF SURVEYOR		United
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			forLife
FOLLOWUP TO SURVEY COMPLETED ON 11/2/2016				CK FOR ANY UNCORRE			

LCSL22

METROPOLITAN MEDICAL ASSOCIATES

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

IMMEDIATE REMOVAL PORTABLE 02 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



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO: 0938-039 (X3) DATE SURVEY COMPLETED			
31C0001006			B, WING	11/02/2016				
NAME OF I	PROVIDER OR SUPPLIER		े े	REET ADDRESS, CITY, STATE, ZIP CODE	· · · · ·	14212010		
METROPOLITAN SURGICAL ASSOCIATES			40 ENGLE STREET ENGLEWOOD, NJ 07631					
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Q 000	INITIAL COMMEN	TS	Q 000					
	A Federal Re-certi on 11/1 and 11/2/1	fication survey was conducted 8.						
	Oxygen Concentra	pardy regarding the use of an tor in an Operating Room ual use in the home, wa s				· · ·		
	The following Cond compliance:	litions for Coverage are out of						
	42 CFR 416.41 Go Management	verning Body and						
	42 CFR 416.44 Env	vironment						
;	42 CFR 416.51 Infe	action Control						
	Medical Records Re	eviewed: 20						
	Staff Files Reviewe	d/Interviews; 15 \	1					
-	Medical Instrument: AORN= Association Nurses	n of periOperative Registered						
1. 	CDC=Centers for D Prevention CI=Chemical Indica	tor/Integrator						
	Advisory Committee IDSA=Infectious Dis	sease Society of America			Ś	R		
	IFUs=Instructions fo OPA=Ortho-Phthala OR=Operating Rool	ildehyde		ļ	ۍ ۱mei	יטי tican		
				TITLE	Uni	o o ta Te		
				excused from correcting provide	Z/2	8-19-		

Lays recovery the date these documents are made available to the raciity. If deticlencies are cited, an approved plan of correction is requisite to continued program participation.

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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

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.

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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



(Quo not addressed

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

1. There is now on going documentation of patlents' 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.

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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 ican 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 the corrective action. The order templates have been amended to facilitate comparison and precribing

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.

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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.

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.

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 the deficiency by the Site Survey Team on Nov. 2, 2016.

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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 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 **ricans** advance directive section of the medical record to the chart review process. Both will report their findings to the QAC.

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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.

0240/0741

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.

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 Office. The meetings' purpose will be to review the cited findings, review the ASC's policies regarding hand hygien and infection control, as well as, role-play scenarios so that staff can better understand the real if applications of these standards.

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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.

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.

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 <u>ongoing</u> basis. Shortcomings will be brought to the attention of the cleaning staff and reported to the QAC.

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.

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 vigilines

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 the 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.

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.
- S. 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.

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/AAN (guideline) 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 Proce ting staff,

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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. NOT

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

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.

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.

The Sterilization Consultant shall perform an in-service that will include specific instructions 2. 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.

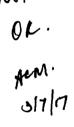
З. The SPT shall be responsible for keeping a daily temperature log for the Decontamination area. In the event that the temperature is out of acceptable range the SPT shall immediately notify the CSPDT who shall immediately turn on cooling units until the Decontamination area temperature is within acceptable 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 Sterillzation 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 <u>daily</u> 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.

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.

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 performation the DON. Lack of compliance will be reported to the QAC.

4. The AMD was responsible for this POC.

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	302 - METROPOLITAN MEDICAL	COMPLETED
			ASSOCIAT)
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		310001008			11/02/2016
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mericor		-0000//// 00		ENGLEWOOD, NJ 07631	
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Any deficiency statement anding 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 and is obable 10 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

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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 terricant ensure that the plan of correction meets city code and is in compliance with the National Fire Protection Association's Life Safety Code.

S. Axis Architectural Studio has already begun drafting blueprints for the proposed prof 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.

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



CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			[LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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	Medical Records Re Staff Files Reviewed					
-	Abbreviation Key: AAMI=Association f Medical Instrumenta AORN= Association Nurses CDC=Centers for D Prevention CI=Chemical Indica	or the Advancement of ation of periOperative Registered isease Control and tor/Integrator				
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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 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.

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/willicans continue to monitor the progress of Axis Architectural Studios until all deficiencies are corrected and the final plan of correction is fully completed.

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metropolitan odd #1 Ned 117 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 territories 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 Alle Link 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 metical 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 deficiency by the Site Survey Team on Nov. 2, 2016.

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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 inservice 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.

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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 oncorrect 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 th 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 balients 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 dance. Directives prior to the initiation of care at this ASC. The Facility will update its online information to

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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 in the Site Survey Team's finding by the AMD. Following this, and at the request of the QAC, the DON reviewed a catalogue of the ASC's available medical equipment to ensure that no 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 inservice 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 obvious soiling.

2. An in-service to review of the Facility Cleaning Manual to assure delineation of this serview of this corrective action with the cleaning staff by the Infection Control Officer was november 15, 2016 to assure systemic correction.

3. The Infection Control Officer observed the staff and the ORs for compliance on a dal to see 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 appropriate Canss Physician and Nursing staff on a daily basis for a two-week period; if complete compliance is roted, a will then become part of the monthly Infection Control Rounds.

4. The ICO and the AMD will be responsible for implementation of this corrective active 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 teneor 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 safeg iards by the Sterilization Consultant with the all Sterile Processing Technician (SPT), the Certified Sterile Processing and the Distribution Lead Technician (CSPDT).

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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 inservice 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 provide espective equipment, such as, gloves, gowns, masks and eye protection to its staff.

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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 channels the 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 the the time 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 complete 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 fold be doors equipped with a manual doorstop are inspected and the manual doorstops are either removed for replaced with an approved hold-open device compliant with the National Fire Protection Associate Lie. 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 frecuency 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.

3. The Governing Body has ultimate responsibility for assur ng 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 with ricans continue to monitor the progress of Axis Architectural Studios until all deficiencies are corrected and the final plan of correction is fully completed.

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 ?rotection 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 µ lan 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.

3. Architectural plans are scheduled to be completed and submitted to the building department of Canss 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/Lost **Ditted** 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 arch text 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 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.

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 snoke 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.

3. The ASC has retained the services of the appropriate contracting company to complete the ericans 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 nite notice of any planned 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 Life 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 of 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 the standard technic chart review process. Any potential identified deficiencies will be addressed by the Director 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 med.cine 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 inservice 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, tollowing 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 nericans mandated quality assurance meeting of the medical staff held on January 17, 2017. Awareness by the **ited** physician staff to document a transfer order, along with, awareness by the nursing staff of such a transfer order, along with, awareness by the nursing staff of such a **ited test** for **ited test**.

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 **COMPLANCE** 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. 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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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 inservice 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 function Compliance has been reported to the QAC by the Infection Control Officer.

United for Life

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 in the field of 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 or Life

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 steple 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 reference **CONTROL** 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 inservice with non-complying personnel and shall report non-compliance to the QAC.

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

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

Q242 D

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

Systemic compliance will be achieved by an in-service reviewing universal precaution standards 2. 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.

The Infection Control Officer will initially monitor all personnel on a daily basis for a two-week 3. 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 noncomplying personnel and shall report non-compliance to the QAC.

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

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

Q261

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

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

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

The AMD was responsible for this POC. 4.

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

K161

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

United

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 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 prowork shall be completed by September 1, 2017

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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





Retropolitan Surg associ - add # 3 2/10/18

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. /

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

ot 2/10/18



New Jersey State Department of Health Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility			Date	Case Number
Cherry Hill Women's Ce	nter		7/16/19	NJ00124488
Administrator/CEO			Type Facility	Time Required to Correct
Jennifer Groves			Acute	
Type of Survey			Matter Under Consideratio	n
ComplaintSu	vestigation EFor Immedi Irveillance Attention	iate	Pharmacentica	
Census/Bed Capacity	Units Toured	Charts F		mber of Patients Affected
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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

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,

Yusa their for

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





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Je	rsey Department of H	lealth			FOHM	APPROVED
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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





New Jersey Department of Health Health Facility Survey & Field Operations

SURVEY & CERTIFICATION APPROVAL REPORT

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Name of Applicant				.l				ference Number
Cherry Hill Women	s Center						22445	
Applicant Address					Work Site	Address		
502 Kings HWY, No. Cherry Hill, NJ 0800				5	Surgical	Suite		,
Contact Person							Contact 1	
Jenifer Groves, MEd	, MBA			0.00				l Executive Director
Contact Email Address								e Number
jgroves@thewomar	scenters.com						(856) 83	
Visit Conducted by					Date of VI	sit		Date of Revisit
E. DeCicco					9/26/201			Select date.
Description								
	🗌 YES 🔀	NO [Appro	ved 🔲 Di	sapproved	WAIVE	R No.: N/	A DATE ISSUED: Select date.
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New Jersey Department of Health Health Facility Survey & Field Operations

HEALTH CARE FACILITY APPROVAL REPORT	Continued)
Signature of Surveyor	Surveyor Recommendation
Supervisor of inspections 🔲 D. Gorski-Galla 🛛 L. Kiernan 🗌 A. Sousa	Check if additional sheets are attached.

Americans United for Life

		Use Group: <u>B</u> Maximum Live Load: <u>0</u> FER	53 75	it 5:17 ion, lead abatement was performed as scope of work file	ment ion, asbestos abatement was performed f work file	Equipment has been installed and/or frorm Construction Code and is	1; ate:	Date Printed: 9/24/2018 Page 1
Certificate Construction Code Division (Certificate of Approval) Certificate Minuber	State	Cursurucuon Lassification: TYPE VB Use Maximum Occupancy Load: 0 Max Maximum Occupancy Load: 0 Max Description of Work/Use: REPLACE RTUS - 4 UNLTTS - THE WOMEN'S CENTER (LESS 20% DCA PLAN REVIEW)	Certificate Comments:	 Certificate of Clearance - Lead Abatement 5:17 This serves notice that based on written certification, lead abatement was performed as per NAC5:17 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	The following conditions must be met no later than: or the owner will be subject to fine or order to varate: This certificate has an expiration date of: Conditions to be met:	Check Number: Collected By:
CHERRY BID Mercer Street, Room 205 HILL Cherry Hill, NJ 08002	Identification Block: 286.18 Lot: 12 Qual: Work Site Location: 502 KINKS 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 <u>HUTCHINSON</u> Address <u>621 CHAPEL AVENUE CHERRY HILL NJ 08002</u> Teterpiwne. <u>(6556) 423-5007</u> Tan. (000) 108002 License Number or Builders Registration Number: 346101325500 Federal Emp. Number: 223766253 19HC0022700	 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 to the construction code and is approved for 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 Amer Amer Job	Construction Official Fee: \$0.00

Cherry Hill Women's Center

Plan of Correction

COPY

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.







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,

United

forLife

Eric DeCicco Surveyor Physical Plant/Life Safety Survey and Certification

Encl.

PRINTED: 09/28/2018 FORM APPROVED

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CHERRY HILL WOMEN'S CENTER COPTEMPERATURE/HUMIDITY LOG – STERILIZATION

DA TRUE.

TEMPERATURE NORMAL RANGE: 68°F - 73°F HUMIDITY NORMAL RANGE: 30% - 60% Please report any abnormal findings to the supervisor

9/27/18

TIME	TEMP	HUMIDITY %	INITIALS	NOTES	7
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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: 9/27/18

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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: 9127/18

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES	
6:30A	640	48%	OT	Jenele in room temp check	
9:30A	640	49%6	OT	3 people in man	
11:30A	65° 63°	50%	OT	teno check	
a:30m	ሬ <mark>ን</mark> °	50%	(Non)	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 9127113

$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	TIME	TEMP	HUMIDITY %	INITIALS	NOTES
$\frac{1120 \text{ mm}}{2:33 \text{ pm}} = \frac{71^{\circ}}{71^{\circ}} = \frac{52^{\circ}}{9^{\circ}} = \frac{9^{\circ}}{9^{\circ}} = \frac{52^{\circ}}{9^{\circ}} = \frac{12^{\circ}}{9^{\circ}} = \frac{12^{\circ}} = \frac{12^{\circ}}{9^{\circ}} = \frac{12^{\circ}}{9^{\circ}} = 12^{\circ$	6:30am	70'F		yn	readings at prening
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	11:30 ain			4m	6 Staff members 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) 9/27/13

DATE:

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
<u>30 am</u>	68.2°F	49.9 70	(192)	readings at orening no activity ir room temp. check. no activity in room, 2 stat
1:30am	71.8°F	46.190	(Tan)	Do activity is room
11:30 am	69.6°F	54.640	(Do)	temp. check
2 30m	(28-2°F	55.1%	(A)	no activity in room 2 stat
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Biological Testing Record Month: Sect 2018

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CV= Control Vial

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Temperature/Humidity Log-OR 1



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Temperature Normal Range: 68°F - 73°F Humidity Normal Range: 30% - 60% (Please report any abnormal findings to your supervisor)

TIME TEMPERATURE **HUMIDITY %** INITIALS NOTES <u>50.2%</u> 50.2% 10:3bam 71.1º F (F) reddings at opening 9:39am 70.7°F Blachvity in roc ericans hited for Life

DATE: 9 28 18

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
6:35 am	70.2°F 71.1°F	59.9%		readings of again
9:35 cm	71.1°F	47 7%		B activity in room
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Temperature/Humidity Log – Decontamination



Temperature Normal Range: 60°F - 65°F Humidity Normal Range: 30% - 60% (Please report any abnormal findings to your supervisor)

9 28 18 DATE:

TIME	TEMPERATURE	HUMIDITY %	INITIALS	NOTES	
10:32am 9:37am	64° F			readings of maning	
9:37am	65°F	53°10 54%	A	I no activity in room	
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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



TIME TEMP HUMIDITY % INITIALS NOTES $6:37cm$ $71^{\circ}F$ $50^{\circ}/_{\circ}$ 10° $7eading s at openyors 9:40an 71^{\circ}F 51^{\circ}/_{\circ} 10^{\circ} 3etaff in room? 9:40an 71^{\circ}F 51^{\circ}/_{\circ} 10^{\circ} 3etaff in room? 9:40an 10^{\circ} 10^{\circ} 3etaff in room? 10^{\circ} 10^$		*		NOTO		a * ⁶ .
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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

	L	DATE: 9/28/1	6		
TIME	TEMP	HUMIDITY %	INITIALS	NOTES	7
:33am	69°F	51°/0	(Na)		$\mathbb{E}[\{q^{(i)}, 0\} : (\nabla h + h^{(i)} + (q + m))] \to [n]$
1:37 am	69° F	50%	- (Ser)	no activity in room]
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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.



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 onsite 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)

nited

- 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:

orLife The Infection Control Program, which is governed by the facility's Quality Improven 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 Americans disease exposure involving patients, employees, medical staff and other initial of the staff of the staff
 - M. Definitions will be provided for surgical site infections and other nosocomial infections* for surveillance purposes to provide for uniform Life 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 United nosocomial infection reports, including employee health reports and there is the 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



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- 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.







29.5

DATE: _____PAGE: ____

UNIT PROFILE

SYSTEM = RTU-H

LOCATION = 100 F. MODEL = USIILEBUTHZASAGFORD SERIAL= 33/8/8/111

MANUFACTURER = ((()

STATIC PROFILE

		63
FILTER SP IN = COIL SP IN = COIL SP IN =	STATIC -0.4 b	APPARATUS Gilter De Coil
	-0.69" +0.77	Gas Heat

	DESIGN	ACTUAL			
CFM ANALYSIS			011220	DESIGN	ACTUAL
SUPPLY FAN TRAVERSE =	2400	Non Durt Contry	SUPPLY FAN		AUTOAL
TERMINAL =	2350	2314		208-230	216-211-2
RETURN TERMINAL =	1605	12/2	AMPERAGE =	99-01	EILE C-E
OUTSIDE AIR =	865	12162	SERVICE FACTOR =	<u></u>	5.4-5.6-5.8
RELIEF AIR=	1000	868	FRAME NUMBER =	6-94-94-94-94-94-94-94-94-94-94-94-94-94-	
	10		MOTOR MANUFACTURER =		56172
			PRINT DESIGN HP =	1.05	Marailon
DRIVE PACKAGE			MOTOR TAG HP =		Contraction of the second
FAN PULLEY PD =			APPROXIMATE BHP=		NIL
FAN SHAFT DIAMETER =		8.5~	FINAL HZ SET PT.=		NIA
FAN RPM =		1.17"	FINAL SP SET PT.=	*************	
MOTOR FULL PITCH =	None	897	MIN. SP SET PT.=		
FINAL MOTOR PITCH =		4.75			199 - C
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MOTOR SHAFT DIAM =		0.875			
MOTOR RPM =	1725	1768	BELT SIZE =		AX57
DIRECT DRIVE FINAL SPEED='			BELT QTY =	*******	S
			CENTERLINE =	*************	1.025
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NUMBER OF FILTERS =			TEMPERATURES	DRY BULB	
SIZE =			OUTSIDE AIR =	78.6	
CONDITION OF FILTERS =		10x251	MIXED AIR =		
		Clean	RETURN AIR =		
			SUPPLY AIR =	68.6	64.0
×				57.9	52.1







DATE: 3/15 ____ PAGE: _

UNIT PROFILE

LOCATION = ROUF

SYSTEM = RTU-1

MODEL = <u>48KCERU4AZASAFORO</u> SERIAL= <u>338689510</u>

MANUFACTURER = _____

STATIC PROFILE

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CFM ANALYSIS				DESIGN	ACTUAL
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TERMINAL =	1250	1208	VOLTAGE =	208-230	211-211-210
RETURN TERMINAL =	1125		AMPERAGE =	5.2-4.6	3.0-3.1-3.2
OUTSIDE AIR =	225	938	SERVICE FACTOR =		1.15
RELIEF AIR=	003	208	FRAME NUMBER =		56HZ
		+	MOTOR MANUFACTURER =		Marathon
20			PRINT DESIGN HP =	1.42	
DRIVE PACKAGE		/	MOTOR TAG HP =		NIL
		<u> </u>	APPROXIMATE BHP=		
FAN PULLEY PD =		4.25	FINAL HZ SET PT.=		NA
FAN SHAFT DIAMETER =		0,625"	FINAL SP SET PT.=		
FAN RPM =	None	1272	MIN. SP SET PT.=		
MOTOR FULL PITCH =		3,125			
FINAL MOTOR PITCH =		3.125"	BELT INFORMATION		
MOTOR SHAFT DIAM =		0.6251	BELT SIZE =		
MOTOR RPM =	1725	747	BELT QTY =		AX 38
DIRECT DRIVE FINAL SPEED=	*********				
			CENTERLINE =		14.125"
			CARRIAGE ADJ. =		10.75" -1.75"
·			IDLER PULLEY YES / NO		No
FILTER DATA					lencans
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CONDITION OF FILTERS =		16x25x2	MIXED AIR =	68.0%	
		(PCy)	RETURN AIR =	107.54	
	1		SUPPLY AIR =	55.7%	49.5%
				<u> </u>	77.07





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 = $\mathcal{M}T\mathcal{V}-($					
THE MODE OF AIR BEING TRAVERSED =					
THE LOCATION OF THIS TRAVERSE = (out / i http://					
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 = 20 S					
THE SIZE OF THE $0.2.$ AT THIS TRAVERSE POINT = 28×14.25					
THE FREE AREA (LENGTH X WIDTH DIVIDED BY 144) = 2.777					
THE AVERAGE FPM (VELOCITY) AT THE TRAVERSE POINT =					
THE STATIC PRESSURE AT THE TRAVERSE POINT = $\frac{-0.004}{100}$					
THE AIR TEMPERATURE AT THE TRAVERSE POINT = $\underline{\mathcal{P}} \cdot O^{\circ} F$					
INSTRUMENT USED= Version					
93 99 94					
56 60 50					

J

452-6=75





DATE: ______ PAGE: _____

AIR TERMINAL DATA SHEET

SYSTEM: RTV-1

TERMINAL	TERMINAL	ROOM	DESIGN	DEGLON					
NUMBER	SIZE	NAME	AK	DESIGN FPM	DESIGN	TEST	FINAL	FPM	NOTE
	45"×24"	ORI		- C2	CFM	CFM	CFM	2	
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3					250	162	250		
4					250	188	246	[
_5					250	224	241	-	
					250	229	236		
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DATE: _____ PAGE: ____

UNIT PROFILE

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SYSTEM = RTU-Z LOCATION = Roof

MANUFACTURER = Carrier

MODEL = <u>42K/ F.F.O4AZA5AFOAO</u> SERIAL= <u>331808951</u>)

STATIC PROFILE

	STATIC	APPARATUS
FILTER SP IN =	-0.30	dilla a
COIL SP IN =		Jul Cil
COIL SP IN =		JX Coil
COIL SP IN =		
FAN SUCTION SP -	-0.53	
FAN DISCHARGE IN SP =	JA Env	
COIL SP OUT =	10.35	Gias Iteat
·		

CENT ANALYON	DESIGN	ACTUAL			24
CFM ANALYSIS			SUPPLY FAN	DESIGN	ACTUAL
SUPPLY FAN TRAVERSE =		VA Wet Gutt,			
TERMINAL =	1250	1770			2-115-205
RETURN TERMINAL =	1125	157	AMPERAGE =	5.2-4.6	25-2.6-2.7
OUTSIDE AIR =	775		SERVICE FACTOR =		1.15
RELIEF AIR=		211	FRAME NUMBER =		
			MOTOR MANUFACTURER =		561-12.
			PRINT DESIGN HP =	1.47	Marchian
DRIVE PACKAGE		<u> </u>	MOTOR TAG HP =	1. 2	and the second sec
FAN PULLEY PD =		I	APPROXIMATE BHP=		NIL
FAN SHAFT DIAMETER =		1.25	FINAL HZ SET PT.=		NIA
		0,625	FINAL SP SET PT.=		
FAN RPM =	None	1114	MIN. SP SET PT.=		
MOTOR FULL PITCH =		3.125	WINV. OF SET PT.=		
FINAL MOTOR PITCH =		2.75~	PELT INFORMATION		
MOTOR SHAFT DIAM =		0.625	BELT INFORMATION		
MOTOR RPM =	1725		BELT SIZE =		CAR38
IRECT DRIVE FINAL SPEED=	1161	1765	BELT QTY =		1000
MAR			CENTERLINE =		14.3125
		-	CARRIAGE ADJ. =		
			IDLER PULLEY YES / NO		+1.23.25
FILTER DATA			526	Ar	herteans
NUMBER OF FILTERS =			TEMPERATURES	DEV DULC	
		2	OUTSIDE AIR =	DRY BULL	WETBUCB
SIZE =		16x25x2-		71.04	L BARA
CONDITION OF FILTERS =		Cican	MIXED AIR =	68.1 F	Lo Fifa
			RETURN AIR =	67.7"F	
24			SUPPLY AIR =	55.3°F	49.415





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 = $2\pi\sqrt{-2}$ THE MODE OF AIR BEING TRAVERSED = $3000 \text{ f}(1) \text{ Marked}$, exhaust, relief THE LOCATION OF THIS TRAVERSE = $12\pi\sqrt{-2}$ THE LOCATION OF THIS TRAVERSE = $12\pi\sqrt{-2}$ THE AREA OF THE BUILDING THAT THIS TRAVERSE SERVES = $12\pi\sqrt{-2}$ THE AREA OF THE BUILDING THAT THIS TRAVERSE SERVES = $12\pi\sqrt{-2}$ THE CFM DESIGN FOR THIS TRAVERSE POINT = 225 THE ACTUAL CFM (VELOCITY X FREE AREA) AT THE TRAVERSE = 211 THE SIZE OF THE $0.2\pi\sqrt{-2}$, AT THIS TRAVERSE POINT = 28.0×11 , 25° THE FREE AREA (LENGTH X WIDTH DIVIDED BY 144) = 2.77 THE AVERAGE FPM (VELOCITY) AT THE TRAVERSE POINT = 76 THE AVERAGE FPM (VELOCITY) AT THE TRAVERSE POINT = 76 THE STATIC PRESSURE AT THE TRAVERSE POINT = 7.005° THE AIR TEMPERATURE AT THE TRAVERSE POINT = 71.0° f INSTRUMENT USED = $\sqrt{20}$ f	
101 93 97 - - - - - - SS SS </td <td></td>	

453 -16=76 x 2.77





DATE: 9/18 PAGE:

AIR TERMINAL DATA SHEET

SYSTEM: <u>LTV-2</u>

TERMINAL	TERMINAL			8		. 3			
NUMBER	SIZE	ROOM	DESIGN	DESIGN	DESIGN	TEST	FILLE		
1	48'X24'		AK	FPM	CFM	CFM	FINAL CFM	FPM	NOTES
2		OR II			250	243	248.	1	
3					250	215	<u>228</u>		[
4					250		238		
	+				250	180	235		
	+				2.70	265	248	53.	
	+				250	227	260		
A.					250	1130	1229		
5									
	2								
Retvin		21							
	14 KIO	MI T							
2		ORIF			375	304	7.7.7		
3							323		
		d				233	316		
					075	302	318		
		<u> </u>			125	839	957		
							10		
	1								
					0.5				
	· (c)		1						
			5		3				
								7	
							07		
						A	meri	can	IS
						T	T		1
	36						Jni	6	
						f	or l	11	ρ
						1			





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DATE: 9/18 ____ PAGE:__

UNIT PROFILE

SYSTEM = RTU-3 MANUFACTURER = Carrie

MODEL = UKLEBOGHZASHFOHO SERIAL= 33)8189518

STATIC PROFILE

LOCATION = <u>loof</u>

STATIC	APPARATUS
-0.32	FILERS
12	Dx Co.
- 0.54	7.9
+ 0.46"	bus Hect
	UMA TICK

	DESIGN	ACTUAL		DEGION	
CFM ANALYSIS			SUPPLY FAN	DESIGN	ACTUAL
SUPPLY FAN TRAVERSE =	1200	NA Dot 64			
TERMINAL =	1330	1370			Z10-209-210
RETURN TERMINAL =	1100	955	AMPERAGE =	8.8-8.6	4.1-4.3-4.6
OUTSIDE AIR =	300		SERVICE FACTOR =	*****************	1.15
RELIEF AIR=	300	318	FRAME NUMBER =		SC. HT.
			MOTOR MANUFACTURER =		Morathan
	<u> </u>		PRINT DESIGN HP =	272	
DRIVE PACKAGE	·		MOTOR TAG HP =		All.
			APPROXIMATE BHP=		NIA
FAN PULLEY PD =		4.25"	FINAL HZ SET PT.=		
FAN SHAFT DIAMETER =		0.625"	FINAL SP SET PT.=		
FAN RPM =	None	1125	MIN. SP SET PT.=		
MOTOR FULL PITCH =		3,75			<u></u>
FINAL MOTOR PITCH =	*********	2.75	BELT INFORMATION		
MOTOR SHAFT DIAM =	*********	0.875	BELT SIZE =		124-0
MOTOR RPM =	1725	1-7-74	BELT QTY =		HX38
DIRECT DRIVE FINAL SPEED=					
			CENTERLINE =		14.5
			CARRIAGE ADJ. =		FLO-1.625
			IDLER PULLEY YES / NO		
FILTER DATA					lericans
			TEMPERATURES	DRY BULB	WET BULB
NUMBER OF FILTERS =		<u> </u>	OUTSIDE AIR =	71.07F	1127-
SIZE =	*******	16×16×2	MIXED AIR =	GTIPF	
CONDITION OF FILTERS =		/ tean	RETURN AIR =	(ele:0")	Co a FP
			SUPPLY AIR =	57,51-	
				J+, 5 /	51.8%



DATE: 4/18 PAGE:

TRAVERSE DATA SHEET

BUTLER BALANCING CO. INC.

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 = $LTU - 3$
THE MODE OF AIR BEING TRAVERSED =
supply, return, outside air, mixed, exhaust, relief
THE LOCATION OF THIS TRAVERSE = ROOF (i'Atule)
THE AREA OF THE BUILDING THAT THIS TRAVERSE SERVES = $1270 - 3$
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 = 28.25×14
THE FREE AREA (LENGTH X WIDTH DIVIDED BY 144) = 2.74
THE AVERAGE FPM (VELOCITY) AT THE TRAVERSE POINT =
THE STATIC PRESSURE AT THE TRAVERSE POINT = -0.008
THE AIR TEMPERATURE AT THE TRAVERSE POINT = $\frac{71.0^{\circ}}{6}$
INSTRUMENT USED= Upla del
134 131 126
110 97 96
United
<u> </u>

694=6=116

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DATE: 9/18 PAGE:

AIR TERMINAL DATA SHEET

SYSTEM: RTU = 3

TERMINAL NUMBER	TERMINAL	ROOM	DESIGN	DESIGN	DESIGN	TEST	FINAL	FPM	
NUMBER	SIZE	NAME	AK	FPM	CFM	CFM	CFM		
	2408	Recover			185	208	186		<u> </u>
2					190	220	200		
3	d	d	-		185	235	195		
<u> </u>	1206	TLT	2	- E	45	117	48		<u> </u>
5	<u></u>	entrance			85	88			
67_		Corridor			30	87	97.		
7		Utility Kon			45				
8	2408	Recovery				92	46		
9	1	1		7	1.90	214	189		
10	d			<u> </u>	185	229	193		
					190	213	190		
			-[]-	7.1	1330	1703	1370		
<u> </u>									
					*		20		
Alda a									
Lourn									
	24x24	RECOVERY			275	185	248		
2		2 J	1						
3					275	299	240		
4 8						318	239		
					275	253	228	1 0	
			┼───┼						
25					1100	1055	955	8.0	
			<u> </u>						
19								$\rightarrow +$	
			j					$ \rightarrow +$	
			<u>├</u>						
				<u> </u>			mor		

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.

- <u>.</u> Please login to ProjectDox below to access the released drawings and documents. These can be found in the "Released" folder.
- You may download and/or print the released documents for your use.

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Assigned by: Shron Schral

THIS NOTIFICATION IS NOT A CONSTRUCTION PERMIT

proposed to be built have been reviewed and released in conformance with the provisions of the Regulations and issued before any work can be performed. Construction plans and specifications for the subject structure for the New Jersey Uniform Construction Code, N.J.A.C. 5:23. All prior approvals must be secured, all permit fees must be paid, and a construction permit must be applied for

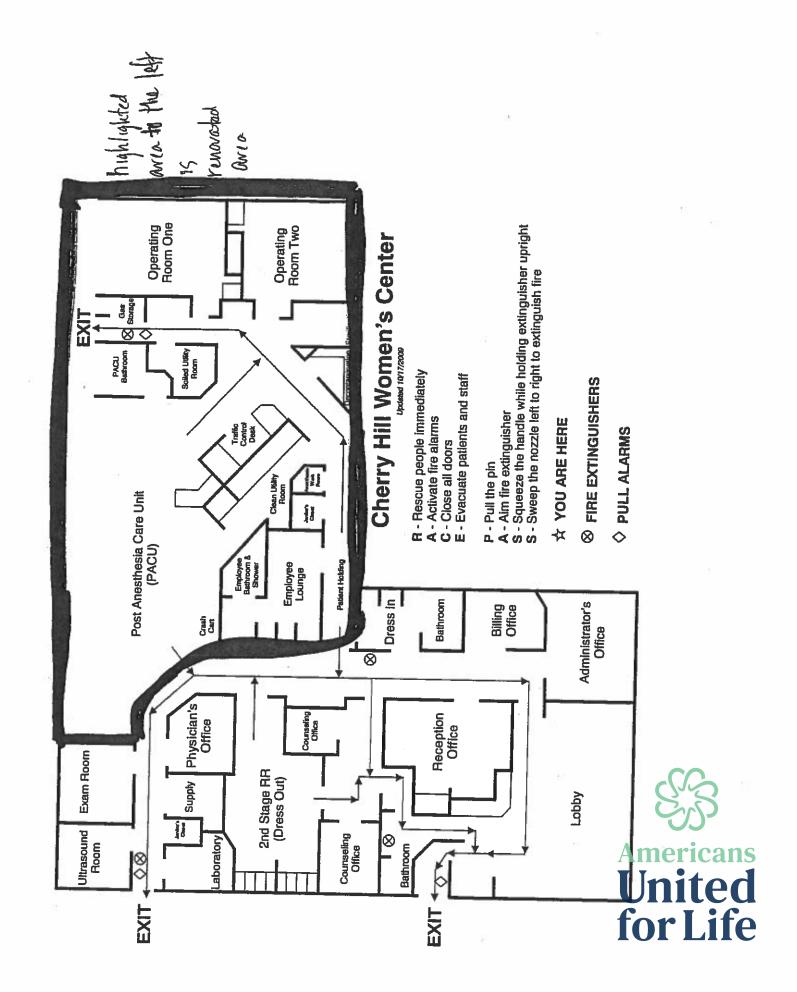
at (609) 633-0800 or at <u>pianreviewintake@dca.ni.qov</u>. If you do not have access to the specified folder or have questions related to this plan review, please contact us

For any technical issues please contact the System Administrator at planreviewintake@dca.nl.gov

this email. This is an automated email notification and this email account is not monitored. Please do not reply to







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CHERRY HILL WOMEN'S CENTER

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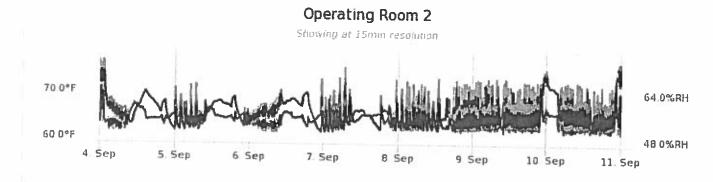


BI= Biological Test

CV= Control Vial

COMMENTS	
Tech Initials MOD	
Results +++	
Date CV Removed 9126 9126	
Time CV in Inc. 7. UDA 7. UDA 7. UDA	
Date CV in Inc. 1025 1026 1026 1026	
Control Vial Lot# 015505000 015505000 015505000000000000	
B B () () () () () () () () ()	
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Date BI Removed CCD CCD CCD CCD CCD CCD CCD CCD CCD CC	
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	ESS -
Load# BI	Americans United
	United for Life
HUN X 3 3 3 3 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	

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

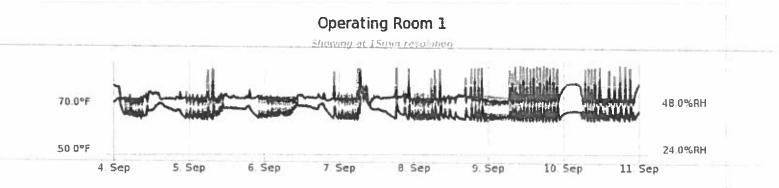
ChannelCommentThere were no annotations for this time period



DicksonOne

09/04/2018 - 09/10/2018 Temperature and Humidity Operating Room (1&2) log





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

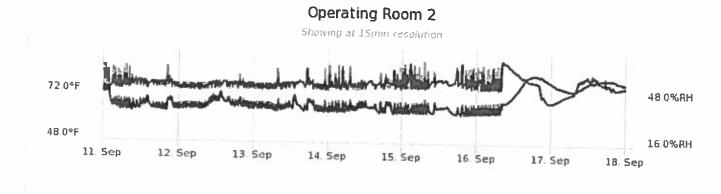
Annotation At	Channel	Comment
	There were no annotations for this time pe	



Phone: 1-800-757-3747 Fax: 1-800-676-0498 Email: support@dicksonone.com

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

ChannelCommentThere were no annotations for this time period

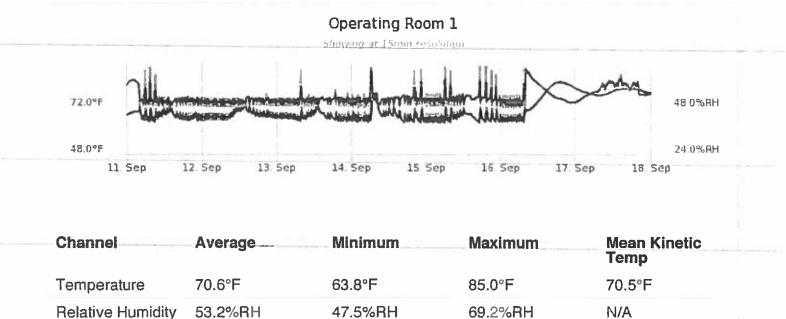


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DicksonOne

09/11/2018 - 09/17/2018 Temperature and Humidity Operating Room (1&2) log

Operating Room 1



Device Not Reporting	
Triggered	09/12/2018 10:28:06 PM EDT
Duration	1 hr, 37 mins
Comments	0

46.2°F

Annotation At

Dew Point

Channel

53.2%RH

52.7°F

Comment

69.2%RH

68.7°F

N/A

52.6°F

There were no annotations for this time period

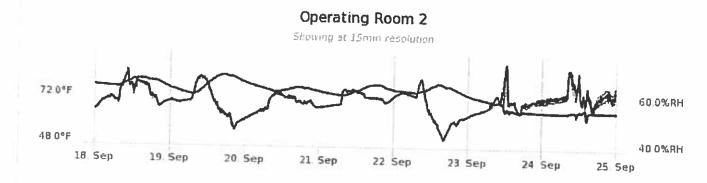
Americans United for Life

Phone: 1-800-757-3747 Fax: 1-800-676-0498 Email: support@dicksonone.com

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09/18/2018 - 09/24/2018 Temperature and Humidity Operating Room (1&2) log

Operating Room 2



Average	Minimum	Maximum	Mean Kinetic Temp
60.4°F	50.1°F	70.8°F	• 60.3°F
75.7°F	63.4°F	84.8°F	75.7°F
60.9%RH	43.8%RH	76.2%RH	N/A
	60.4°F 75.7°F	60.4°F 50.1°F 75.7°F 63.4°F	60.4°F 50.1°F 70.8°F 75.7°F 63.4°F 84.8°F

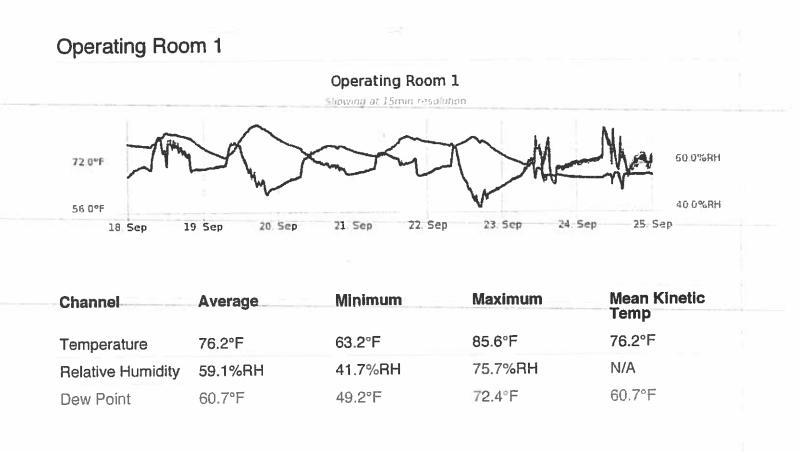
Annotation At

ChannelCommentThere were no annotations for this time period



DicksonOne

09/18/2018 - 09/24/2018 Temperature and Humidity Operating Room (1&2) log



Annotation At	Channel	Comment
	There were no annotati	ions for this time period



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:

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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. Itericans 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 ited 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 **Mericans** include birth control, smoking during pregnancy, malignant hyperthermia, drug use **Interted** risk factors during pregnancy and abortion care.

for Life

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.



Policy and Procedure Manual

Policy: Temperature, Air Flow and	Date Effective: 8/22/2011
Humidity Levels	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:

- 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 <u>kept in each area (separate books for Decontam ,Prep/Pkg/Sterilization, and Sterile Storage).</u>
- 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 i Herited Care Facilities ST-79" 2006.

REVIEWED: Every 3 years: 4/2009

Americans

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Developed 8/21/07

REVISED: 8/22/11

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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, LABELEI AS TO DEFECTM AND REPORTED FOR REPAIRS.

E. Anesthetic Machines

the anesthesia machines are standardized and equipped with required with require pressure gauges, as well as flow meter and inhalation/exhalation valves. In a distort the following: the anesthesia machines are standardized and equipped with required safety features such as ans 1.

for Life

- Pin Index System
- Oxygen Analyzers e.g. Pulse oxymeter
- Oxygen tanks with at least one being full
- **EKG** monitor
- Ct CO₂ 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: 5577 2018

DATE	TEMPERATURE	HUMIDITY %	INITIALS	NOTES
9-1-18	USF	60%		I NOTES
9.4-18	(05°F	60%	JAB -	
9.5-18	6 <u>6</u> f	.601-	MARS	
9/6/8	655	60-/-	mess	
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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

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

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

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 pontrolled environment. When stacking container systems, the user should take care to ensure that they are one upon another and that they can be removed easily. Written policies and procedures for m handling, rotation, and labeling of container systems should be developed and enforced. or Life

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State of Netr 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

United

forLife

Survey and Certification Americans

Encl.

PRINTED: 09/28/2018 FORM APPROVED

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Item IV - 'X' the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties).	Item IV - 'X' the appropriate block offered by the ASC. Under "Other subspecialities).	en a facility is such as a facility also	Related Provider Number - Complete this block when a facility is participating under more than one provider number, such as a facility also
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Regional Office will complete.	Medicare & Medicaid Services Regional Office will complete	an those considered	Detailed instructions are given for questions other than those considered self-explanatory.
NOTE: If an ASC is operated by a hospital, has a Distinct Part SNF, ICF and ICF/MR, the related provided humber field on the application for each provider (including the hospital) will have the hospital povder number. State/County and State Region Codes - Leave mark the Centers for	NOTE: If an ASC is operated fiv and ICF/MR, the related provider provider (including the hospital) v State/County and State Region	the original and first two our files. If a return he State agency may be	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.
her of the highest evel of care.	participating as a hospital. The number in the block for each rel provider will be the provider number of the highes. Level of care.	staining a decision as to ance in completing the	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.
	ERTIFICATION IN THE MEDI ng instructions before completing thi	AMBULATORY SURGICAL CENTER REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM (Please see statement on reverse and read the following instructions before completing this form)	AMBULATORY SURGIO



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

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. fristine this proti Bir, PR

S. Lynn Sked⁴B.S., R.N., CPM Supervising Health Care Evaluator Assessment and Survey





Encl.

Post-Certification Revisit Report

blic 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 alitating 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 cluding 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 eduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 31C0001113	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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 aported 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 Ily 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).

<u>'4) Item</u>		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y	 5) Date
ID Prefix	Q0080	Correction Completed 06/18/2010	ID Prefix	Q0081	Correction Completed 06/18/2010	ID Prefix		Correction Completed
Reg. # LSC	410.40		Reg. # LSC			Reg. # LSC	416.43(b), 416.4	06/18/2010 3(c)(2), 416
ID Prefix Reg. # LSC	416.43(d)	Correction Completed 06/18/2010	ID Prefix Reg. # LSC		Correction Completed 06/18/2010	ID Prefix Reg. # LSC	Q0101 416.44(a)(1)	Correction Completed 06/18/2010
ID Prefix Reg. # LSC		Correction Completed 06/18/2010	ID Prefix Reg. # LSC		Correction Completed 06/18/2010	ID Prefix Reg. # LSC	Q0221 416.50(a)(1)	Correction Completed 06/18/2010
ID Prefix Reg. # LSC	Q0240	Correction Completed 06/18/2010	ID Prefix Reg. # LSC	Q0241 416.51(a)	Correction Completed 06/18/2010	ID Prefix Reg. # LSC	Q0242 416.51(b)	Correction Completed 06/18/2010
	Q0244 416.51(b)(2)	Correction Completed 06/18/2010	ID Prefix Reg. # LSC	Q0245 416.51(b)(3)	Correction Completed 06/18/2010		Q0260 416.52	Correction Completed 06/16/2010
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Form reproved

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blic 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 initialining 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 duding 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 duction Project (0938-0390), Washington, D.C. 20503.

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Name of Facility		Street Address, City, State, Zip Code	
CHERRY HILL WOMENS CENTER	(ii	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 ported 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 illy 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).

'4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5) Date
		Correction			Correction		Correction
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ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE S COMPL	
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	Surveyor: 11609 Medical Records r	eviewed - 21				
	Employee Files rev	viewed - 14				
	Abbreviations					
Q 080	ASC - Ambulatory 416.43 QUALITY A PERFORMANCE	ASSESSMENT &	Q 080			
9	an on-going, data-	velop, implement and maintain driven quality assessment and ovement (QAPI) program.				
	Surveyor: 11609 Based on a review of evidence and sta that the ASC failed on-going, data-drive performance impro	is not met as evidenced by: of information provided, lack aff interview, it was determined to implement and maintain an en quality assessment and vement (QAPI) program.				
	Findings include:				-	
	program of quality in analyzes, and track	to develop an ongoing mprovement that measures , s quality indicators, adverse infection control outcomes. (S	3
1	Assurance Program	to formulate a Quality In that established indicators, ess and safety of services, is and implement			Ame	S icar

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 Jays 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.

TATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE :	
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Q 080	Continued From p	age 1	Q 080		····	
	improvements.(C	ross refer Q 82)				
	Assurance Program	d to formulate a Quality m that established distinct ects.(Cross refer Q 83)				
	that addresses the effectiveness, spec frequency, and det expectations for sa sufficient staff, time training to impleme refer Q 84)	d to implement a QAPI program ASC's priorities and evaluates cifies data collection methods, tails, clearly establishes its afety and adequately allocates e, information systems and ent the QAPI program. (Cross c)(1) PROGRAM SCOPE; (TTIES	Q 081			
	limited to, an ongoi measurable improv outcomes, and imp quality indicators of associated with imp the identification an	n must include, but not be ing program that demonstrates vement in patient health proves patient safety by using r performance measures proved health outcomes and by ad reduction of medical errors. st measure, analyze, and track				
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M CMS-2567	7(02-99) Previous Versions	Obsolete Event ID: 6K3J11	Facili	ty ID: NJ3100011113	continuation sheet	
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IMATEMENT OF DEFIDENCIES (XI) PROVEMSUPPLIERCIA IDENTIFICATION NUMBER (XI) PROVIDENCIA IDENTIFICATION NUMBER (XI) PROVIDENTIFICATION NUMBER (XI) PROVIDENCIA IDENTI	STATEMENT OF DEFICIENCIES (*1) PROVIDERSUPPLERCIAN (23) MULTIPLE CONSTRUCTION (31) DATE SUPPLY MARE OF PROVIDER OR SUPPLIER 3100001113 8. WNG 0210012 0210012 CHERRY HILL WOMENS CENTER SIMULATORY OF DEFICIENCIES 92/08/2010 0210012 0210012 CHERRY HILL WOMENS CENTER SIMULATORY OF DEFICIENCIES PROVIDER SPAN OF CORRECTION 0210012 0210012 CAD BE DEFICIENCY WILS THE PROCEED BY FILL PROVIDER SPAN OF CORRECTION PROVIDER SPAN OF CORRECTION 020012 PREFIX SIMULATORY OR LSC DENTIFYING INFORMATION PROVIDER SPAN OF CORRECTION 00014 Q 081 Continued From page 2 Q 081 PROVIDER SPAN OF CORRECTION 000014 Q 081 Continued From page 2 Q 081 PROVIDER SPAN OF CORRECTION 000014 Q 081 Continued From page 2 Q 081 PROVIDER SPAN OF CORRECTION 000014 Q 081 Continued From page 2 Q 081 PROVIDER SPAN OF CORRECTION 000014 Q 081 Continued From page 2 Q 081 0010111 00014 000014 Q 082 Continued From page 2 Q 081 0010111 00014 00014 000014		DEPARTMENT OF HEALTH AND HUMAN SERVICES DENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 02/16/20 FORM APPROVE		
NUMBE OF PROVIDER 0 STREET ADDRESS, CITY, STATE, 2/P CODE B32 KINGS HIGHWAY NORTH STREET ADDRESS, CITY, STATE, 2/P CODE B32 KINGS HIGHWAY NORTH CHERRY HILL, WOMENS CENTER AWJD USUMMARY STATEMENT OF DEFICIENCIES B32 KINGS HIGHWAY NORTH CHERRY HILL, NO 0634 Different Colspan="2">COUNTIES PREVE TAG AMJD ESUMMARY STATEMENT OF DEFICIENCIES B32 KINGS HIGHWAY NORTH CHERRY HILL, NO 0634 Different Colspan="2">CHERRY HILL, NO 0634 AMJD ESUMMARY STATEMENT OF DEFICIENCIES B32 KINGS HIGHWAY NORTH CHERRY HILL, NO 0634 AMJD ESUMMARY STATEMENT OF DEFICIENCIES B32 KINGS HIGHWAY OR LSC DESTIFYING INFORMATION TAG DIFFERENCED TO THE APPROPRIATE CHERRY HILL, NO 0634 Q 081 Continued From page 2 Q 081 DIFFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DIFFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Q 081 This STANDARD is not met as evidenced by: Surveyor: 11509 Q 081 Improvement that measures, analyzes, and tracks qualify indicators, adverse patient events, and infection control outcomes. Improvement that measures, analyzes, and tracks qualify indicators. Improvement that measures, analyzes, and tracks qualify indicators. 2. The facility failed to provide evidence of reviewing problems, tracking and trending and establishing indicators. Q 082 Q 082 0. Differiement was confirmed b	31C0001113 02/08/2010 DAME OF PROVIDER OF SUPPLIER CHERRY HILL WOMENS CENTER DAME OF PROVIDER OF SUPPLIER CHERRY HILL WOMENS CENTER DEVENDENCES DEVENDENCES SUPPLIER DEVENDENCES DEVENDENCES TAG SUPPLIER DEVENDENCES TAG SUPPLIER DEVENDENCES TAG SUPPLIER DEVENDENCES SUPPLIER DEVENDENCES SUPPLIER DEVENDENCES SUPPLIER SUPPLIER DEVENDENCE OF OPERICES SUPPLIER DEVENDENCE OF OPERICES SUPPLIER DEVENDENCE OF OPERICES SUPPLIER DEVENDENCE OF OPERICES SUPPLIER O 081 O 1081 O 1081 SUPPLIER DEVENDENCE	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY	
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CHERRY HILL WOMENS CENTER Solutional Solution CMUID SUMMARY STATEMENT OF DEFICIENCIES Solution CHERRY HILL, NO 08034 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCE TO THE SHOULD BE THENDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Provide Status CROSS-REFERENCE TO THE SHOULD BE DEFICIENCY Continued From page 2 Q 081 Q 081 Continued From page 2 Q 081 This STANDARD is not met as evidenced by: Surveyor: 11609 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 messures, analyzes, and tracks quality indicators, diverse patient events, and Infection control outcomes. Findings include: 1. Even though th facility has developed an quality assurance plan for th facility alled to provide evidence of measuring any quality indicators. Q 082 3. The facility failed to provide evidence of measuring any quality indicators. Q 082 4. On interview employee #1 stated that she could not provide evidence of any of the above. Q 082 (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services funished in the ASC. Q 082 (b)(2) The ASC must use the data collected to - (1) Monitor the effectiveness and safety of its Facility 1013000113	CHERRY HILL WOMENS CENTER 502 KINGS HIGHWAY NORTH (20) SUMMARY STATEMENT OF DEFICIENCIES PROVE CHERRY HILL, NJ 80304 (20) SUMMARY STATEMENT OF DEFICIENCIES PROVE CHERRY HILL, NJ 80304 (20) SUMMARY STATEMENT OF DEFICIENCIES PROVE CHERRY HILL, NJ 80304 (20) SUMMARY STATEMENT OF DEFICIENCIES PROVE CHERRY HILL, NJ 80304 (20) Continued From page 2 (20) (20) Continued From page 2 (20) (20) This STANDARD is not met as evidenced by: Surveyor: 11609 Surveyor: 11609 (20) 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 identify thresholds and indicators to be analyzed. C 2. The facility failed to provide evidence of measuring any quality indicators. Q 082 3. The facolity failed to provide evidence of measuring any quality indicators. Q 082 4. On interview employee #1 stated that she could not provide evidence of any of the above. Q 082 (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. Q 082 (b)(2) The ASC must use the data collected to - () Monitor the effe	NAME OF	PROVIDER OR SUPPLIER		-'	STR		02/	08/2010	
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4. On interview employee #1 stated that she could not provide evidence of any of the above. 5. This was confirmed by employee #2. 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 M CMS-2567(02-99) Previous Versions Obsolete Event ID: 6K3J11	4. On interview employee #1 stated that she could not provide evidence of any of the above. 5. This was confirmed by employee #2. 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 MCMS-2567(02-99) Previous Versions Obsolete Event ID: 8K3J11		measuring any qual 3. The facolity failed reviewing problems.	ity indicators. I to provide evidence of tracking and trending and						
Q 082 416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM Q 082 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. Q 082 (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its American M CMS-2567(02-99) Previous Versions Obsolete Event ID: 6K3J11 Facility ID: NJ310001113	Q 082 416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM Q 082 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. Q 082 (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its Americal M CMS-2567(02-99) Previous Versions Obsolete Event ID: 6K3J11 Facility ID: NJ310001113		4. On interview emp	loyee #1 stated that she could						
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 M CMS-2567(02-99) Previous Versions Obsolete Event ID: 6K3J11 Facility ID: NJ310001113 If continuation sheet Page Sof	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 M CMS-2567(02-99) Previous Versions Obsolete Event ID:6K3J11 Facility ID: NJ310001113 If continuation sheet Page Sof	Q 082	416.43(b), 416.43(c))(2), 416.43(c)(3) PROGRAM	Q 08	2				
(i) Monitor the effectiveness and safety of its American M CMS-2567(02-99) Previous Versions Obsolete Event ID: 6K3J11 Facility ID: NJ310001113 If continuation sheet Page 3 of	(i) Monitor the effectiveness and safety of its American M CMS-2567(02-99) Previous Versions Obsolete Event ID: 6K3J11 Facility ID: NJ310001113 If continuation sheet Page 3 of		indicator data, incluc relevant data regard	ling patient care and other				S	S	
it continuation sheet Page 3 Di	if continuation sheet Page 5 Di		(b)(2) The ASC mus (i) Monitor the eff	t use the data collected to - ectiveness and safety of its			1	Amer	ican	
		M CMS-256	7(02-99) Previous Versions C	Dbsolete Event ID: 6K3J11	F	acility	ID: NJ310001113 If contin	lation sheet	Page Shear	
	tor Lif									

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE S COMPL	
		31C0001113	B. WING			
AME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP (08/2010
CHERRY	HILL WOMENS CE			502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034	JODE	
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
Q 082	services, and qual (ii) Identify oppo		Q 082	2		2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	track adverse patie causes, implement	e improvement activities must ent events, examine their t improvements, and ensure are sustained over time.				
	strategies through	ist implement preventive but the facility targeting adverse ensure that all staff are strategies.				
	Surveyor: 11609 Based on a review staff interview on 1, the facility failed to Program that estab effectiveness and s	is not met as evidenced by: of information provided and /21/10, it was determined that formulate a Quality Assurance lished indicators, monitors afety of services, track i implement improvements.				
	Findings include:					
1	1/20/10 at approxim 1/21/10 at approxim failed to provide evi Program that estable effectiveness and s	at the entrance conference on nately 10AM and again on nately 1PM, the facility staff dence of a Quality Assurance lished indicators, monitors afety of services, track implement improvements.				
ຊ 083 4		ed by employees 1 & 2. MANCE IMPROVEMENT	Q 083		Ś	5
(1) The number and	scope of distinct			Ame	ica ı
CMS-2567	(02-99) Previous Versions	Obsolete Event ID: 6K3J11	Eac	ality ID: NJ310001113	continuation sheet	+

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES			FORM	D: 02/16/201 APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE : COMPL	
	31C0001113	B. WING		02/	08/2010
NAME OF PROVIDER OR SUPPLIER CHERRY HILL WOMENS CEN	TER	5	REET ADDRESS, CITY, STATE, ZIP CO 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		00/2010
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLÉTIO DATE
(2) The ASC must d being conducted. T minimum, must inclu	ts conducted annually must d complexity of the ASC's	Q 083			
Surveyor: 11609 Based on a review o staff interview on 1/2 the facility failed to fo	not met as evidenced by: f information provided and 1/10, it was determined that ormulate a Quality Assurance shed distinct improvement				
1/20/10 at approxima 1/21/10 at approxima failed to provide evide	at the entrance conference on ately 10AM and again on ately 1PM, the facility staff ence of a Quality Assurance shed distinct improvement				
Q 084 2. This was confirmed 416.43(e) GOVERNII RESPONSIBILITIES	d by employees 1 & 2. NG BODY	Q 084			
program- (1) Is defined, imp by the ASC. (2) Addresses the	nust ensure that the QAPI lemented, and maintained ASC's priorities and that all aluated for effectiveness.			Ame	n S rican
M CMS-2567(02-99) Previous Versions Ob	aluated for effectiveness.	Facilit	y ID: NJ310001113 If co.	Ame ntinetics free for	

CENTE	RS FOR MEDICAR	H AND HUMAN SERVICES			PRINTED: 02/16/20 FORM APPROVE OMB NO: 0938-03		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILC		(X3) DATE S COMPL	URVEY	
		31C0001113	B. WING		02//)8/2010	
NAME OF P	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO		012010	
	HILL WOMENS CE			502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
Q 084		- 1	Q 08	4			
	 (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. 						
	Surveyor: 11609 Based on staff inte on 1/20 and 1/21/1 facility failed to imp addresses the AS0 effectiveness, spe- frequency, and det expectations for sa sufficient staff, time	his STANDARD is not met as evidenced by: urveyor: 11609 ased on staff interview and a lack of evidence in 1/20 and 1/21/10, it was determined that the icility failed to implement a QAPI program that ddresses the ASC's priorities and evaluates fectiveness, specifies data collection methods, equency, and details, clearly establishes its cpectations for safety and adequately allocates ufficient staff, time, information systems and aining to implement the QAPI program.			1.		
	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.				S		
		ed by employees 1 & 2. ICIAL ENVIRONMENT	Q 101		Q	N)	
_	The ASC must prov	vide a functional and sanitary			Ame	ica	
M CMS-2567	7(02-99) Previous Versions	Obsolete Event ID: 6K3J11	Fa	cility ID: NJ310001113 If c	ontinuation sheet	Page 0 of	
					for		

TATEMEN	TOF DEFICIENCIES	E & MEDICAID SERVICES				M APPROV D. 0938-0
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31C0001113	B. WING			00/00/0
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO		08/2010
	HILL WOMENS CEN		50	2 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
Q 101	Continued From pa	ige 6	Q 101			
	Each operating roo equipped so that th can be performed in	e provision of surgical services. m must be designed and e types of surgery conducted n a manner that protects the ne physical safety of all ea.				
	Surveyor: 11609 Based on a tour and 2/2/10 and staff inte	s not met as evidenced by: d observation of the facility on rview, it was determined that functional environment for			e	
	Findings include:					
	1. in OR #1:					
	a. There was cracki mattress of the OR t	ing observed under the table.				
	b. Rusting was obse table.	rved at the base of the OR				
t	2. In OR #2 chipping the door jam.	of paint was observed on				
3	3. This was confirme	d by employee #2.				
	Surveyor: 15481					
f	acility failed to ensu	n, it was determined the re the room was equipped so performed in a manner that ety.			Ş	S
F	indings include:				Ame	ricar
	(00.00) D				- T T - 4	
UM3-2567	(02-99) Previous Versions O	bsolete Event ID: 6K3J11	Facility	ID: NJ310001113 If co	ontinuation sheet	
					for	

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 02/16/20 FORM APPROVE OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M A. BUI			(X3) DATE S COMPLE	URVEY	
		31C0001113	B. WI	1G_		02/0	8/2010	
	PROVIDER OR SUPPLIER			STF 5	REET ADDRESS, CITY, STATE, ZIP CODE 02 KINGS HIGHWAY NORTH	02/0	0/2010	
					HERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETI DATE	
Q 101	1 · · · · · · · · · · · · · · · · ·	5	Q 1	01				
	Staff #1, in Operation							
	416.50(a)(1) NOT	ICE OF RIGHTS	Q 2	21				
	representative with the patient's rights procedure, in a lar	ovide the patient or the patient's in verbal and written notice of in advance of the date of the nguage and manner that the ent's representative						
	Surveyor: 11609 Based on a review and staff interview, failed to notify patie	is not met as evidenced by: of 19 of 19 medical records , it was determined tha ASC ents, in advance to the date of otification of Patient Rights.						
ŀ	Findings include:					2		
	of a copy of Patient Rights i	es performed, was dated the ure. These were records1						
	the notification of ri		Q 24	10				
I		ntain an infection control to minimize infections and ases.				S	Ŝ	
	This CONDITION i	s not met as evidenced by:				Ame	ica	
/ CMS-256	7(02-99) Previous Versions	Obsolete Event ID: 6K3J11		Facili	ty ID: NJ310001113 If contin	uation sheet f	age o of	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM): 02/16/20 1 APPROV
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE S COMPL	
	31C0001113	B. WING		02/0	8/2010
AME OF PROVIDER OR SUPPL		50	EET ADDRESS, CITY, STATE, ZIP CC 02 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034		10/2010
PREFIX (EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CON (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
of evidence and 1/21/10, it was of establish an infe- to minimize infe- diseases. Findings includes 1. The facility fai program design- investigate infeo- diseases. (Cross 2. The facility fai integral part of th Cross refer Q 24 3. The facility fai plan of action for managing infecti 416.51(a) SANIT The ASC must p environment for by adhering to pr standards of prac This STANDARE Surveyor: 15481 Based on observ facility failed to p environment. Findings include:	 ew of information provided, lack staff interview on 1/20 and determined that the facility failed to ection control program that seeks ctions and communicable e: iled to maintain an ongoing ed to prevent, control, and tions and communicable as refer Q 242) led to make infection control an ne quality assurance program. (14) led to provide and implement a preventing, identifying and ons. (Cross refer Q 245) ARY ENVIRONMENT rovide a functional and sanitary the provision of surgical services ofessionally acceptable ctice. is not met as evidenced by: ation, it was determined the rovide a functional and sanitary 	Q 240 Q 241		S	S
1. On 2/8/10, at 1 Staff #1, in Opera	0:05 AM, in the presence of ating Room #1, a ceiling tile was			Amer	ica r
CMS-2567(02-99) Previous Versio	ons Obsolete Event ID: 6K3J11	Facility	y ID: NJ310001113 If c	ontinuation sheet	

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					PRINTED: 02/16/201 FORM APPROVE		
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(90) 14				<u>). 0938-0391</u>	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI			(X3) DATE : COMPL		
		31C0001113	B. WIN	IG _		02/0	08/2010	
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
CHERRY	Y HILL WOMENS CEN	TER		5	02 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034		i	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
Q 241		-	Q 2	41				
	2. On 2/8/10, at 10:	corner of the room. 20 AM, in the recovery room, ained, in the center of the						
Q 242		ON CONTROL PROGRAM	Q 2	42				
	designed to prevent infections and comr addition, the infection program must include ASC has considered	ntain an ongoing program t, control, and investigate municable diseases. In on control and prevent de documentation that the d, selected, and implemented d infection control guidelines.						
	This STANDARD is Surveyor: 11609	not met as evidenced by:						
	of evidence and staf that the facility failed program designed to	of information provided, lack if interview, it was determined to maintain an ongoing o prevent, control, and s and communicable						
	Findings include:							
	patient with fever, se vaginal bleeding w operating physician o evidence of followup staff on the days of t	, in the second s				S	NS I	
	infections, contacting	tient phone call regarding physicians or patients in any rate or evidence of a formal				Ame	ricans	
FORM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: 6K3J11	F	l Facilit	y ID: NJ310001113 If continu	tion sheet P	age 10 01 15	
					1	for	Life	

ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE S COMPL	
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NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATI			<u>08/2010</u>
CHERRY	HILL WOMENS CE	NTER	5	CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)		(X5) COMPLET DATE
Q 242			Q 242			-
	infection control pr	ogram could be provided.				
	3. There was no do to indicate which n that have been add	ocumented evidence provided ationally recognized standards opted by the ASC.				
	1/20/10 at approxir 1/21/10 at approxir	at the entrance conference on nately 10AM and again on nately 1PM, the facility staff idence of a formalized ogram.				
Q 244	4. This was confirm 416.51(b)(2) INFEC - QAPI	ned by employees #1 and 2. CTION CONTROL PROGRAM	Q 244			
	[The program is -] An integral part of assessment and pe program	of the ASC's quality erformance improvement				
	Surveyor: 11609 Based on a review of of evidence and sta that the facility failed	s not met as evidenced by: of information provided, lack ff interview, it was determined d to make infection control an quality assurance program.				
	Findings include:					
	patient with fever, so vaginal bleeding w operating physician	QA Plan provided states: "Any evere pain or very heavy vill always be referred to the or back up physician."No o could be provided to survey the survey.			S	
2	2. No evidence of pa	atient phone call regarding			Ame	ricar
I CMS-2567	7(02-99) Previous Versions (Obsolete Event ID: 6K3J11	Facilit	y ID: NJ310001113 If cont	linuation sheat P	

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPL). 0938-039 SURVEY ETED
		31C0001113	8. WING			
NAME OF F	ROVIDER OR SUPPLIER		s	REET ADDRESS, CITY, STATE, ZIP		08/2010
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Q 244		•	Q 244	1		<u> </u>
	way to trend infection	ng physicians or patients in any on rate or evidence of a formal ogram could be provided.				
	1/20/10 at approxir 1/21/10 at approxir	I at the entrance conference on nately 10AM and again on nately 1PM, the facility staff idence of a formalized ogram.				
Q 245		ned by employees #1 and 2. CTION CONTROL PROGRAM S	Q 245			
	preventing, identify and communicable	providing a plan of action for ing, and managing infections diseases and for immediately octive and preventive measures vement.				
	This STANDARD i Surveyor: 11609	s not met as evidenced by:				
	of evidence and sta that the facility faile	of information provided, lack ff interview, it was determined d to provide and implement a eventing, identifying and s.				
	Findings include:					
	patient with fever, s vaginal bleeding v operating physician	QA Plan provided states: "Any evere pain or very heavy vill always be referred to the or back up physician."No o could be provided to survey the survey			Ame	ican
	7(02-99) Previous Versions					
	. (Event ID 0K3J11	ra0	ility ID: NJ310001113 If	continuation sheet i	Lif

AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER CHERRY HILL WOMENS CENTER (X4) ID PREFIX TAG Q 245 Q 245 Continued From page 1 2. No evidence of patier infections, contacting pf way to trend infection ra infection control program 3. When requested at th 1/20/10 at approximately 1/21/10 at approximately failed to provide evidence infection control program	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) 12 12 12 12 12 12 12 12 12 12 12 12 12	A. BUILDIN B. WING _ STI	REET ADDRESS, CITY, STATE, ZIF 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	(X3) DATE S COMPL	
CHERRY HILL WOMENS CENTER (X4) ID PREFIX TAG SUMMARY STATEME (EACH DEFICIENCY MUS REGULATORY OR LSC ID Q 245 Continued From page 1 2. No evidence of patier infections, contacting pł way to trend infection ra infection control program 3. When requested at th 1/20/10 at approximately failed to provide evidence infection control program	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) 12 12 12 12 12 12 12 12 12 12 12 12 12	ID PREFIX TAG	REET ADDRESS, CITY, STATE, ZIF 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	P CODE CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLET
CHERRY HILL WOMENS CENTER (X4) ID PREFIX TAG SUMMARY STATEME (EACH DEFICIENCY MUS REGULATORY OR LSC ID Q 245 Continued From page 1 2. No evidence of patier infections, contacting pł way to trend infection ra infection control program 3. When requested at th 1/20/10 at approximately failed to provide evidence infection control program	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) 12 12 12 12 12 12 12 12 12 12 12 12 12	ID PREFIX TAG	CHERRY HILL, NJ 08034 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	P CODE CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI
PREFIX TAG (EACH DEFICIENCY MUS REGULATORY OR LSC ID Q 245 Continued From page 1 2. No evidence of patier infections, contacting pl way to trend infection ra infection control program 3. When requested at th 1/20/10 at approximately failed to provide evidence infection control program	ST BE PRECEDED BY FULL DENTIFYING INFORMATION) 12 12 12 12 12 12 12 12 12 12 12 12 12	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET
 No evidence of patient infections, contacting privile way to trend infection ra- infection control program When requested at the 1/20/10 at approximately 1/21/10 at approximately failed to provide evidence infection control program 	nt phone call regarding hysicians or patients in any ate or evidence of a formal m could be provided. he entrance conference on ly 10AM and again on ly 1PM, the facility staff ce of a formalized	Q 245			
infections, contacting pr way to trend infection ra infection control program 3. When requested at th 1/20/10 at approximately 1/21/10 at approximately failed to provide evidence infection control program	hysicians or patients in any ate or evidence of a formal m could be provided. he entrance conference on ly 10AM and again on ly 1PM, the facility staff ce of a formalized				
Q 261 416.52(a)(1) ADMISSIO	y employees #1 and 2. N ASSESSMENT	Q 261			
in section 1861(r) of the practitioner in accordance	h patient must have a history and physical by a physician (as defined Act) or other qualified				
This STANDARD is not Surveyor: 11609 Based on a review of 19 where patients had proce staff interview, it was det not perform or obtain a c physical assessment of s performed by a physician	of 19 medical records edures performed and termined that the ASC did comprehensive history & surgical patients				
Findings include:				S	S
Reference Policy entitled Physical" states:	I: "Medical History &			1	1)
				Ame	ICal
M CMS-2567(02-99) Previous Versions Obsolet	te Event JD: 6K3J11	Facili	ity ID: NJ310001113	f continuation shell f	age (9 of

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE S COMPL	
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NAME OF I)8/2010
	HILL WOMENS CE	NTER	5	REET ADDRESS, CITY, STATE, ZIP COD 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034	E	
(X4) ID PREFIX TAG	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
Q 261	"1. ALL patients a	re required to complete a	Q 261			
		m prior to each procedure. ew the history during the interview				38
	 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. 	cultate the lungs, check heart nd document.				
Q 266	2. This was confirm 416.52(c)(2) DISCI	ned by employees # 1 and 2. HARGE - ORDER	Q 266		:	
	[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 i Surveyor: 11609	s not met as evidenced by:			_	2
	where patients had staff interview, it wa	of 19 of 19 medical records procedures performed and is determined that physicians narge order by a physician.			Ame	rica
/I CMS-256	7(02-99) Previous Versions	Obsolete Event ID: 6K3J11	Facili	ty ID: NJ310001113 If cont	inuation sheet P	age 14 of

CENTE	RS FOR MEDICAR	TH AND HUMAN SERVICES	_		FORM	D: 02/16/20 A APPROV D. 0938-03
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		31C0001113	B. WING			00/2040
IAME OF P	ROVIDER OR SUPPLIE	R	STR	EET ADDRESS, CITY, STATE, ZIP (08/2010
CHERRY	HILL WOMENS CE			2 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034		
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Q 266	Continued From p	bage 14	Q 266			
	Findings include:					
i i i i i i i i i i i i i i i i i i i	procedures perfor Record" entitled "	dical records where patients had rmed, the section on the "PACU Discharge Order" was blank rds 1 through 4, 6 through 11, 1.				
	2. This was confin	med by employees 1 and 2.				
					:	
						1
					~	
					S	NS NS
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CMS-2567	(02-99) Previous Versions	s Obsolete Event ID:6K3J11	Facility	/ ID: NJ310001113 If c	continuation sheet P	age 15 of
					for	



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

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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, pristine this proto BSN, DR

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

	AINT AND SURVEILLA	ANCE REPORT	
Facility		Date I	Cose Number
Cherry Hill Womens(Case Number
	<u>ienter</u>	10/20/14	NJ 6007-5219
Administrator/CEO		TypelFacility	Time Required to Correct
JenterGroves		ASC	
Type of Survey		Matter Under Consider	ation
Revisit Investigation	For Immediate	19	18
Complaint Surveillance	Attention		
Census/Bed Capacity Units Toured	Charts R	eviewed	Number of Patients Affected
Facility Representatives/Titles	, Remarks		
Jenifer Groves / Adm	instrator No	+ Valid	49 -
Derigti Croves / no .			
,			
When this form is utilized for a survey, the follow	ng needs to be addressed:		
I inis survey was reviewed with the Administrat	or or his/her authorized repre	sentative at the conclus	ion of the survey. He/she was
advised of the areas where standards were no N.J.S.A. 26:2H-5(b). He/she was further advise failure to correct these definitional to the	a inal II was necessary to cor	rect conditions which do.	not most the standards and their
	a fine of up to \$5,000,00 ner	violation per day in accor	dance with N.J.S.A. 26:2H-14 as
amended. Refusal to sign does not negate the fill Signature of Responsible Official	acility's responsibility to correc	t deficiencies.	a,
Signature of Responsible Official	Signatur	6) Investigator	
and pur	\sim (X	ouse N	eska
	NARRATIVE		
An unannounced visit y	vas made to this facility	to investigate a con	nplaint. The complaint was
and staff interviews. Pr	epresentative (s). The in	vestigation include	review of documentation
the facility representativ	e (s). After supervisory	raing the investigat	Ion were discussed with
		renew, denoiencies	may lonow.
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			ANG Phre
		ENTERED ON A	
		BY.	Americans
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State of New Jersey DEPARTMENT OF HEALTH PO BOX 367 TRENTON, N.J. 08625-0360

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CHRIS CHRISTIE Governor

KIM GUADAGNO Lt. Governor COPY

MARY E. O'DOWD, M.P.H. Commissioner

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,

Atte

Louise A. Steska, MSN, RN Health Care Services Evaluator/Jurse Assessment and Survey



Encl./LS

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:		(X3) DATE COM	SURVEY
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NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
CHERRY	HILL WOMENS CEN		S HIGHWAY I HILL, NJ 080			
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	compliance with the	's Center is in substantial e requirements of N.J.A.C. andards for Ambulatory Care mplaint visit only.				
	Complaint #: NJ00	075219		DEG 122 ACUTE CASE O ACUTE CASE O DEG E	VED 114	
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PRINTED: 10/29/2014



State of New Jersey DEPARTMENT OF HEALTH PO BOX 367 TRENTON, N.J. 08625-0367

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CHRIS CHRISTIE Governor

KIM GUADAGNO

MARY E. O'DOWD, M.P.H. Commissioner

November 21, 2014

Re: Cherry Hill Womens Center Complaint # NJ00075219

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 ricans United for Life



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



Re: Cherry Hill Womens Center Complaint # NJ00075219

Dea

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.

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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.



for Life

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

Dear

Your email to Commissioner Mary E. O'Dowd has been referred to me for response.

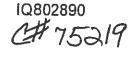
An investigation will be conducted by Department staff. At its conclusion, you will be notified in writing of the results of the investigation.

In the interim, if you have any additional concerns, please contact the Complaint Program at 609-292-9900.

Sincerely

Atison Gibson, RN, MA, MPA Assistant Commissioner Health Facility Survey & Field Operations





New Jersey State Department of Health Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility Date Case Number 5 NJ00077! Administrato Type Facility Time Required to Correct 7 ype of Surve Matter Under Consideration Revisit **Chrvestigation** For Immediate **Complaint** Surveillance Attention Census/Bed Capadity Units Toured **Charts Reviewed** Number of Patients Affected Facility Representatives/Titles Remarks/Issues 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 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: 8,24 14 BY: nited orLife AAS-29



State of New Jersey DEPARTMENT OF HEALTH **PO BOX 367**

COPY

TRENTON, N.J. 08625-0360

www.nj.gov/health

CHRIS CHRISTIE Governor

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KIM GUADAGNO Lt. Governor

MARY E. O'DOWD, M.P.H. Commissioner

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, MSN, RN Health Care Services Evaluator Nuse iCans Assessment and Survey Jnited

forLife

Encl.

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PRINTED: 05/23/2014 FORM APPROVED

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 22445		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 05/08/2014		
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	ATE, ZIP CODE		23
HERRY	HILL WOMENS CEN		SS HIGHWAY N			
		CHERRY	HILL, NJ 080			
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A 000	8:43A INITIAL COM	MENTS	A 000			
	compliance with the	's Center is in substantiai e requirements of N.J.A.C. andards for Ambulatory Care implaint visit only.				÷ Ž
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<u>New Jer</u>	sey Department of F				
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New Jersey State Department of Health Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility Date Case Number Cherry Hill Women Administrator/CEO 2 20 N. TOO0701 Time Required to Correct Jene SC Idminis Type of Sulvey Matter Under Consideration]Revisit Investigation For Immediate Complaint Surveillance Attention Census/Bed Capacity Units Toured **Charts Reviewed** Number of Patients Affected Facility Representatives/Titles Remarks/Issues Luz Caraballo Unsubstantio 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 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: Americans Inited or Life

SUP



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 Muse icans Assessment and Survey

for Life

Encl.

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

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA1	<u>. 0938-039</u> E SURVEY IPLETED
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Q 000	000 INITIAL COMMENTS						
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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 of 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 corring the program participation.

Event ID: 60VQ11



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

> United for Life

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

Americans

United

for Life

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.ni.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

United

for Life

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 LL Governor

CHRISTOPHER R. RINN Acting Commissioner

or Life

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 <u>N.J.A.C.</u> 8:43E-2.4, <u>N.J.A.C.</u> 8:43E-3.6, <u>N.J.S.A.</u> 26:2H-13 and <u>N.J.S.A.</u> 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, <u>N.J.A.C.</u> 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 112 Rfs

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



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5. EFFECTIVE DATE CHANG (L9)	E OF OWNERSHIP	7. PROVIDER/SU	JPPLIER CATE		(L6) 07631 <u>15</u> (L7)	5. Validation 6. Complaint 7. On-Site Visit 9. Other
	01/25/2011 (L34)	02 SNF/NF/Duni	05 HHA 06 PRTF	09 ESI 10 NF		8. Full Survey After Complaint
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To (b):		Program Re	quirements		And/Or Approved Waivers Of 2. Technical Personnel	
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DICENTENSION DATE:	27. ALTERNATIVE				03-Risk of Involuntary Termination	OTHER
/7 mm	A. Suspension of A		(1 4 A)		04-Other Reason for Withdrawal	07-Provider Status Change
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			(L3	3) [DETERMINATION APPROVA	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

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.



JRM CMS-1539 (7-84) (Destroy Prior Editions)

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FORM AFPHCIVED INTELCATION IN THE MEDICARE PROGRAM Instructions before completing this form) Participating as a hospital. The number in this block to	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 ICFAMR, 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 Officiation in the Centers for	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. Itele Nork, the appropriate block contract or referral, place a '2' in the appropriate block.	de Fiscal Year Ending Date Asa	a - Government 4. Dharacy 11. I Thoracic 12. I Urology 13. I Other (Specify)	egan Providing Services A Go REPRESENTATION ON THIS STATEMENT, MAY BE ILLFULLY FAILING TO FULLY AND ACCURATELY TC OR, WHERE THE ENTITY ALREADY PARTICIPATES, N', AS APPROPRIATE. Date OI - QO - QO I
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES AACOULATORY SURGICAL CENTER REQ (Please see statement on reverse and whether the Conditions of Coverage are met. Assistance in completing the form is available from the State account	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	305445 SOS445 I IDENTIFYING INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION City, County, and State ENGL & WOOD INFORMATION INFORMATION City, County, and State ENGL & WOOD INFORMATION INFORMATION City, County, and State ENGL & WOOD INFORMATION City, COUNTY, COUNTY, COR AND CITARY AND CITARY COR CITY, COUNTY, COUNTY, CON CITY, COUNTY, COUNTY, CON CITY, COUNTY, COUNTY, CON CITY, COUNTY, COUNTY, CON CITY, COUNTY, COUNTY, COUNTY, CON CITY, COUNTY, COUNTY, CON CITY, COUNTY, COUNTY, CON CITY, COUNTY, COUNTY, COUNTY, CON CITY, CITY, CON CITY, CITY, CITY	III SERVICES 1. Laboratory in blocks) Ase SURGICAL 1. Cardiovascular SURGICAL 2. Foot (X appropriate 3. General blocks) Ase Obstatric Control	V CHARACTERISTICS 1. Number of Operating Rooms WHOEVER KNOWINGLY AND WILLFULLY MA PROSECUTED NDER APPLICABLE FEDERA DISCLORE HE INFORMATION REQUESTED A TEHOUATION OF ITS ACREEMENT OR CO Signature of Arthonomotional (Somin Inter- com CMS-377 Bash Doroom

Metropolitan Medical Associates



OCT 5 - 2016

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Secretary/Treasurer Sewrence S. Reed, MD ~ annul Led Foad Nahal, MD AAAASF President 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. merican Association for Acception Metropolitan Surgical Associates, Inc. Ambulatory Surgery Fartlittes, Inc. food Mahai presents this certificate to 30105.57 Certified from 4/13/2016 to 4/13/2017 **Certification Number 4303** Life LATIN



State of Netr Jersey DEPARTMENT OF HEALTH AND SENIOR SERVICES PO BOX 367 TRENTON, N.J. 08625-0367

www.nj.gov/health

Governor KIM GUADAGNO Lt. Governor

CHRIS CHRISTIE

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, MSN, RN Health Care Services Evaluator/Nulse Assessment and Survey



Encl.

Form Approved OMB NO. 0938-0390

Public reporting for th	is collection of information is a	P(ost-Certification I	Revisit Report		0112 110. 0938-03
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Name of Facility				1		6/9/2011
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(Y4) Item	(Y5) Date	(Y4) Item		(Y5) Date		
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	00/09/20	011 ID Prefix	Q0104	Completed 06/09/2011		Complete
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	00/09/20	11 ID Prefix	Q0181	Completed 06/09/2011	ID De F	Complete
Reg. # 416.47(1 LSC)	Reg. #	416.48(a)		ID Prefix Q0220	06/09/201
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e Agency ewed By RO	Reviewed By		Signature of Su		as. Was a Summary of 7) Sent to the Facility?	YES NO

Form Approved OMB NO. 0938-0390

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n CMS - 256	7B (9-92)			Page 1 of 1		or journ to the P	acility? YES	NO
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State of Netr Jersey DEPARTMENT OF HEALTH AND SENIOR SERVICES 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

cans

Jnited

for Life

CONSENT FOR OBSERVATION IN THE AMBULATORY SURGERY CENTER

BENEFICIARY NAME:

Eltaneilija George In Avenue Patersox, ADDRESS:

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.

AI BENEF RE/RESENTATIVE THE BENEFICIARY SIGNATURE DATE

8



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 four United to have been affected by the deficient practice.

Metropolitan Surgical Association February 14, 2011 Page 2

- 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

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

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 Humpson BSN, DR

mericans

United

for Life

Louise A. Steska, MSN, RN Health Care Services Evaluator/Nurse Assessment and Survey

Encl.

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE COMPI	D. 0938-0 SURVEY ETED
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	Medical records reviewed: 20 Staff interviews / staff files reviewed: 17 416.44(a)(3) IDENTIFICATION, PREVENTION, AND MAINTENANCE					
Q 103			Q 103			
	environment for the services.] The ASC must esta and preventing infed	vide a functional and sanitary provision of surgical blish a program for identifying ctions, maintaining a sanitary eporting the results to ies.				
	Dased on staff interv documents on 1/20/ facility failed to follow discharge, in order to	is not met as evidenced by: view and a review of 11, it was determined that the v up on each patient after o identify and track infections patient's stay in the ASC.				
F	Findings include:					
ir o p fo ir p a lis	ow the facility monit infections, Staff #8 st of the patients have p atient returns to the pollow up visit, the fac offection control surver rimary physician, a l sking about infectior	/20/11 at 11:08 AM, about tors and tracks patient tated the following: "Not all primary physicians, but if the facility for their two week cility staff will complete an ey form. If the patient has a etter is sent to the physician hs. A general letter (but not a s also sent to Planned months."			S	
ATORY DI		SUPPLIER REPRESENTATIVE'S SIGNAT			ų.	
hise	v // Ant	ul '	URE	TITLE	Ameta	GATE TH
ficiency si afeguards g the date flowing the n participa		asterisk (*) denotes a deficiency which the tion to the patients. (See instructions.) if a plan of correction is provided. For n are made available to the facility. If defi	he institution m	He Multimotion	ing It is determin	red that

)RM CMS-2567(02-99) Previous Versions Obsolete

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES				FORM): 02/14/2 / APPRO\) <u>. 0938</u> -0:
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	(2) 0.5 gallo in suites of rooms (C) The dispension horizontal spacing of other; (D) Not more th gallons (37.8 liters) of use in a single smoke storage cabinet; (E) Storage of q gallons (18.9 liters) in compartment shall m NFPA 30, Flammable Code; (F) The dispense over or directly adjace (G) In locations of coverings, dispensers	ons (2.0 liters) for dispensers sers shall have a minimum f 4 feet (1.2m) from each an an aggregate of 10 of ABHR solution shall be in e compartment outside of a quantities greater than 5 a single smoke eet the requirements of a and Combustible Liquids ers shall not be installed ent to an ignition source; with carpeted floor installed directly over all be permitted only in mpartments; and are maintained in	Q 104				
		9 ¹⁰ C					
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fa Sa dis	ased on observation, cility failed to meet th	ot met as evidenced by: it was determined the le provisions of the Life g Alcohol Based Hand Rub tions above ignition	ं				
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1. Sta	On 1/20/11, at 11:15 aff #9, in the pre-op n	AM, in the presence of ourse station and PACU				S	ß
MS-2567(02	2-99) Previous Versions Obso	lete Event ID: RL8Z11	Facility ID	NJ31C0001008	18		ran
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1		() Emergency ca	at least the following:					
1		(2) Oxygen	4. ²					
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		(4) Cardiac defibri	llator.				90 1	
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		(7) Laryngoscopes	and endotracheal tubos				~	
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	s	upplies specified by t	the medical staff.					
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		ASC must maintain					Chy.	\mathcal{O}
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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	FOR	D: 02/15/2 M APPROV <u>D. 0938-0</u> SURVEY
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	medical records of P	MED CONSENT FOR RS (SAME DAY) forms in the atient #1 and #19 did not ian obtained informed	5335		×	
	obtained by the facility indicated that the could The 'counselor' was n	on the morning of January consent should have been / counselor. She further nselor was not a physican. ot qualified to obtain use of a medical device.				
1.11	 Based on a review ive patients it was det ecords included patien 	of the medical records of ermined that not all medical nt identification.	25			
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en Pa pa se FC da	atient #19 did not include atient #19 did not include atient on the form. The action at the top of the atry. Additionally, an I DR <u>CERVICAL DILAT</u>	n the medical record of				8
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	C. Based on observa documents, and med was determined that i an accurate medical i	ical record review of #20, it		n ^e s	25	
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p to co tro pa ac inv pr	by sician, treating phy ogether shall obtain a consent from patients. eatment or activity th atient's health or safe ctivities requiring info cludeAnesthesia/	visician and counselor ppropriate informed before starting any at presents a risk to the etyTreatments and rmed consent All operative ical Abortion"				
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STATEME	ERS FOR MEDICAR	H AND HUMAN SERVICES <u>E & MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA			FOR	D: 02/14/2(M APPROV <u>D. 093</u> 8-03
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	b. The "Consent for and Anesthesia" in m control methods with b. The "Consent for and Anesthesia" in m control methods with b. The evaluation control methods with b. The "Consent for and Anesthesia" in m contains sign "Evaluating Physician However, the evaluat treating physician fail the anesthesia risks a	Termination of Pregnancy nedical record #20 dated natures on the lines titled, n," and "Treating Physician." ting physician and the ed to inform Patient #20 of and benefits or the risks and		9 5	ъ. Л Д	17
2 181 4 L	procedure on 1/20/11 416.48(a) ADMINISTI Drugs must be prepar	al Drocedure prior to the	Q 181			
s	standards of practice.					8
in to di	iterview, it was detern ensure that a physic	ot met as evidenced by: nedical records and staff nined that the facility failed ian order was in place to nous solution and/or the ent.	×		3	
	ndings include:			-10 	a du	2
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United for Life

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE S. COMPLE	PRINTED: 02/14/20 FORM APPROV OMB NO. 0938-03					AND HUMAN SERVICES	RS FOR MEDICARE	CENTE
NAME OF PROVIDER OR SUPPLIER 01/2 METROPOLITAN SURGICAL ASSOCIATION STREET ADDRESS, CITY, STATE, ZIP CODE 40 ENGLE STREET ENGLEWOOD, NJ 07631 (Main of the provide state of the proceeded by Full, REGULATORY OR LSC DEWITHING MFORMATION) Implement (ECAH CORRECTIVE AD OF CORRECTION (ECAH CORRECTIVE AD OF CORRECTION SIGULATORY OR LSC DEWITHING MFORMATION) Implement (ECAH CORRECTIVE AD OF CORRECTION (ECAH CORRECTIVE AD OF CORRECTION (ECAH CORRECTIVE AD TO THE APPROPRIATE DEFICIENCY) 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. Q 181 2 220 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. Q 220 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). 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). The facility failed to provide patients with information concerning its policies on advance directives, including a description of applicable State health and safely laws. Advance of the date of the patient is not advance directives, including a description of applicable <	URVEY	(X3) DATE S	E CONSTRUCTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	OF CORRECTION	AND PLAN
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Q 181 Continued From page 9 Q 181 1/20/11 and 1/25/11, there was no evidence that a physician order was written to discontinue the Q 181 a physician order was written to discontinue the intravenous and / or hep lock from the patient. Q 220 2. This was confirmed by Staff #9 and Staff #15. Q 220 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. Q 220 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). 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.	(XS) COMPLET DATE		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	TIX	PRE	MUST BE PRECEDED BY BUILT		PREFIX
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 Q 220 2. This was confirmed by Staff #9 and Staff #15. 416.50 PATIENT RIGHTS Q 220 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: 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). 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). The facility failed to provide patients with information concerning its policies on advance of the adaet of the procedure. (Cross refer Q223). 		8			C	as written to discontinue the	a physician order wa	
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 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 			- <u>*</u> 12			n, document review, patient I record review, it was acility failed to promote and	Based on observation interview and medical determined that the fa exercise patient rights	
 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 		4	65	~		C8 Of the facility's nationt	ights, in advance of th	ri v
directives, including a description of applicable State health and safety laws, in advance of the			් - 			On in writing regarding	sciosure of information hysician financial inte SC, in advance of the	pl A
					a U V v	Its policies on advance description of applicable laws, in advance of the	rectives, including a c ate health and safety	in dir dir St
4. The facility failed to fully inform patients about treatment options and failed to ensure that	ß	S				ailed to ensure that	atment options and fi	
CMS-2567(02-99) Previous Versions Obsolete Event ID: RL8Z11 Facility ID: NJ31C0001006 If continuation that Face	GAR	DI shart Face	U31C0001006 If continuation	acility ID: 1	 F	lete Event ID: RL8Z11	2-99) Previous Versions Obso	:MS-2567(0;
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AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI 'A. BUIL	ULTIPLE CONSTRUCTION DING	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	31C0001006	B. WIN	G	01/25/2011	
	POLITAN SURGICAL	ASSOCIATION		STREET ADDRESS, CITY, STATE, ZIP COL 40 ENGLE STREET	 DE	
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE A		
Q 220	patients are given the to make an informed (Cross refer Q229). 5. The facility failed	to ensure that patients and	Q 22	DEFICIENCY)		
Q 221	The ASC must provid representative with ve the patient's rights in	and dignity. (Cross refer E OF RIGHTS de the patient or the patient's erbal and written notice of advance of the date of the	Q 22 [.]	1		
l I F	This STANDARD is r Based on observation medical record review determined that the fa patients with verbal an	age and manner that the s representative not met as evidenced by: , patient interview and			3	
1 tr a 2. th	Medical Record #1 of at Patient #1, whose of at Patient #1, who patient #1, wh	contained documentation	6. 			
pro	ceived a copy of the f	sting to the fact that she acility's patient rights on idvance of the date of the			S	
·		ete Event ID: RL8Z11	Facilit	y ID: NJ31C0001008 If continu	ation shoet Fana G Cor 24	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE	
		-31C0001006	B. WING		-	
NAME OF I	PROVIDER OR SUPPLIER				01/	<u>25/20</u> 11
METRO	POLITAN SURGICAL	ASSOCIATION	40	EET ADDRESS, CITY, STATE, ZIP ENGLE STREET	CODE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		IGLEWOOD, NJ 07631	<	
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETIO DATE
Q 221	Continued From page	ge 11			")	L
2	3. Medical Record a that Patient #3, who signed a document a received a copy of th	#3 contained documentation se procedure was or attesting to the fact that she he facility's patient rights on in advance of the date of the	Q 221	9 21 - 12	il e	
	signed a document a	4 contained documentation se procedure was on ttesting to the fact that she e facility's patient rights on n advance of the date of the		н н ж. Я). 	
s	igned a document at eceived a copy of the	contained documentation procedure was or testing to the fact that she facility's patient rights on advance of the date of the		2- 70 24		3
223 41	gned a document atte ceived a copy of the	esting to the fact that she facility's patient rights on dvance of the date of the	Q 223		5) 	
The phy AS 420 mu	e ASC must also dis vsician financial inter C facility in accordan O of this subchanter	close, where applicable, ests or ownership in the ce with the intent of Part Disclosure of information urnished to the patient in he procedure.				
		met as evidenced by:		> 4	S.	S*
ma-2007 (02-)	99) Previous Versions Obsole	te Event ID: RL8Z11	Facility ID: I	NJ31C0001008 If cor	ntinuation sheet Page	12 of 24
		12			Uni	lea
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INCOMEN		E & MEDICAID SERVICES	(Max tar				M APPROV <u>D. 0938-03</u>
NU PLAN	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCT	ION	(X3) DATE COMPL	SURVEY
		31C0001006	B. WING				
iame of F	ROVIDER OR SUPPLIER		e	PEET Apparent		01/:	25/2011
	OLITAN SURGICAL		· _ ·	ADDRESS, C 40 ENGLE STREE ENGLEWOOD, N			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	d)	PROVID	ER'S PLAN OF CORD		
TAG		SCIDENTIFYING INFORMATION)	PREFIX TAG	I ICAUTUU	RRECTIVE ACTION SH ERENCED TO THE AP DEFICIENCY)		(X5) COMPLETIC DATE
Q 223	Continued From pa	age 12	Q 223	1			<u> </u>
	A. Based on obser it was dete	vation and patient interview on ermined that the facility failed to		~			
Γ	NAMOR L'ANCIN #50						
14.1	m mining regarding	physician financial interests or SC, in advance of the date of					
	the procedure.	, in advance of the date of					
	Findings include:		1.1				
	On she did not receive :	Patient #20 stated that	34				
1.4	insciusule of inform;	a copy of the facility's ation in writing regarding					
18	mysiciali linancial in	lierests or ownership in the			5 .		
		scheduled for inselor. Staff #12 interviewed					
10							
l a	dvised Patient #20 (le ASC, just prior to	of the physician ownership of Patient #20's procedure on			19 25		
	. (BIDELTAR in advance of the line					
da	ate of the procedure).				10	
B.	Based on medical	record review and staff					
1 11 1	leiview. II was detei	mined that the feelility failed					
int	formation in writing	5 With disclosure of		19 19			
1	OLOGIO OL OAMUELZUIT		. č				
	e date of the proced	ure,				1. c	
Fir	idings include:	24					
1.	On 1/20/11 and 1/2	5/11, during a review of					
1 1110	uical records #1 thr						
1 9110	inic in ninkine eviu	PDC9 that the notionta					
Jieg	arung privsician fin	information in writing					
Owi	leisnip in the ASC.	in advance of the date of					
ine	procedure.		-			Chr	$\dot{\mathbf{o}}$
2. 1	This was confirmed	by Staff #15.	2.601			Chr.	$P \mid$
S-2567(02-	99) Previous Versions Obso	Dete Event ID: RL8211	Facility I	D: NJ31C0001008	Mar at		mande
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						Uni	lea
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ND PLAN (IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA					
	1 1	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		N	(X3) DATE	D. 0938-0
			A. BUILDI	8 		COMPL	ETED
		31C0001006	B. WING				
	ROVIDER OR SUPPLIER	5.	ST	REET ADDRESS OF		01/2	25/2011
	OLITAN SURGICAL		/ *	REET ADDRESS, CIT 40 ENGLE STREET ENGLEWOOD, NJ			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID		R'S PLAN OF CORRECT		
TAG		SCIDENTIFYING INFORMATION)	PREFIX TAG		ECTIVE ACTION SHOU ENCED TO THE APPRO DEFICIENCY)		(X5) COMPLET DATE
Q 224	416.50(a)(2) ADVA	NCE DIRECTIVES	Q 224				<u> </u>
	requirements:	ply with the following					:
		tient or, as appropriate, the live in advance of the date of					
	me procedure, with i	nformation concerning its directives, including a					
14	rescription of applica	able State health and active			44		
1.00	aws, and, if requeste lirective forms.	ed, official State advance		20			
	(ii) Inform the pati	ent or, as appropriate, the			ň		
p							
	are.	ions regarding the patient's					
	(iii) Document in a	prominent part of the					
pa th	auciil S current meni	ical record, whether or not cuted an advance directive.					
		cuted an advance directive.		÷.	5 a .	.ē.	
pro its des	policies on advance scription of applicab	tot met as evidenced by: tion and patient interview on ined that the facility failed to th information concerning directives, including a le State health and safety date of the procedure.			4 n 8	# ×	28
Fin	dings include:						
		s	-4	53			
	did not receive info	Patient #20 stated that rmation about the facility's ectives prior to the visit			49 - 43		220
3010	nselor. Staff #12 inte	While the facility					
#20	about a "Living Will	aff #12 asked Patient iust prior to Patient #20's					
1 1 1 1 2 2	edure on a second se					S	ຊ່
						7	<u>۲</u>
>-2567(02-9	9) Previous Versions Obsole	te Event ID: RL8Z11	Facility ID): NJ31C0001008	A	meri	can
			20		If continuation	sneet Page	14 of 24
					L	m	tec
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	2	31C0001006	B. WIN	IG			1	
LINTDO-	PROVIDER OR SUPPLIER			STREET ADD			01/	25/2011
	POLITAN SURGICAL A			40 ENGLE	RESS, CITY, STA STREET OOD, NJ 076			
(X4) ID PREFIX TAG	REGULATORY OR LS	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI) TAG	X (E	PROVIDER'S PL ACH CORRECTIN	AN OF CORREC	11000	(X5) COMPLETION DATE
Q 224	Continued From pag	e 14	Q 2	24				┼────
	to provide the patient concerning its policie including a descriptio	I record review and staff rmined that the facility failed ts with information s on advance directives, n of applicable State health dvance of the date of the				10	a:	8
F	Findings include:			12				
p in di S	provide evidence that formation concerning irectives, including a	25/11, in a review of medical 9, the facility was unable to the patients received g its policies on advance description of applicable y laws, in advance of the					23 33 73	
u 229 41	This was confirmed 16.50(b)(1)(iii) EXER IFORMED CONSEN		Q 229					
pro	he patient has the rig Be fully informed abo ocedure and the expension prformed.	ht to -] out a treatment or ected outcome before it is						2
					20			00
fully opti give info	it was determined it was determined it was determined it inform Patient #20 it is information new it is information new primed decision regard	that Patient #20 was eded in order to make an ding her care and failed to	* 				-	т. ¹⁴
Poli proc	icy" prior to Patient # cedure.	itied "Informed Consent 20's anesthesia and					S	
:MS-2567(02-1	99) Previous Versions Obsole	te Event ID: RL8Z11	Facil	ity ID: NJ31C00	01008	If continuatio		icans
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	PARTMENT OF HEALT	H AND HUMAN SERVICES				PRINTE	D: 02/14/201
	EMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION		M APPROVEI 0. 0938-039
	• •	BENTINGATION NUMBER:	A. BU			(X3) DATE COMP	SURVEY LETED
	E OF PROVIDER OR SUPPLIER	31C0001006	8. WI	NG			
1		ASSOCIATION		40	EET ADDRESS, CITY, STATE, ZIP COD ENGLE STREET	<u>01/</u> E	25/2011
(X4) PRE	DID SUMMARY STA	TEMENT OF DEFICIENCIES	<u>I</u>	E	IGLEWOOD, NJ 07631		
	G REGULATORY OR L	SC IDENTIFYING INFORMATION	ID PREFIJ TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		(X5) COMPLETION DATE
Q 2	229 Continued From particular Findings include:	ge 15	Q 2	29			<u> </u>
	physician, treating physician, treating physician, treating physician, treating physician, together shall obtain consent from patient treatment or activity	All operative		10			15
4	an oughout her stay a	urveyor followed Patient #20 t the ASC.	2				~ >
	a. On Staff #12, a counselor	Patient #20 stated to	18		* ^C		
	Staff #12 stated to Par				8 V 4		
	professional, but a cou direct Patient #20's qui member of the facility i	ot a health care Inselor. Staff #12 failed to estion about ' account ' to a medical staff.					~
Q 232	The evaluating physicial physician failed to informanesthesia risks and be benefits of the surgical procedure on	In and the treating In Patient #20 of the	22			2	
1	[The patient has the righ Receive care in a sat	nt to -] fe setting	Q 232		92 10		2
	This STANDARD is not	-				d'	Š
CMS-258	7(02-99) Previous Versions Obsole	ete Event ID: RL8211	Facili	ty ID-1	NJ31C0001008	Amori	cans
				-y	If continua	tion sheet Page	16 of 24
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AND PLAN	NT OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MH	TIPLE CONSTRUCTION	<u>OMB NO</u>	APPRO
54		IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE : COMPL	SURVEY ETED
		31C0001006	B. WING			
	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO	01/:	25/2011
METRO	POLITAN SURGICAL	ASSOCIATION	J	40 ENGLE STREET	DE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		ENGLEWOOD, NJ 07631		
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		(X5) COMPLET DATE
Q 232	- of the second of the second participation of the second se	ge 16	Q 232		<u> </u>	<u> </u>
I	Based on documen it was dete not receive care in a	t review and observation on mined that Patient #20 did a safe setting.				
	Findings include:			5		
5	.Medical assistants a maintaining adequat closetsAfter resto	ility, "Protocol for Stocking of torage Closets," states, " are responsible for e stock in the supply storage cking, the medical assistant supply storage sheet (see		t0		
r F d	#20 a garbage can, the mext to the stretcher, There were no emesi- ecovery room area o Providing a trash can lid not provide for the	Patient #20, while in born, stated to Staff #13 that "Staff #13 gave Patient hat was sitting on the floor to use as an emesis basin. s basins available in the manual statements basin rather than an emesis basin patient's emotional health espect and dignity are		8 5 8 8 9 9 8		
w th	hich Patient #20 require Supply Storage Clr	sheet, mentioned in the to contain emesis basins, lired, as a supply to keep in oset. CONTROL PROGRAM	Q 242	Ë	~	
inf ad pro	dition, the infection c pgram must include c chas considered, si	n an ongoing program ontrol, and investigate vicable diseases. In ontrol and prevent locumentation that the elected, and implemented fection control guidelines.		5 2 ² 2	S	ŝ

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CENTE	ERS FOR MEDICARE	AND HUMAN SERVICES	i.		FOR	D: 02/14/2 M APPRO\ <u>D. 09</u> 38-0:
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ILTIPLE CONSTRUCTION DING	(X3) DATE	
		31C0001006	B, WING	3		
	PROVIDER OR SUPPLIER	ASSOCIATION		STREET ADDRESS, CITY, STATE, ZIP CODE 40 ENGLE STREET ENGLEWOOD, NJ 07631	<u>[11</u> :	<u>25/2011</u>
(X4) ID PREFIX - TAG	I CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORP.		(X5) COMPLETI DATE
Q 242	Continued From page	ge 17	Q 24			<u> </u>
	nationally recognize	d infection control guidelines.	624			
		A		1. AL		ø
	A. Based on observ review of documents determined that the infection control polic	not met as evidenced by: ation, staff interview and a on 1/20/11, it was facility failed to implement cies and failed to maintain an gram that follows up on each				
	pauent after dischard	e, in order to identify and associated with the patient's		2		
	Findings include:			8		
[]	 Staff #8 stated on follows CDC (Centers infection control polic 	1/20/11 that the facility s for Disease Control) for ies.	6 14 ₁₀	-2		` 0
2 5 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2002 Guideline for Ha Settings" states "Wi coap and water, wet h in amount of product nanufacturer to hand	DC "MMWR October 25, and Hygiene in Health-Care hen washing hands with lands first with water, apply recommended by the s, and rub hands together 15 seconds, covering all and fingers"	÷		×	
st pa se	lates All personnel	Exposure Control Plan," participating in direct must wash hands for 10 ter patient contact				
(11)	ygienie, states "yya	sility policy titled, "Hand sh hands thoroughly and water and soapUsing	ž.	w ^a _a a c.	Ś	Ŝ.

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STATEME	NT OF DESIGNATION	H AND HUMAN SERVICES					FOR	D: 02/14/2 M APPRO\
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		CONSTRUCTION		<u>_OMB NO</u>	<u>D. 0938-0</u> ;
	24 -	1	A: BUI	LDING			(X3) DATE COMPI	SURVEY
	PROVIDER OR SUPPLIER	31C0001006	B, WIN	IG				
			T	STREET			01/	25/2011
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Q 261	Continued From pag	e 22			DEFICIENCY	OPRIATE	DATE
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i I A	a. In 20 of 20 medica Examination" was do areas checked off: "/	al records, a "Physical cumented with the following Abdomen, Extremities, enitalia, Vagina / Cervix and	/		ł		
2 267 b 4 A	. This was confirmed 16.52(c)(3) DISCHAF DULT	by Staff #9 and Staff #15. RGE WITH RESPONSIBLE	Q 267				
co pa		he attending physician.				-	-
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accorr respor verified	npanied by another p nsibility for the patien d by the administrativ	They also must be erson who accepts t. This information is re staff as well as the		2			3
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Q 267	Continued From pa	ge 23	Q 267			21
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c c p w to re	leep sedation must company of a respon nust be specific to the xemptions to entire ermitted. Additionation who have undergone be discharged with	enced policy indicated that ceive conscious sedation or be discharged in the nsible adult. Exemptions ne individual patient. Blanket classes of patients are not ily, the policy allows patients conscious or deep sedation nout the company of a re facility fails to find one for				
de in the pai	the company of a re attending physicial tient may be dischard	ternoon of January 20, 2011, to not receive conscious or required to be discharged esponsible adult, nor does n write an order that the rged without a responsible n the patient does not eep sedation.	S1		21	
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	ire resistance rating with partitions and d with an automatic se	eparated from other parts of parriers have at least one hour or such areas are enclosed oors and the area is provided prinkler system. High hazard with both fire barriers and 3.3.2, 39.3.2		12 V 3	12	e.
fa	cility failed to separ ther parts of the built	not met as evidenced by: n, it was determined that the rate hazardous areas from ding with self closing doors.				
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articipation.	e trese documents are	trisk (*) denotes a deficiency which the in to the patients. (See instructions.) Exce plan of correction is provided. For nursin made available to the facility. If deficien	astitution may be opt for nursing h og homes, the al cies are cited, a	e excused from correcting provid omes, the findings stated above bove findings and plans of correction is in approved plan of correction is	ing it is determined ard disclosable to cliquing the disclosable requisite to continu	days la the lea the lea the
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	deemed appropriate Life Safety Code wi result in unreasonal	e, specific provisions of the hich, if rigidly applied, would ble hardship upon an ASC, but ll not adversaly affect the	QTU	4		
	code imposed by State in Classical Code imposed by State and ASC.	of the Life Safety Code do not MS finds that a fire and safety ate law adequately protects		10		
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PoC Addendum# 2

METROPOLITAN SURGICAL ASSOCIATES

40 Engle Street Englewood, NJ 07631 Tel: (201) 567-0522 Fax: (201) 816-9863 Email: <u>metmedical@aol.com</u>

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:

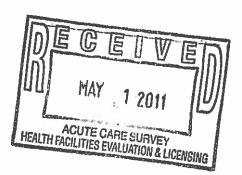
Enclosed please find an addendum to our Plan of Correction for the cited deficiencies as a result of the Health Survey conducted on January 20, 2011 and January 25, 2011 by the surveyors from the Department of Health and Senior Services. Should you have any additional questions or concerns please do 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,

Tartin Susan Martinel

Administrator







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ADDENDUM TO FEEDERAL PLAN OF CORRECTION

Q103

3. The Facility Administrator will be responsible for monitoring compliance and will report to the Infection Control Committee.

May 25, 2011



STUJI Q IV3 NOT covered ADDENDUM TO FEDERAL PLAN OF CORRECTION Q162 PoC Addendum #1

3. The cited deficiencies of practice relating to CFR 416.47(b) are to be addressed as follows:



(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 OKSIDDINA

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 ericans

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Q223 Ot S123/11/pr.

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

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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

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- 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



FEDERAL

Q103

- 1. The plan of correction will be implemented to survey potential patients starting from the beginning of the year.
- 2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

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.

- 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



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Q105

- The cited deficiency that may have affected patients has been addressed and a corrective in the second secon
- 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

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- 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:
 - 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.



for Life

- 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.

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- 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.

- 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
- 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.

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

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
- 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.

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

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The corrective action has been completed as of 2/15/2011 5.

Q223

United 1. The cited deficiency that may affected patients has been addressed and a corrective action

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- 2. The corrective action systematically addresses this cited concern so that future patients will
- 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.
- 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

3/31/11 3/31/11 Nor 7. When

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- The cited deficiency that may have affected patients has been addressed and a corrective 1. action has been accomplished.
- 2. The corrective action systematically addresses this cited concern so that future patients will
- 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.

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.

The corrective action has been completed as of 2/23/2011

The cited deficiency that may have affected patients has been addressed and a corrective 1. action has been accomplished.

The corrective action systematically addresses this cited concern so that future patients not be affected.

The plan of correction focuses on the proper implementation of the "Informe Policy". A memorandum will be drafted by 2/24/11, and issued by the Facility Adm and the Medical Director to all Medical and Counseling staff members. It will emphasize requirement that physicians adequately review proposed procedures with patients as

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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

3/31/1

- 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

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- 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 term policy has been updated to include monitoring of patients via telephone. The Infection I is the set of th

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

- 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

- 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 Metropoli an 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 filricans

United for Life

5. This corrective action has been completed as of 2/22/2011

- 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

- 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 icans
- 2. The corrective action systematically addresses this cited concern so that future patient will ted for Life

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- 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

Americans United for Life

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New Jersey State Department of Health Acute Care Survey COMPLAINT AND SURVEILLANCE REPORT

Facility						
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State of Netro 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



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 mericans place, what the goal is for compliance, and to whom the results will be united to will be reported.
- 4. The date on which each item addressed on the PoC will be corrected. for Life
- 5. Do not reference and/or include attachments with your PoC.

Metropolitan Surgical Associates Page 2

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 De Cicco/SP

Eric DeCicco, CFI Surveyor Physical Plant/Life Safety Survey and Certification

Encl.



PRINTED: 06/13/2018 FORM APPROVED

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(VA) DAT	E BLIDING
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	8 Chapter 43A-Sta	n compliance with N.J.A.C. Title indards for Licensure of facilities for this complaint only				
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	for review and appr	uction, plans shall be submitted roval, in accordance with the hapter, to the Healthcare Plan				
3) 	by: Based on observation determined that the prior to any construct	NT is not met as evidenced on and staff interview, it was facility failed to ensure that ction, plans were submitted althcare Plan Review Unit of Community Affairs.			94	
F	Findings include:					
s ti s ti a	surveyor observed n he stairs, to the mai stairwell was enclos which was not enclo survey. Staff #1 was his new construction	the facility on 4/24/18, this new construction, at the top of in stairwell. The main ed with a set of double doors sed during the previous s unable to provide plans for in that was submitted and w Jersey Department of Plan Review Unit.			S	32
tr	. Staff #1 confirmente ne New Jersey Depa ffairs, Healthcare P	d plans were not submitted to artment of Community Plan Review Unit.			Amer Uni	

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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.





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

Americans

nited

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

New Jersey State Department of Health Acute Care Survey COMPLAINT AND SURVEILLANCE REPORT

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					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

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,

Jeress Draham Pr

Teresa Graham RN, BSN Health Care Service Evaluator/Nurse Assessment and Survey Americans



Encl.

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New Jersey Department of H STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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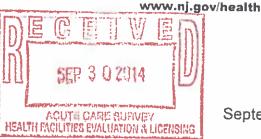
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State of New Jersey

DEPARTMENT OF HEALTH PO BOX 367

TRENTON, N.J. 08625-0360

CHRIS CHRISTIE Governor KIM GUADAGNO Lt. Governor



MARY E. O'DOWD, M.P.H. Commissioner

September 19, 2014

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

Sincerely,

Teriso Draham Pr

Teresa Graham RN, BSN Health Care Service Evaluator/Nurse Assessment and Survey **United**

for Life

Encl.

New Jersey Department of I				FORM APPRO
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A BUILDING	(X3) DATE SURVEY COMPLETED	
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	71370	B WING	C	
NAME OF PROVIDER OR SUPPLIER	CTDCPT -			09/12/2014
	OTTELT	DDRESS, CITY, ST		
PLANNED PARENTHOOD OF	SHREW	NEWMAN SPR	702	
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A 000 8:43A INITIAL CON	/MENTS	A 000		
N J A C. Htle 8 Cha	ostantial compliance with apter 43A-Standards for latory Care Facilities for this (C#NJ00074921)			
			D C C	
			ACUTE C.A. HEALTH FACILITIES EV	
RATORY DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	ane Divector o 11 9/24/14	United
EFORM	- Laven	won	and Directord	A ROM DATE
- Contract	A1	2.5	No. of Concession, Name of	

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State of New Jersev 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

I

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,

Health Care Service Evalu Assessment and Survey





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

United

for Life

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.

Pilgrim Medical Center, Inc April 7, 2015 Page 2

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.



Statement of Deficiencies Citation Summary Sheet

PRINTED: 06/02/2016

For: PILGRIM MEDICAL CENTER, INC (70789 / NJ70789) Survey Event: 239U11, Exit Date 01/13/2015

Citations Cited This Visit

Regulation	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 SER	/
State	Z7BQ	8.00	00	4733	HOSKEEPING-SANITATN-SAFTY:HOSKPING PATNT SER	/
State	Z7BQ	8.00	00	4797	HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SER	V



If continuation sheet 1 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		70700	B. WING			04/42/2045	
	OVIDER OR SUPPLIER	70789	B. WING 01/13/2015 ADDRESS, CITY, STATE, ZIP CODE 01/13/2015				
			DOMFIELD AVENUE				
			LAIR, NJ 07042				
X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
A 000	8:43A INITIAL COM	/IENTS	A 000				
	This was a State Re- resulted in deficiencie						
	Medical Records revi	iewed: 20					
	Staff interviews/ Staff	f files reviewed: 20					
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: mmwr="" pdf="" rr="" rr5116.pdf="" www.cdc.gov=""> and at <http: mmwr="" mmwrhtml="" preview="" rr<br="" www.cdc.gov="">5116a1.htm></http:></http:>			A4183				
				Amer	Bican		
					Uni	tec	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
		70789	B. WING		01/ [,]	13/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1	
PILGRIM I	MEDICAL CENTER, INC					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
A4183	Continued From page	e 1	A4183			
	by: Based on observation 1/9/15, it was determ	☐ is not met as evidenced in and staff interview on ined that the facility failed to ended infection control ered to by staff.				
	Findings include:					
	Health Care Settings Healthcare Infection Committee and the IC Hygiene Task Force, and Mortality Weekly (No. RR-16). Recommendations: 1. Indications for Ha antisepsis	eline for Hand Hygiene in Recommendation of the Control Practices Advisory CA/SHEA/APIC/IDSA Hand published in the Morbidity Report at MMWR 2002; 51 and washing and Hand ands after removing gloves.				
	rub or alternately was	ty policy titled, "Hand lse an alcohol based hand sh hands with antimicrobial are8. After removing				
	was observed chang without using an alco	e Laboratory area, Staff #16 ing gloves several times hol based hand rub or Is with antimicrobial soap				
	was observed chang	e Operating Room, Staff #19 ing gloves without using an ub or washing his/her hands ap.			Amer	\$ Can
	3. At 11:55 AM, in th following was observ	e Operating Room, the ed:				tod
ATE FORM			6899 2 3	9U11	for	uation shree 2

STATEMENT	OF DEPARTMENT OF HEA OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	
		70789	B. WING		01/	13/2015
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
	MEDICAL CENTER, INC		OMFIELD AVENUE LAIR, NJ 07042			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
A4183	Continued From pag	e 2	A4183			
	paper from the floor a He/She then picked of gloves and handed th b. Staff #19 did not r gloves and use an al wash his/her hands w 4. These findings we	oves, Staff #19 picked up and threw it in the garbage. up a package of sterile hem to the physician. remove the contaminated cohol based hand rub or with antimicrobial soap. ere confirmed by Staff #1.				
A4190	Methods for process shall conform with th editions, if in effect, i reference: The Asso of Medical Instrumen	ATN PT CARE ITEMS ing reusable medical devices e following or revised or later ncorporated herein by ciation for the Advancement itation (AAMI) requirements, tice: Steam Sterilization and	A4190			
	by: Based on direct obse document review cor	T is not met as evidenced ervation, staff interviews and inducted on 1/7/15, it was facility failed ensure that it esociation for the			Amer	B ican
TE FORM			⁶⁸⁹⁹ 239	ÐU11	for	uation shoet 3

TATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE COMPI	
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ILGRIM MEDICAL	CENTER, INC		OMFIELD AVENUE LAIR, NJ 07042			
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Advance guidelin steriliza facilitie ST 46 H standar approve Finding Referen Advance Steriliza edition, should potentia 1. In th sterile in multi-tie HVAC 4 unit. a. The materia HVAC 6 instrum c. Dus HVAC 6 instrum c. Dus	nes, "Compre- ation and steril s" ST79. (ST7 by consolidatin rds [ST 33, ST ed 7/10/2009). Is include: Ince #1: AAMI cement of Med ation in Health ST 79 section be stored in a al for contamin the Sterilization nstrument tray ered transport (Heating, Vent HVAC unit was al, exposing pin nsulation was ite debris. air conditione unit, was blow itents. t, debris and ir unit can compo nstrument tray f#2 was immen n at 12:15 PM	lical Instrumentation (AAMI) hensive guide to steam ity assurance in health care 9 replaces and supersedes ng ST 46 with 4 other AAMI 37, ST 42, and ST 35] (Association for the lical Instrumentation) Care Facilities, 2014 a 8.9.2 states, "Sterile items manner that reduces the hation." Room at 12:10 PM, nine /s were stacked on a table stored in front of the ilating and Air Conditioning) as wrapped in torn insulating nk insulating fibers. The coated with a layer of dust r unit, located behind the ing air towards the sterile hsulation fibers from the romise the integrity of the /s.	A4190		Amer	Sicans
TE FORM			⁶⁸⁹⁹ 239			uation shree 4

STATEMENT	Sey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE S COMPL	
		70789	B. WING		01/	13/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		10/2010
PILGRIM I	MEDICAL CENTER, INC		OMFIELD AVENUE	l .		
	1		LAIR, NJ 07042			
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A4190	Continued From page	e 4	A4190			
	removed from the Ste	erilization Room.				
		taff #2 confirmed that the ought to the Operating Room				
A4286	8:43A-14.6(a)(3) INF STRL PRCSNG ENV	EC PREV & CTRL: MAINT /RNMNT	A4286			
	maintained as follows decontamination and	clean processing areas: system vents, and sterilizer				
	by: Based on observatio conducted on 1/7/15 the facility failed ensu	Γ is not met as evidenced n and staff interviews , it was determined that the ure that it provides a clean ment in its clean processing				
	Findings include:					
	presence of Staff #3, pack counter contain	Room at 11:40 AM, in the the wall above the prep and ed exposed particulate ation was cited on the emains uncorrected.				
		iculate matter can generate and is not a cleanable			S.	ß
	b. This finding was o Staff #2.	confirmed by Staff #1 and			Amer	can
TE FORM	1		6899 23	9U11	for	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:	(X3) DATE COMPI		
		70789	B. WING		01/	13/2015
		STREET A	ADDRESS, CITY, STATE,			13/2013
LGRIM	MEDICAL CENTER, INC	MONTC	LAIR, NJ 07042			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
A4286	Continued From pag	e 5	A4286			
	2. At 12:10 PM, ste stored in front of the	rile instrument trays were HVAC unit.				
	exposing some of the	as wrapped in torn insulation, e pink insulation material. coated with a layer of dust				
		insulation fibers from the promise the integrity of the				
	 c. This finding was of Staff #2. 	confirmed by Staff #1 and				
A4702	8:43A-17.3(d) HOSKEEPING-SAN PATNT SERV	ITATN-SAFTY:HOSKPING	A4702			
	selected and approv Infection Control Cor	mmittee. They shall be correctly according to the				
	by: Based on documenta	T is not met as evidenced ation review, observation and cted on 1/7/15, it was			C	
	determined that the t cleaning supplies are the Infection Control accordance with the	facility failed to ensure that e selected and approved by Committee and used in manufacturer's instructions			S.	3
	for use (IFUs).				Amer	
E FORM	1		6899 220	9U11	for	

(X4) ID PREFIX TAG A4702 (DVIDER OR SUPPLIER EDICAL CENTER, INC SUMMARY ST		B. WING			
(X4) ID PREFIX TAG A4702 (EDICAL CENTER, INC				01/1	3/2015
(X4) ID PREFIX TAG A4702 (000 DI 0	DDRESS, CITY, STATE	, ZIP CODE		
A4702 (SUMMARY ST					
		MONICL ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	LAIR, NJ 07042	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
F	Continued From page	e 6	A4702			
	Findings include:					
s " F	11:40 AM, two contai signs, one with "50% 'Alcohol," were store prep and pack counte					
f		#3, these solutions are used fecting environmental terilization Room.				
	Disinfecting, Cleaning	lity's "Approved Antiseptics, g, (sic) Agents" lists Alcohol z" used for "skin prep" and ent.				
3	3. Vinegar was not ir	ncluded on the approved list.				
l f	unable to provide doo facility Infection Cont	off #2 and Staff #3 were cumented evidence that the rol Committee has selected pove cleaning solutions.				
ι		Iff #2 and Staff #3 were manufacturer's IFUs the ons.				
ł	8:43A-17.3(I) HOSKEEPING-SANI PATNT SERV	TATN-SAFTY:HOSKPING	A4733			
r c f	minimize and elimina of rodents, flies, roac facility. The premises condition as to preve	ntrols shall be used to te the presence hes and other vermin in the shall be kept in such nt the breeding, harborage, All openings to the outer air			Ameri	S can
E FORM			6899 23	9U11	for I	

TATEMENT	OF DEFICIENCIES	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE : COMPL	
		70789	B. WING		01/	13/2015
AME OF PF	ROVIDER OR SUPPLIER	1	DDRESS, CITY, STATE,	ZIP CODE		
	MEDICAL CENTER, INC					
(X4) ID PREFIX TAG	(EACH DEFICIENC	MON I CI TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	LAIR, NJ 07042	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
A4733	Continued From pag shall be effectively p of insects.	e 7 rotected against the entrance	A4733			
	by: Based on observatio 1/7/15, it was determ ensure that all openi maintained to protec insects or vermin. Findings include: 1. At 10:00 AM, in th open ended pipe sec	T is not met as evidenced n and staff interview on hined that the facility failed to ngs to the outside are t against the entrance of the presence of Staff #1, an ction was visibly protruding e lower level Storage Room.				
	air-gap to the outside rear entrance exterio	he presence of Staff #1, an e was visible underneath the or door. ere confirmed by Staff #1.				
A4797		I&SAFTY:ENVIRNMNTL PT	A4797			
		nmental condition shall be nd environmental surfaces o sight and touch.			Ş	3
	This REQUIREMEN by:	T is not met as evidenced			Amer	can
TE FORM			6899 230	9U11	for	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	
		70789	B. WING		01/13/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
PILGRIM I	MEDICAL CENTER, INC		OMFIELD AVENUE LAIR, NJ 07042	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
A4797	 1/7/15, it was determ ensure that all interior clean to sight and too Findings include: 1. At 9:45 AM, in the flooring in the Steriliz Area was found to ha have un-cleanable gas separated from the w 2. At 10:15 AM, in the floor located in the loo in disrepair, visibly w had open seams whit cleaning. 3. At 11:30 AM, in the Post Anesthesia Cam the second floor, had damage and monolit openings. 4. At 11:50 AM, in the stained ceiling tiles w Medication Storage F 	n and staff interview on hined the facility failed to or surfaces are maintained uch. e presence of Staff #1, the ter Room and Processing ave surface damage and to aps where the floor base had vall. the presence of Staff #1, the wer level Staff Kitchen, was forn with curled edges and ch would preclude proper the presence of Staff #1, the e Unit (PACU), located on d several areas of wall hic floor surface defects and the presence of Staff #1, three were found located in the	A4797		Amer	Bican
ATE FORM			6899 23	9U11	for	uation sheet 9



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, RAmericans Health Care Services Survey and ited for Life

Evaluator/Nurse Certification Encl.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
70789	B. Wing		7/15/2015	
10100 ¥1		Y2		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).

ITEI	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	A4183 8:43A-14.3(a)(5)	Correction Completed 07/15/2015	ID Prefix Reg. # LSC	A4190 8:43A-14.4(a)(1)	Correction Completed 07/15/2015	ID Prefix Reg. # LSC	A4286 8:43A-14.6(a)(3)	Correction Completed 07/15/2015
ID Prefix Reg. # LSC	A4702 8:43A-17.3(d)	Correction Completed 07/15/2015	ID Prefix Reg. # LSC	A4733 8:43A-17.3(l)	Correction Completed 07/15/2015	ID Prefix Reg. # LSC	A4797 8:43A-17.4(a)(15)	Correction Completed 07/15/2015
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	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	Amerio	Correction Completed
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SU	JRVEYOR		Unit fort	ed
FOLLOWI	JP TO SURVEY C	DMPLETED ON		CK FOR ANY UNCORRECTE ORRECTED DEFICIENCIES				5 🗌 NO

State fol 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 retrained 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 guestion 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 01C Arm 6/4/15 accumulates on such units. The boiler was wrapped in pink insulation material which has since been a 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, Atterica immediate re-sterilization of these nine packs. That said, this deficiency has been corrected as of Janu 15, 2015 at which time the sterilization team was instructed that no sterile packs are to be placed this location to ensure sterility.

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 of is the latest model 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 retraining and remedy as needed. The facility will remain in compliance with functional and sanitary conditions and environmental in compliance with control through staff in-services infection 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 debrister of the present.

Pilgrim will ensure that this deficiency doe by ite of the recur by continuation of regular environmental rounds specifically using a monthly inspection for Life 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 guestion 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 pink insulation material which has since been а 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 the sterilizers functioning of 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 unit initially extremelv hot was covered with insulation. The instruments in question, as Staff #2 re-sterilized immediately recalls, were 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 2015 at which time the sterilization team was 15, instructed that no sterile packs are to be placed in this location to ensure stability.

Please also be advised that the sterilization is serviced by two separate intake/outtake area 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 alr conditioning units which is used extensively hospitals and, in accordance with the owner's manual, utilizes an intake/outtake system with rate of morio exchange of up to 11.4 cubic meters per minute. The system is a Daikin model # EDUS041501 and the owne manual, the Engineering Data Manual" can be found a http://www.daikinac.com/content/assets/DOC/Engine/ Hannals/EDU041501.pdf. The owner's manual includ

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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 thev will findings, report all including any deficiency, to the Infection Control Committee for retraining and remedy as needed. The facility will remain in compliance with functional and sanitary environmental conditions and in compliance with infection through control staff in-services and continued environmental rounds monitoring as indicated herein.

• 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 noncorrosive 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.

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 dail observations and they will report all findings including any deficiencies to the Infection Controlor Committee for remedy as needed. Any modification to the list of acceptable and approved cleaning materi will be reviewed and approved by the Infection Con Committee prior to implementation.

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10/4/15

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 а monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. A11 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 monthly inspection a and observation of the physical plant to be performed by the Administrator or Alternate Administrator. A11 findings will be reported to the building and maintenance committee for remedy as needed.

The floor located in the lower level stafi kitchen was replaced and on or before May 1, 2015, will be sealed with an acrylic sealant to eliminate any gaps that would prevent proper cleaning.

nibi

Pilgrim will ensure that this deficiency does recur by continuation of regular environmental specifically using a monthly inspection

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 а monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. All will findings 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.

Americans

United

forLife



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 pach includes deficiency statement.



Pilgrim Medical Center, Inc April 7, 2015 Page 2

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,





Evaluator/Nurse

Encl.



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	



	-	ID HUMAN SERVICES MEDICAID SERVICES				(M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONST G			(X3) DATE	E SURVEY PLETED
		31C0001229	B. WING				01	/13/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
PILGRIM I	MEDICAL CENTER, INC				OMFIELD AVENUE LAIR, NJ 07042			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS		QO	00				
	resulted in the Condit Governing Body and Control being out of c	Managment and Infection ompliance.						
Q 040	Medical Records reviews/ Staff interviews/ Staff 416.41 GOVERNING MANAGEMENT	files reviewed: 20	Q 04	40				
	implementing, and mo the ASC's total operat has oversight and acc assessment and perfe program, ensures tha programs are adminis quality health care in	sponsibility for determining, initoring policies governing tion. The governing body countability for the quality prmance improvement						
0 101	Based on observatio records, review of pol staff interview, it was governing body failed effective in carrying o management of the fa oversight and leaders evidenced by the lack Condition for Coverage	icies and procedures, and determined that the to demonstrate that it is ut the operation and acility. The necessary ship was not provided as to f compliance with 416.51 ge: Infection Control.	0.1	01			Ś	3
Q 101	416.44(a)(1) PHYSIC	e a functional and sanitary	Q 1			An	ieri	cans
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE	TT	ni	X6 D. TE
								94/13/2015
Any deficiency other safeguar	statement ending with an as	sterisk (*) denotes a deficiency which the on to the patients . (See instructions.)	e institution may	be excused thomes the	d from correcting providing it is det the findings stated above are disclosed		hat 🗖	JTe

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined has other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosed to be an excused from correcting providing it is determined by a stated above are disclosed to be a stated above are disclosed t 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.

PRINTED: 06/02/2016

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		31C0001229	B. WING			01/	/13/2015
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
PILGRIM I	MEDICAL CENTER, INC				393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 101	Each operating room equipped so that the can be performed in a lives and assures the individuals in the area This STANDARD is r Based on observatio determined the facility environment is mainta the general public. Findings include: 1. On 1/7/15 at appro- presence of Staff #1, wooden exit stairway was structurally defici 2. This finding was c 416.51 INFECTION C The ASC must mainta program that seeks to communicable diseas This CONDITION is in Based on observatio document review con determined that the fa- there is an ongoing pu- and investigate infect diseases. The infectii implemented the natio control guidelines tha	rovision of surgical services. must be designed and types of surgery conducted a manner that protects the physical safety of all a. not met as evidenced by: n and staff interview, it was y failed to ensure that a safe ained for patients, staff, and bximately 9:30 AM, in the it was noted that the leading from the lower level tent and in need of repair. confirmed by Staff #1. CONTROL ain an infection control o minimize infections and		240		S.	S
	Findings include:				A	neri	cans
				_			

Event ID: MOGT11

Facility ID: NJ70789



	-	D HUMAN SERVICES			FORM	MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		31C0001229	B. WING		01/	13/2015
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PILGRIM N	MEDICAL CENTER, INC			393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
Q 240 Q 241	and sanitary environm surgical services is prithe professionally accipractice. (Cross refer 2. The facility failed to Infection Control policit that the AAMI (Associon of Medical Instrument selected for its Infection implemented and more Q 242) 416.51(a) SANITARY The ASC must provide environment for the poly adhering to profession standards of practice. This STANDARD is in Based on observation conducted on 1/7/15, facility failed to ensure sanitary environment services by adhering	e ensure that a functional nent for the provision of ovided in accordance with ceptable standards of to Tag Q 0241) o ensure compliance with its cies and procedures, and tation for the Advancement cation) guidelines that it has on Control program is nitored. (Cross refer to Tag ENVIRONMENT e a functional and sanitary rovision of surgical services sionally acceptable	Q 24	0		
	Findings include:					
	ST 79 section 3.3.7.4 be located in a restric			Α	S. meri	8
				A		calls

Event ID: MOGT11

Facility ID: NJ70789



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	VIDER/SUPPLIER/CLIA				OMB NO	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	31C0001229	B. WING			01/	13/2015
NAME OF PROVIDER OR SUPPLIER				, CITY, STATE, ZIP CODE	•	
PILGRIM MEDICAL CENTER, INC			393 BLOOMFIELD			
PREFIX (EACH DEFICIENCY MUST BE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			OVIDER'S PLAN OF CORRECTI I CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
 Q 241 Continued From page 3 any potential sources of conta above the prep and pack court exposed particulate material. was cited on the 5/28/14 surv uncorrected. a. The exposed particulate ma loose fibers and dust, and is r surface. b. This finding was confirmed Staff #2. 2. At 11:42 AM, two quart-siz were stored on the prep and p a. The two containers were c contained tape and other resis b. At 11:43 AM, Staff #3 state containers are "used to keep sliding." 3. At 11:45 AM, a Prepzyme spray was stored on a shelf a pack counter in the Sterilization a. Staff #3 stated that the spr Decontamination Room for so is stored in the Sterilization Ries 4. The facility failed to provide sanitary environment for the r surgical instruments. Reference #2: AAMI (Associa Advancement of Medical Instri 	at 11:40 AM, the wall netr contained This observation ey and remains natter can generate not a cleanable by Staff #1 and by Staff #1 and re plastic containers back counter. aracked, and dues. ed that the the towels from enzymatic foam bove the prep and on Room. ray is used in the biled instruments but oom. e a functional and eprocessing of its ation for the	Q 2	41		S. meri	Scans

Event ID: MOGT11

Facility ID: NJ70789



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	-	ID HUMAN SERVICES				FORM	APPROVED
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-	CORRECTION	IDENTIFICATION NUMBER:	l` í				LETED
		31C0001229	B. WING _			01/	13/2015
NAME OF PI	ROVIDER OR SUPPLIER	I		STI	REET ADDRESS, CITY, STATE, ZIP CODE		
PILGRIM I	MEDICAL CENTER, INC				3 BLOOMFIELD AVENUE		
				МС	ONTCLAIR, NJ 07042		
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TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
			-		DEFICIENCY)		
Q 241	O antimum d Emma mana	. 4					
Q 241		Care Facilities, 2014 edition	Q 2	41			
		tates, "Sterile items should					
		r that reduces the potential					
	for contamination."						
	1. In the Sterilization	Room at 12:10 PM, sterile					
		e stored in front of the HVAC					
	(Heating, Ventilating a	and Air Conditioning) unit.					
	a. The HVAC unit wa	as wrapped in torn insulation,					
	exposing some of the	pink insulation material.					
		oated with a layer of dust					
	and white debris.						
		nsulation fibers from the					
		romise the integrity of the					
	sterile trays.						
		o provide a functional and					
	sanitary environment instruments.	for the storage of its sterile					
Q 242		N CONTROL PROGRAM	Q 2	42			
		ain an ongoing program					
	infections and commu	control, and investigate					
	addition, the infection						
		e documentation that the					
		selected, and implemented					
	nationally recognized	infection control guidelines.					
		not met as evidenced by:					
		bservation, staff interviews				8	K
	and document review	conducted on 1/7/15, it was					
		acility failed to ensure that			A		
	an ongoing intection (control program that adheres			An	neri	cans
						40 11	Fod

Event ID: MOGT11

Facility ID: NJ70789



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	-	ID HUMAN SERVICES				FORM	APPROVED
					CONSTRUCTION		0.0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMP	PLETED
		31C0001229	B. WING			01/13/2015	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PILGRIM I	MEDICAL CENTER, INC				93 BLOOMFIELD AVENUE		
				N	IONTCLAIR, NJ 07042		
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PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	~	CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
Q 242	to its policies and pro nationally recognized that it had selected , i the Advancement of M implemented and mai Findings include: Reference #1: Facilit "Designation Of Time	cedures and to the infection control guidelines .e., AAMI [Association for Medical Instrumentation], is intained. y document titled, Related Or Event Related ocedure: 1. Sterile items	Q 2	242			
	packaging is not com punctured or otherwis contaminated through handling."Storage storage is not permitte	promised, i.e. (sic) torn, wet, se suspected of being n improper storage of Conditions: 10. Sterile ed near a running water fluids, windows, doors or					
	section 8.9.2 states, "						
	sterile instrument tray multi-tiered transport	Room at 12:10 PM, nine vs were stacked on a table and stored in front of /entilating Air Conditioning)				<u> </u>	
	exposing some of the	is wrapped in torn insulation, pink insulation material. oated with a layer of dust				S	S
	b. An air conditioner	unit located behind the			An	neri	cans
	7(02.00) Brovious Versions Obs					<u>n 1</u>	

Event ID: MOGT11

Facility ID: NJ70789



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CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		31C0001229	B. WING			01/	13/2015
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PILGRIM I	MEDICAL CENTER, INC				393 BLOOMFIELD AVENUE		
				Ν	MONTCLAIR, NJ 07042		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
0 242	Continued From page	<u> </u>		- 1 -			
QZTZ		ng air towards the sterile		242			
		nsulation fibers from the omise the integrity of the					
	2. Staff #2 was imme situation at 12:15 PM	diately made aware of the					
	3. At 12:25 PM, the r removed from the Ste	-					
		aff #2 confirmed that the ught to the Operating Room					
	-						
	Findings include:						
	Health Care Settings: Healthcare Infection C Committee and the IC Hygiene Task Force, and Mortality Weekly (No. RR-16). Recommendations:	line for Hand Hygiene in Recommendation of the Control Practices Advisory CA/SHEA/APIC/IDSA Hand published in the Morbidity Report at MMWR 2002; 51			Ar	S. neri	S cans
L	1. Indications for Har	nd washing and Hand					

Event ID: MOGT11

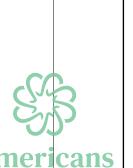
Facility ID: NJ70789



PRINTED: 06/02/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION G		(X3) DATE : COMPI	SURVEY
		31C0001229	B. WING			01/1	13/2015
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZI	P CODE		
PILGRIM	MEDICAL CENTER, INC			393 BLOOMFIELD AVENUE MONTCLAIR, NJ 07042			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE		(X5) COMPLETION DATE
Q 242 Q9999	antisepsis J. Decontaminate ha Reference #2: Facilit Hygiene" states, "U rub or alternately was soap during patient ca gloves" 1. At 10:45 AM, in th was observed changi without using an alco washing his/her hand during patient care. 2. At 11:50 AM, in the was observed changi alcohol based hand re with antimicrobial soa 3. At 11:55 AM, in the following was observed a. While wearing glov paper from the floor a He/She then picked u gloves and handed th b. Staff #19 failed to gloves and use an alo wash his/her hands we FINAL OBSERVATIO 1/7/2014 - During the	nds after removing gloves." y policy titled, "Hand se an alcohol based hand sh hands with antimicrobial are8. After removing e Laboratory area, Staff #16 ng gloves several times hol based hand rub or s with antimicrobial soap e Operating Room, Staff #19 ng gloves without using an ub or washing his/her hands up. e Operating Room, the ed: wes, Staff #19 picked up and threw it in the garbage. p a package of sterile term to the physician. remove the contaminated cohol based hand rub or vith antimicrobial soap. re confirmed by Staff #1. NS	Q 2			S	Š
	observed drying on a	shelving unit. Above this				ieri	cans
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: MOC	GT11	Facility ID: NJ70789			ee ife



PRINTED: 06/02/2016 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION		E SURVEY PLETED
		31C0001229	B. WING			01/	/13/2015
	ROVIDER OR SUPPLIER			393 E	EET ADDRESS, CITY, STATE, ZIP CODE Bloomfield avenue NTCLAIR, NJ 07042		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
Q9999	unit is an HVAC unit. dust and debris and h the side. This unit wa cooling instruments. physician and the sur understanding and sa About 30 minutes late ascertain the disposit find out that they wer instead of re-cleaning instruments. At this t Plan of Correction wa	The unit was covered with nad exposed insulation on as blowing the dust onto the Staff discussed this with the gical tech, who indicated aid this practice would stop. er, the surveyor returned to tion of the instruments, to e sent to the OR for use, g and reprocessing the ime an IJ was called and a as requested.	Q9			S. meri	
FORM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: MO	GT11	Facility			• • • • • •
					f	or I	Life

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

PRINTED: 06/02/2016



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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
31C0001229 _{Y1}	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).

ITEI	м	DATE	ITEM		DATE	ITEM	DATE
Y4		Y5	Y4		Y5	Y4	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	Americans
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGN	ATURE OF SURVEYOR	•	United
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLI	E		fortlife
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?							

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RESPONSE TO STATEMENT OF DEFICIENCIES

• <u>Q040 416.41</u>

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, Administrator the and the Director of Nursing met and reviewed their responsibilities with regard to oversight, with respect to the general dayto-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. Americans

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• <u>Q101 416.44(a)(1)</u>

This deficiency has been corrected as of 15, 2015 at which time the stairway in question

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 а 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.

• <u>Q 241 416.241(a)</u>

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.

Or.

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Pilgrim will ensure that this deficiency does not recur by continuation of regular environmental rounds specifically using monthly inspection а and observation of the physical plant to be performed by the Administrator or Alternate Administrator. A11 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. AAN findings will be reported to the building and maintenance committee for remedy as needed.

The Prepzyme Enzymatic foam spray was re from the sterilization area and returned to 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 inservices and continued environmental rounds monitoring as indicated herein.

OK

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, was due to an OSHA recommendation that it this extremely hot unít was initially covered with insulation. The instruments in question, as Staff #2 recalls. immediately were re-sterilized 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. Th said, this deficiency has been corrected as of Januar 15, 2015 at which time the sterilization team

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/Engineering Manuals/EDUS041501.pdf. The owner's manual includes detailed diagrams of the intake/outtake system and the filtration system on pages 81-84.

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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 findings, they will report all including any deficiency, to the Infection Control Committee for retraining 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 if a pink insulation material which has since been removed and will be replaced with appropriately seven (14)

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6/4/15

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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. 0k hcm 4/4/15

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.

• <u>K 115 416.44(b)(1)</u>

This deficiency has been corrected on or about \checkmark February 1, 2015 at which time the opening in the wall above the door to the lower level storage room was repaired using $\frac{1}{2}$ " 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 а monthly inspection and observation of the physical plant to be performed by the Administrator or Alternate Administrator. A11 findings will be reported to the building and maintenance committee for remedy as needed.

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 Pilgrim anticipates installation will another. be completed on or before May 1, 2015. A number of attempts have been made to make this correction sooner; however, manufacturer the prior never delivered the items as promised. A new contractor 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 normal 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.

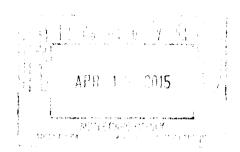
By:

Nicholas v. Campanella, MD, FACOG Medical Director, C.E.O.



393 Bloomfield Avenue Montclair, New Jersey 07042 Toll Free in New Jersey: (800) 772-2174 Other Areas: (201) 746-1500

rdr/a





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 Plan of Correction a 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.



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 Director, the Medical Alternate Medical of the Director, the Administrator and the Director of Nursing met and reviewed their responsibilities with regard to oversight, with respect to the general dayto-day operations as well as compliance with CMS specifically including conditions of coverage 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, enforcement of the administration and inflation control program.

Pilgrim will ensure that this does not recur by holding semi-annual meetings of the Governing Body, at all policies and procedures will be which time and proper oversight. for compliance reviewed 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. Anv deficiencies discovered as a result of such meetings shall be reported to the quality assurance committee event the Governing In the Body for remedv. 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 Americans policy committee.

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United

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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.

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Please see responses to Tag Q 0241 and Q 242.

• <u>Q 241 416.241(a)</u>

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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.

• <u>Q242 416.51 (b)</u>

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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 Contrpletions Committee for remedy as necessary. **United** for Life

• 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 $\frac{1}{2}$ " 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.



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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&P	s
State	3B6I	9.00	00	4797	HOSKEEPING-SANI&SAFTY:ENVIRNMNTL PT CARE SER	V



ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI ID PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING:		COMP	LETED
	22445	B. WING		12/	08/2017
OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	• • • •	
LL WOMENS CENTER			тн		
	CHERRY	YHILL, NJ 08034			1
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
INITIAL COMMENTS		A 000			
	-				
Medical records revie	wed: 20				
Personnel files review	ved/staff interviews: 23				
8:43A-3.5(d)(1) GEN PERSONNEL	REQUIREMENTS:	A1185			
of employment and a education regarding, plans and procedures and control program, policies and procedur and, if appropriate, gi	t least annual in-service at a minimum, emergency s, the infection prevention universal precautions, es concerning patient rights, ven the patient population of				
by: Based on document r conducted on 12/8/20 the facility failed to er receive orientation at at least an annual in- at a minimum, emerg the infection prevention universal precautions	review and staff interview 017, it was determined that isure that all personnel the time of employment and service education regarding, ency plans and procedures, on and control program, , policies and procedures			Ş	
Findings include:				Amer	ican
1. A review of (11) el	even out of (11) eleven			Uni	toc
I I I I I I I I I I I I I I I I I I I	SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I NITIAL COMMENTS This was a State Re-I on 12/7/2018 and 12/ Medical records reviee Personnel files review 3:43A-3.5(d)(1) GEN PERSONNEL All personnel shall records review of employment and at education regarding, olans and procedures and control program, oblicies and procedures and control procedures and control program, oblicies and procedures and control program, oblicies and procedures and control program, oblicies and procedures and control program, oblicies and procedures and control procedures and control	LL WOMENS CENTER	LL WOMENS CENTER D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID NITIAL COMMENTS A 000 This was a State Re-Licensure survey conducted on 12/7/2018 and 12/8/2017. A 000 Wedical records reviewed: 20 Personnel files reviewed/staff interviews: 23 3:43A-3.5(d)(1) GEN REQUIREMENTS: A1185 PERSONNEL A1185 All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency olans and procedures, the infection prevention and control program, universal precautions, bolicies 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: assed 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: Findings include:	CHERRY HILL, NJ 08034 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE FRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) preferix TAS PROVIDERS PLAN OI (EACH CORRECTVE AD CROSS-REFERENCED TO DEFICIEN NITIAL COMMENTS A 000 A 000 NTIAL COMMENTS A 000 no 12/7/2018 and 12/8/2017. A 1000 Wedical records reviewed: 20 Personnel files reviewed/staff interviews: 23 3:43A-3.5(d)(1) GEN REQUIREMENTS: PERSONNEL A 1185 All personnel shall receive orientation at the time of employment and at least annual in-service aducation regarding, at a minimum, emergency Jans and procedures, the infection prevention and control program, universal precautions, poolicies 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 field 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, he infection prevention and control program, universal precautions, policies and procedures procedures, planes and procedures the infection infection prevention and control program, universal precautions, policies and procedures concerning patient rights, and identification of alder abuse. Findings include: 1. A review of (11) eleven out of (11) eleven <td>LL WOMENS CENTER CHERRY HILL, NJ 08034 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST 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) NITIAL COMMENTS A 000 NITIAL COMMENTS A 000 Personnel files reviewed/staff interviews: 23 A1185 3:43A-3.5(d)(1) GEN REQUIREMENTS: PERSONNEL A1185 All personnel files reviewed/staff interviews: 23 A1185 3:43A-3.5(d)(1) GEN REQUIREMENTS: PERSONNEL A1185 All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency polans and procedures, the infection prevention and control program, universal precautions, solicies and procedures concerning patient rights, solicies and procedures of child abuse and/or etder abuse. File REQUIREMENT is not met as evidenced by: 3ased on document review and staff interview conducted on 120/2/071, it was determined that he facility failed to ensure that all personnel teceive orientation at the time of employment and at least an annual in-service education regarding, at a minitum, emergency plans and procedures, broncerning patient rights, and identification of sider abuse. File August Au</td>	LL WOMENS CENTER CHERRY HILL, NJ 08034 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST 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) NITIAL COMMENTS A 000 NITIAL COMMENTS A 000 Personnel files reviewed/staff interviews: 23 A1185 3:43A-3.5(d)(1) GEN REQUIREMENTS: PERSONNEL A1185 All personnel files reviewed/staff interviews: 23 A1185 3:43A-3.5(d)(1) GEN REQUIREMENTS: PERSONNEL A1185 All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency polans and procedures, the infection prevention and control program, universal precautions, solicies and procedures concerning patient rights, solicies and procedures of child abuse and/or etder abuse. 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If continuation sheet 1 of 22

STATEMEN	sey Department of Hea T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
		22445	B. WING		12/08/2017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
HERRY	HILL WOMENS CENTER		GS HIGHWAY NORT Y HILL, NJ 08034	ſH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
A1185	employee files (#1, # #21, #22 and #23), la education regarding procedures, infection universal precautions abuse.	e 1 2, #4, #5, #8, #9, #13, #20, acked evidence of annual emergency plans and a prevention and control, s, patient rights, and elder gs were confirmed by Staff	A1185			
A1297	8:43A-3.7(a) GEN RI EMPLOYEE HEALTH The policy and process shall include policies that physical examination performed upon emp and shall specify the other persons provid services shall received the content and the f	H edures manual of the facility and procedures to ensure ations of employees are bloyment and subsequently circumstances under which ing direct patient care e a physical examination and requency of the ployees and other persons	A1297			
	by: Based on document conducted on 12/8/2 the facility failed to he physical examination employees, subsequ examination perform	-			Ameri	Sican
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STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
		22445	B. WING	12/08/2017		
NAME OF PI	ROVIDER OR SUPPLIER	I	ADDRESS, CITY, STATE	. ZIP CODE	1 12/	0.2011
		502 KIN	GS HIGHWAY NOR			
	HILL WOMENS CENTER	CHERR	Y HILL, NJ 08034			
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A1297	Continued From pag	e 2	A1297			
	Findings include:					
	employee files (#1, # #20, #21, #22 and #2 history and physical subsequently.	e (12) out of twelve (12) 2, #3 #4, #8, #9, #13, #15, 23), lacked evidence of a examination upon hire and gs were confirmed with Staff				
A2376	8:43A-9.4(a) PHARM OF MEDS	ACEUTICAL SVCS: ADMIN	A2376			
	in writing. Each writte name of the drug, do	nistered shall be prescribed en order shall specify the use, frequency, and route of hall be signed and dated by				
	by: A. Based on docume					
	1. The administration	n of Morphine 4 mg IVP, on , was recorded in Medical			S	3
	a. There was no evid for Morphine.	dence of a physician's order			Ameri	can
	1		6899	01.44		ICI
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STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
		22445	B. WING		12/08/2017	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		00/2011
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		CHERRY	' HILL, NJ 08034			
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A2432	Continued From pag	e 3	A2432			
A2432	8:43A-9.5(b) PHARM STORAGE OF DRU(A2432			
	All drugs shall be sto as indicated by the U Pharmacopoeia, proc package inserts.					
	by: Based on observatio of facility policy, it wa	Γ is not met as evidenced n, staff interview, and review as determined that the facility injection practices are ce with its policies.				
	Administration; Contr "Procedure 7. Mult	y policy titled, Medication - rol and Storage of states, ti use vials must be used ening. Do not use expiration g."				
	General Chapter 797 has been opened or needle-punctured) th discarded within 28 c	d States Pharmacopia (USP) 7 [16] states, "If a multi-dose accessed (e.g., e vial should be dated and days unless the manufacturer shorter or longer) date for			رې م	D ²
	Care Unit (PACU) on 12:35 PM, Staff #18 Nubain from an open	tion in the Post Anesthesia 12/7/17, at approximately obtained a multidose vial of 1 box. Staff #18 withdrew the vial and confirmed that it was			Ameri	S Ican
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STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
	ST CONRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		22445	B. WING		12	/08/2017
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CHERRY H	HILL WOMENS CENTER	502 KING	SS HIGHWAY NOR	тн		
			'HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
A2432	Continued From page	9 4	A2432			
	ready to be administe	ered to the patient.				
	the medication vial hat the above medication	v, Staff #18 confirmed that ad been accessed prior to preparation, and there was n the medication vial label.				
A3945	8:43A-13.4(a) MEDIC REQUIREMNTS FOR		A3945			
	writing and signed an accordance with the I Jersey. All orders, inc	care shall be prescribed in d dated by the prescriber, in aws of the State of New cluding verbal orders, shall signed in writing within				
	by: Based on document r conducted on 12/8/17 facility failed to ensur	es addressing the signing of				
	Findings include:					
	address the procedur	d, "Verbal Orders" fails to e for the signing of verbal per, including that the order n seven (7) days.			<u>(</u> 0	6
	2. This finding was c	onfirmed by Staff #1.			S,	N.
A4071	8:43A-14.2(b) INFEC PROCEDURES	PREV & CONTROL: POL &	A4071		Amer	icans
					UNI	lea
ATE FORM			⁶⁸⁹⁹ 9L	OL11	for	uation Sheet 5 of

TATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE : COMPI	
		22445	B. WING		12/08/2017	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	12/	00/2017
	HILL WOMENS CENTER	502 KIN	GS HIGHWAY NOR			
		CHERRY	'HILL, NJ 08034			
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A4071	from each service in implement, and revie frequently as necess	e 5 committee, with assistance the facility, shall develop, w, every three years or more ary, written policies and g infection prevention and	A4071			
	by: Based on observation on 12/7/2017, it was failed to ensure that s regarding Operating Findings include:					
	"Surgical caps mus	olicy titled, "OR Attire" states, t be worn at all times in all g room 3. All surfaces				
	approximately 11:55	tion in the operating room, at AM, Staff #15 and Staff #16 eir head hair beneath the			S.	ß
A4098	8:43A-14.2(b)(4) INF POL & PROCEDURE	EC PREV & CONTROL: ES	A4098		Ameri	ican to c
E FORM			6899 QI	OI 11		
TE FORM			6899 9L	OL11	for	ation Sher

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP		
		22445	B. WING		12/	12/08/2017	
NAME OF PI	ROVIDER OR SUPPLIER	1 -	DDRESS, CITY, STATE,	ZIP CODE	12/	00/2017	
HERRY	HILL WOMENS CENTER	502 KIN0	GS HIGHWAY NORT	гн			
	1	CHERRY	(HILL, NJ 08034			1	
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A4098	Continued From page 6		A4098				
	from each service in t implement, and revier frequently as necessa procedures regarding control, including, but procedures regarding control practices, incl in accordance with th Health Administration 1910.1030, Occupation	committee, with assistance the facility, shall develop, w, every three years or more ary, written policies and g infection prevention and t not limited to, policies and g the following: Infection uding universal precautions, e Occupational Safety and (OSHA) rule 29 CFR Part onal Exposure to ns, incorporated herein by					
	by: Based on observatior facility policies and pr nationally recognized it was determined tha	 is not met as evidenced n, staff interview, review of rocedures, and review of guidelines and regulations, at the facility failed to ensure practices are implemented SHA regulations. 					
	(3)(i) states, "Provision occupational exposure provide, at no cost to personal protective en limited to, gloves, gove shields or masks and mouthpieces, resusci	e, the employer shall the employee, appropriate quipment such as, but not wns, laboratory coats, face			Amer	Bican	
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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE S COMPL	
		22445	B. WING		12/08/2017	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DRESS, CITY, STATE,	ZIP CODE		
HERRY	HILL WOMENS CENTER		GS HIGHWAY NORT	Н		
			' HILL, NJ 08034			
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A4098	Continued From pag	e 7	A4098			
		nsidered "appropriate" only if				
	-	od or other potentially o pass through to or reach				
		clothes, street clothes,				
	undergarments, skin	, eyes, mouth, or other				
	mucous membranes use and for the durat	under normal conditions of				
	protective equipment					
		0 AM during the entrance confirmed that the facility's				
		gram is based on Center for				
		C), OSHA, and Association				
		of Medical Instrumentation nd recommendations.				
	2. On 12/7/17 at 10: Decontamination are	40 AM, in the a, Staff #8 was observed				
		nd disinfecting a Dilation and				
		erved pouring products of ass jar into a Styrofoam cup.				
	(i) Staff #8 was donr gown.	ned in a blue Eclipse surgical				
	(ii) The Eclipse gown gown is a Level 2 pe	n packaging indicates the rmeable gown.				
	(iii) On 12/8/17, Staf were level 2 permeal	f #7 confirmed the gowns ble gowns.			~	
	b. The facility failed Decontamination are	to ensure staff in the a wear impervious gowns.			S	Ŝ
		A 29 CFR part 1910.1030(d)				
		imens of blood or other materials shall be placed in			Amer	can
		events leakage during			Ini	tor
						ICI
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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMPI	
		22445	B. WING		12/08/2017	
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE	12/	00/2017
	HILL WOMENS CENTER	502 KIN	GS HIGHWAY NORT			
		CHERRY	Y HILL, NJ 08034			
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A4098	Continued From pag	e 8	A4098			
	collection, handling, processing, storage, transport, or shipping."					
	Specimens" states, " procedure is finished suction bottle and tal Room in preparation Laboratory1. De transfer the specime lid. The patients nam cup is placed in the of transport container. container. 3. The ste that the specimen tra the outside door of th Care Unit) closet to t laboratory technician container and drop it 1. On 12/7/17 at 10:4	a, Staff #8 was manually sting a Dilation and				
	a. Staff #8 was pour from a glass jar into a covered it with a lid.	ing products of conception a Styrofoam cup and				
		n the outside of the low "Post-it" sticker with the nd last initial written on it.				
		ced the cup into a red cooler specimen to the laboratory.			S.	S
		up can be easily punctured, ontainer which prevents			Amer	can
					Uni	let
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STATEMENT	ey Department of Hea FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	
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		CHERRY	HILL, NJ 08034			1
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A4112	Continued From page	e 9	A4112			
A4112	8:43A-14.2(b)(6) INF POL & PROCEDURE	EC PREV & CONTROL: ES	A4112			
	from each service in implement, and revie frequently as necess procedures regarding control, including, bu procedures regarding technique, employee	committee, with assistance the facility, shall develop, w, every three years or more ary, written policies and g infection prevention and t not limited to, policies and g the following: Aseptic health in accordance with nd staff training in regard to				
	by: Based on observation conducted on 12/8/1	7, it was determined that the re that medications are				
	Environmental Infecti Facilities (2003) Last https://www.cdc.gov/ s/environmental-guid states, "Construction considerations for en	vironmental infection control on of medicine preparations m a sink)"			Ameri	S
					Uni	tec
TE FORM			6899 9L	OL11	for	tion speet 10

TATEMENT	Sey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	
		22445	B. WING		12/08/2017	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
HERRY	HILL WOMENS CENTER		GS HIGHWAY NOR	ГН		
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A4112	 in Health Care (2016) parenteral medication clean, dry work space obvious contamination sinks)." 1. During a tour of the that the facility's medication of medication of medication of medication of medication of medication. 2. Upon request, Stapprovide a policy and 	nd Medication Vial Practices) states, " Preparation of ns must be performed in a e that is free of clutter and on sources (e.g., water, ne facility, Staff #2 confirmed lication preparation area, for edications from multi-dose djacent to the sink in the m. aff #1 and #2 were unable to procedure addressing the teral medications at least	A4112			
A4183	INFEC PREV MEAS Infection prevention a Centers for Disease Guidelines, and Hosp Practices Advisory C recommendations. A of the following guide providing that there is rationale based upon epidemiologic data. T guideline is incorpora amended and supple Hygiene in Health-Ca Recommendation of Control Practices Adv HICPAC/SHEA/APIC Force, published in th Weekly Report at MM	activities shall be based on Control and Prevention bital Infection Control ommittee (that is, HICPAC) n exception to the adoption eline shall be allowed s a sound infection control a scientific research or The following published ated herein by reference, as emented: Guideline for Hand	A4183		Amer	Bican
TE FORM	1		6899 9L	OL11	Uni for	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING:		(X3) DATE S COMPL	
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		CHERRY	YHILL, NJ 08034			
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A4183	Continued From pag	e 11	A4183			
	at	rice, available at nmwr/PDF/rr/rr5116.pdf_and nmwr/preview/mmwrhtml/rr51				
	16a1.htm.					
	by: A. Based on observa review of nationally r determined that the f functional and sanita provision of surgical (Centers for Disease -HICPAC (Healthcare	T is not met as evidenced ation, staff interview, and ecognized guidelines, it was facility failed to ensure a ry environment for the services by adhering to CDC Control and Prevention) e Infection Control Practices guidelines on hand hygiene.				
	Findings include:					
	Health Care Settings Healthcare Infection Committee[HICPAC] HICPAC/SHEA/APIC	eline for Hand Hygiene in : Recommendation of the Control Practices Advisory and the :/IDSA Hand Hygiene Task he CDC (Centers for Disease				
	Control and Preventi Weekly Report at MM page 32 states, "Recommendations:	on) Morbidity and Mortality /WR 2002; 51 (No. RR-16) 1. Indications for			S.	ß
	are not visibly soiled rub for routinely deco	and antisepsisB. If hands , use an alcohol-based hand ontaminating hands in tions described in items			Ameri	ican
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STATEMEN	Sey Department of Hea T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMPI	
		22445	B. WING		12/	08/2017
NAME OF P	ROVIDER OR SUPPLIER	l.	DDRESS, CITY, STATE	, ZIP CODE	12/	00/2017
HERRY	HILL WOMENS CENTER		GS HIGHWAY NOR	гн		
	SUMMARY ST		' HILL, NJ 08034	PROVIDER'S PLAN OF		
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	hands after contact w mucous membranes, dressings if hands are					
	conference, Staff #2 of Infection Control prog Disease Control (CDO Health Administration	AM during the entrance confirmed that the facility's gram is based on Center for C), Occupational Safety and (OSHA), Association for the lical Instrumentation (AAMI), mendations.				
	2. On 12/7/17 at 10:4 decontamination roor disinfecting a D&E tra	n, Staff #8 was cleaning and				
	 (i) The hand washing area was filled with cl alcohol-based hand r accessible. 	-				
	hands, Staff #10 repli	he/she washes his/her ied, "Sometimes I use the ointed to the OR corridor.			6	2
	hand rub, Staff #10 re	e/she uses alcohol-based eplied by pointing to a bottle was up high on a shelf in room.			Amer	P ican
	3. At 11:16 AM, durir	ng an observation of cleaning			Uni	tor
ATE FORM			6899 9L	OL11	for	tion speet 18 o

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE COMPI	
		22445	B. WING		12/	08/2017
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	, . <u>-</u> ,	
HERRY	HILL WOMENS CENTER	502 KIN	GS HIGHWAY NORT	н		
		CHERRY	/ HILL, NJ 08034			
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A4183	Continued From pag	e 13	A4183			
		perating Room (OR) #1, e following was revealed:				
		served using Opti-cide spray clean and disinfect the OR.				
		led to remove his/her gloves, R, to obtain a green watering				
	Staff #10 returned to gloves on, mopped t	e watering can and mop, the OR, with the same he floor, and failed to remove o exiting the OR to return the op.				
	failed to perform han	emoved his/her gloves and d hygiene, prior to obtaining id returning to OR #1.				
	policy, it was determ ensure that facility po	ation and review of facility ined that the facility failed to plicy and CDC (Centers for delines for hand hygiene are				
	Findings include:					
	states, "CHWC [Che employees are requi frequently, including	between care of each patient you wash your hands and			<u>رې</u>	C)
	Health Care Settings Healthcare Infection Committee[HICPAC]	line for Hand Hygiene in Recommendation of the Control Practices Advisory and the /IDSA Hand Hygiene Task			Amer	S ican
E FORM			6899 9LC	DL11	for	tion speet 14

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE S COMPL	
		22445	B. WING		12/	08/2017
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A4183	Control and Prevention Weekly Report at MM states, "Recommendate Handwashing and Ha Decontaminate hands contact with patients. after contact with a patients. after contact with a patients. after contact with a patient Decontaminate hands 1. During an observative was revealed: a. In the Ultrasound r donned his/her glovet hygiene, and then too i. At 10:30 AM, Staff a failed to perform hand Patient #1 to the Lab b. In the Consult Roo failed to perform hand a physical assessment 12:25 PM, Staff #18 de Operating Room (OR gloves. Staff #18 ther failed to perform hand	the CDC (Centers for Disease on) Morbidity and Mortality IWR 2002; 51 (No. RR-16) ations: 1. Indications for and antisepsis C. is before having direct F. Decontaminate hands atient's intact skin J. is after removing gloves." tion on 12/7/17, the following oom at 10:26 AM, Staff #12 s, failed to perform hand uched Patient #1. #12 doffed his/her gloves, d hygiene, and then escorted Room. m at 11:00 AM, Staff #14 d hygiene before performing	A4183			
A4215	8:43A-14.4(g) INFEC CONTROL:STRILIZA The manufacturer's ir		A4215		S	ß
	testing, disassembly, equipment shall be re	and sterilization of eadily available and followed			Amer	can:
TE FORM			6899 9LC	DL11	for	tion speet 15

New Jers	ey Department of Hea	lth				1014	
STATEMEN	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	_	(X3) DATE S COMPL	
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A4215	Continued From page	e 15	A4215				
	by employees.						
	by employees.						
	by: Based on observatior facility documents an guidelines, it was det failed to ensure manu						
	Findings include:						
	states in ST 79 section	ical Instrumentation) Care Facilities, 2015 edition on 7.2.2 Manufacturers' The written IFU of the device					
	conference, Staff #2 of Infection Control prog Disease Control (CDO Health Administration	O AM during the entrance confirmed that the facility's gram is based on Center for C), Occupational Safety and (OSHA), and Association of Medical Instrumentation ad recommendations.				Ś	ŝ
	of the reprocessing a	I3 AM, a tour was conducted rea and the following was				ý.	2
	revealed:				A	meri	cans
	a. A soiled D&E tray	was being reprocessed, Staff			T `	Ini	tod
STATE FORM			6899	9LOL11	f	If continue	tion seet 6 of 22

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	22445	B. WING		12/	08/2017
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PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
following instrume - 8 Cervical dilator - 2 Allis Clamps - 1 Tenaculum - 1 Sponge forcep - 2 Curettes - 1 Speculum - 1 Small basin (i) The manufactur (ii) At 10:34 AM S IFU's available for (iii) Staff #9 confit posted on the outs reference for steri (iv) At 11:55 AM S remembers printin instruments, howe locate them at tha The facility immed not following IFU's plan of correction 12/8/17. Reference #2: AA Advancement of M Sterilization in Heis states in ST 79 se states, "The clear written IFU should	D&E tray consist's of the ents: rs urer's IFU were requested. Staff #9 confirmed there were no the D&E instruments. rmed he/she uses the signage side of the sterilizer, as his/her lization parameters. Staff #7 confirmed he/she ig the IFU's for the D&E ever he/she was unable to t time. Staff #7 confirmed he/she ig the IFU's for the D&E ever he/she was unable to t time. diately curtailed the practice of s for instruments. An acceptable was received by the facility on AMI (Association for the Medical Instrumentation) alth Care Facilities, 2015 edition ection 7.5.2 Cleaning agents, aning agent manufacturer's	A4215		Amer	Sicans

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
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A4215	Continued From pag	e 17	A4215			
	water). Manual Clea	of diluent (tepid warm aning: Add 1/4 ounceOne diluents(tepid to elevated				
		45 AM, a tour was conducted on area and the following				
		erved using Ergo-Logistics e Detergent to clean and E tray.				
		erved using several pumps of hen mixing the enzyme				
		d he/she uses approximately f enzyme detergent to (1) gallon of water."				
	out one (1) gallon of	sked how he/she measures water, pointed to half-way up 'I usually fill the water to				
		ed there is no marking in the measured to exactly one				
	and dispensed One	erved using a measuring cup Cleaner Enzyme Detergent up and poured it into the sink			Ś	R
	(vi) Staff #8 confirme was a one-half (1/2)	ed that the measuring cup cup.			Amor	
	(vii) Staff #8 was neithe enzyme solution	ither measuring the water nor correctly.			Ameri	tor
TE FORM			⁶⁸⁹⁹ 9LC	DL11	for	tion speet 18 (

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED
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A4215	Continued From page	e 18	A4215			
	2. The above finding #2.	was confirmed with Staff				
A4674	8:43A-17.1(e) HOUSKEEPING-SAN HOUSKEEPING P&F		A4674			
	correctly labeled with and its use, as specif	fecting agents shall be the name of the product ied by the manufacturer, have been repackaged from				
	by: Based on observation determined that the fa cleaning and disinfec	is not met as evidenced n and staff interview, it was acility failed to ensure all ting agents are labeled with uct and its use, as specified				
	and Prevention] Guid	[Centers for Disease Control eline for Disinfection and				
	84 states, " By law, instructions on EPA-r followed. If the user that differ from those product label, the use injuries resulting from	care Facilities, 2008 page all applicable label egistered products must be selects exposure conditions on the EPA-registered er assumes liability from any the off-label use and is enforcement action under			Amer	Bican
ATE FORM			6899 9L	OL11	Uni for	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE S COMPL	
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AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE	1 12/	00/2011
	HILL WOMENS CENTER	502 KIN	GS HIGHWAY NORT	н		
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A4674	Continued From pag	e 19	A4674			
	"Bactericidal Stabil	uctions for Use (IFU) states, ity of Use-Dilution:Always abeled dry containers when				
	conference, Staff #2 Infection Control pro Disease Control (CD Health Administration	0 AM during the entrance confirmed that the facility's gram is based on Center for IC), Occupational Safety and In (OSHA), Association for the dical Instrumentation (AAMI), inmendations.				
	cleaning in Operating AM, Staff #10 was of	on of a room turnover g Room (OR) #1 at 11:10 bserved using a green n, to clean the OR floor.				
	Watering Can contai	Staff #10 confirmed the ned diluted Cetylcide-II wever was unsure of who				
	in the morning, and u	ed he/she dilutes the solution uses two (2) oz. (ounces) of to one (1) gallon of water.				
		n was unlabeled and failed of the product and its use, as ufacturer.			~	
A4797	0.10/(11/(4)(10)	I&SAFTY:ENVIRNMNTL PT	A4797		S	B
		nmental condition shall be nd environmental surfaces			Amer I Ini	ican
E FORM			⁶⁸⁹⁹ 9LC	N 11	for	

New Jers	sey Department of Hea	Ith				i ora	INTER COLD
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE S COMPL	
		22445	B. WING			12/0	08/2017
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A4797	Continued From page	e 20	A4797				
	shall be kept clean to						
		is not met as evidenced					
	by: Based on observatior	h and staff interview					
	conducted on 12/08/1	17, it was determined the					
	-	e that all environmental ned clean to sight and touch.					
	Findings include:						
	1. During a tour cond 10:30 AM, in the pres following were noted:						
	-	residue was identified on cated within the clean utility					
	b. The cabinet base decontamination roor would preclude clean	n was damaged which					
		he pass-thru window in the ibited uncleanable wood-like					
		procedure table being used ed grimy and had a rust-like e.				S.	3
		ice damage and open parted n the monolithic flooring ng locations:				meri	icans
STATE FORM			6899	9LOL11		If continua	tion speet 21 of 22
					10	JII	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		22445			12/	08/2017
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A4797	Continued From pag	e 21	A4797			
	(i) The integral floor	base within OR #1.				
	(ii) In the hallway ad	jacent to OR #2.				
	2. These findings we	ere confirmed by Staff #7.				
					C (7)	5
					E,	5
					Amer	ican
					Uni	ter
E FORM			6899 QI (DL11	for	tion sheet 22

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
	A. Building		DATE OF REVISIT	
	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		DATE	ITEM			DATE	ITEM		DATE
Y4		Y5	Y4			Y5	Y4		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
			130				130		
ID Prefix	A2432	Correction	ID Prefix	A3945		Correction	ID Prefix	A4071	Correction
Reg. #	8:43A-9.5(b)	Completed	Reg. #	8:43A-1	3.4(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-1	4.2(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-1	7.1(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		CV2
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REVIEWED BY REVIEWED BY STATE AGENCY (INITIALS)			DATE SIGNATURE OF		SURVEYOR	-	U	rited	
REVIEWED BY REVIEWED BY CMS RO (INITIALS)			DATE TITLE			fortife			
FOLLOW	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?								
			•		Page 1 of 1			EVENT ID:	9LOL12



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



	sey Department of H	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPI	ETED
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A 000	INITIAL COMMEN	TS	A 000			
	This was a State R on 12/7/2018 and 1	e-Licensure survey conducted 12/8/2017.	Ł		pope utello	
	Medical records re	viewed: 20		(
	Personnel files rev	iewed/staff interviews: 23		· · · · · · · · · · · · · · · · · · ·	1. 4. 1.	
A1185	8:43A-3.5(d)(1) GE PERSONNEL	EN REQUIREMENTS:	A1185			
	of employment and education regardin plans and procedu and control progra policies and proce and, if appropriate	receive orientation at the time d at least annual in-service ig, at a minimum, emergency res, the infection prevention m, universal precautions, dures concerning patient right , given the patient population cation of cases of child abuse e.	S,			
	by: Based on docume conducted on 12/8 the facility failed to receive orientation at least an annual at a minimum, em the infection preve universal precaution	ENT is not met as evidenced int review and staff interview 8/2017, it was determined that be ensure that all personnel in at the time of employment ar in-service education regardin ergency plans and procedures ention and control program, ons, policies and procedures t rights, and identification of	nd g,		SS	8
	Findings include:				Amerio	ans
	1 A review of (11) eleven out of (11) eleven			Init	bd

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 the plan o **for Life**
- 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 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 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.





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.



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.



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



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	



	-	ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE	SURVEY PLETED
		31C0001113	B. WING			12/	08/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	This was a Federal F conducted on 12/7/20	Recertification Survey 017 and 12/8/2017.					
		tantial compliance with ness Regulation CFR					
Q 000		2 CFR Part 416, Subpart C oulatory Surgical Centers.	Q 0	00			
	12/7/2017. The facilit manufacturers' Instru followed for reproces (D&E) instruments. T	rdy (IJ) was identified on y failed to ensure that ctions For Use (IFUs) are sing Dilation and Evacuation he IJ was removed on pt of an acceptable plan of					
	The following Conditi to be out of complian	on for Coverage was found ce:					
Q 081	416.51 Infection Com PROGRAM SCOPE; CFR(s): 416.43(a), 4	PROGRAM ACTIVITIES	Q 0	81			
	limited to, an ongoing measurable improver outcomes, and impro quality indicators or p associated with impro the identification and	ves patient safety by using erformance measures oved health outcomes and by reduction of medical errors.				Ś	3
	(a)(2) The ASC must quality indicators, adv	measure, analyze, and track /erse patient events,			An	ieri	cans
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	E	TITLE	U	11	(X6) DATE 93/42/2918
Any deficiency	statement ending with an a	sterisk (*) denotes a deficiency which the on to the patients. (See instructions.) Ex	institution may	be excused from correcting providing it homes, the findings stated above are o	is determined t	r	ife

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 to the 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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31C0001113	B. WING			12/	08/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
CHERRY I	HILL WOMENS CENTER				02 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
Q 081	furnished in the ASC. (c)(1) The ASC must performance improve (i) Focus on high r problem-prone areas. (ii) Consider incide severity of problems i	other aspects of udes care and services set priorities for its ment activities that - isk, high volume, and ence, prevalence, and	Q	081			
	Based on review of fainterview on 12/8/201 facility failed to estable	not met as evidenced by: acility documents and staff 7, it was determined that the ish an ongoing program that peration and ensures patient					
	Findings include:						
	'Quality Improvement members of the Quali (QIC) are responsible review functions outlin completed; Prioritizing for review; Assuring ti through QI activities a recommendations ma up of a problem resol ongoing findings, stud trends to the Governi	ity improvement Committee for: Assuring that the ned in this plan are g issues referred to the QIC hat the data obtained				S.	S cans
	as appropriate"				AI	neri	calls

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31C0001113	B. WING _			12/	08/2017
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY H	HILL WOMENS CENTER				02 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
Q 081	 Staff #2 provided e improvement Activitie improvement activities referenced document which staff member c different QI indicators The quality assura from 2/26/16 to 8/10/2 did not include evider collected and tracked During interview, S explain what the facili data. The facility was un data analysis, recomm the data collected, as document. PERFORMANCE IMF CFR(s): 416.43(d) The number and s improvement projects reflect the scope and services and operatio The ASC must doo being conducted. The minimum, must include implementing the projects 	evidence of quality s Schedule for performance s as outlined in the above . The schedule outlined ollected data for the nce (QA) meeting minutes 2017 provided by Staff #2, nce of how the data was Staff #2 was unable to ty did with the collected able to provide evidence of nendations and follow up of per the above referenced PROVEMENT PROJECTS coope of distinct complexity of the ASC's ns.	Q (DEFICIENCY)		
	project's results					S	8
		not met as evidenced by: iew and document review, it			An	neri	cans

Event ID: NNPM11

Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES			FOI	RM APPROVED NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		31C0001113	B. WING		1	2/08/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Q 083 Q 181	that a specific annual was conducted.Findings include:1. Upon interview on #3 indicated that they	the facility failed to ensure quality improvement project 12/8/2017, Staff #2 and Staff had not undertaken a y improvement project for	Q 08			
	Drugs must be prepa according to establish standards of practice This STANDARD is n A. Based on docume interview conducted of determined that the fa medications administ writing. Findings include: 1. The administration 9/29/17 at 11:17 AM, Record #13.	ned policies and acceptable not met as evidenced by: ent review and staff				
Q 184	for Morphine. VERBAL ORDERS CFR(s): 416.48(a)(3)		Q 18	34	Amer	o icans
FORM CMS-256	7(02-99) Previous Versions Obs	volete Event ID: NNP	M11	Facility ID: NJ310001113	for	Life

		ID HUMAN SERVICES MEDICAID SERVICES						APPROVED 0.0938-0391	
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN				(X3) DATE SURVEY COMPLETED		
		31C0001113	B. WING				12/	08/2017	
NAME OF PF	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	Ξ			
CHERRY H	HILL WOMENS CENTER			502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
Q 184	Orders given orally fo	r drugs and biologicals must en order signed by the	Q 1	84					
	Based on document conducted on 12/8/17 facility failed to ensure	es addressing the signing of							
	Findings include:								
		d, "Verbal Orders" fails to e for signing of verbal per.							
Q 240	2. This finding was c INFECTION CONTRO CFR(s): 416.51	•	Q 24	40					
		ain an infection control o minimize infections and ses.							
	Based on observatio staff interview, it was							2	
	Findings include:						S	び	
	-	o ensure that medications g aseptic technique. Refer to				An	neri	cans	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: NNPM11

Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		31C0001113	B. WING			12	/08/2017
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY I	HILL WOMENS CENTER				502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 240	Continued From page Tag Q 241.	9 5	Q	240			
	sanitary environment	o ensure that a safe and is maintained for patients, public. Refer to Tag Q 241.					
	3. The facility failed t manufacturers' instru Refer to Tag Q 241.	o ensure that ctions for use are followed.					
		o ensure adherence to CDC ygiene. Refer to Tag Q 241.					
		o ensure implementation of res addressing safe injection g Q 241.					
		o ensure implementation of res addressing OR attire.					
	-	o ensure that its Infection ided that the facility followed er to Tag Q 242.					
Q 241			Q	241	1		
						S.	S S
	This STANDARD is r	not met as evidenced by:			A	mer	icans
FORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: NNPI	vi11	Fa	acility ID: NJ310001113	in lation she	



CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRU A. BUILDING 31C0001113 B. WING	RUCTION	DMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 12/08/2017	
31C0001113 B. WING	DDRESS, CITY, STATE, ZIP CODE	12/08/2017	
	DDRESS, CITY, STATE, ZIP CODE		
CHERRY HILL WOMENS CENTER	S HIGHWAY NORTH HILL, NJ 08034		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
Q 241 Continued From page 6 Q 241 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. Q 241 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/guideline s/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		Salericans	

Event ID: NNPM11

Facility ID: NJ310001113



	-	ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391
		MEDICAID SERVICES	(X2) MUL	TIPLE	E CONSTRUCTION		5. 0936-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _			PLETED
		31C0001113	B. WING			12	/08/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CHERRY	HILL WOMENS CENTER			5	502 KINGS HIGHWAY NORTH		
				0	CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Q 241	public.Findings include:1. During a tour conc presence of Staff #7,	e 7 ts, staff and the general ducted at 10:30 AM, in the the following were noted: residue was identified on	Q	241			
	cabinetry surfaces lo room.	cated within the clean utility					
	b. The cabinet base decontamination room would preclude clean	n was damaged which					
	-	he pass-thru window in the ibited uncleanable wood-like					
	d. The base on the p within OR #1 appeare rust-colored residue o						
		ce damage and open parted a the monolithic flooring ng locations:					
	(i) The integral floor b	base within OR #1					
	(ii) In the hallway adj	acent to OR #2					
		re confirmed by Staff #7.				S	ß
	C. Based on observa review of facility docu	ation, staff interview, and ments, and nationally				し、	J ⁻
	-	s, it was determined that the			Ar	neri	cans

Event ID: NNPM11

Facility ID: NJ310001113



CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31C0001113	B. WING			12/	08/2017
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
					502 KINGS HIGHWAY NORTH		
CHERRY	HILL WOMENS CENTER				CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Q 241	instruments. Findings include: Reference #1: AAMI Advancement of Med Sterilization in Health states in ST 79 section written IFU, states, "T manufacturer should 1. On 12/7/17 at 9:40 conference, Staff #2 of Infection Control prog Disease Control (CDO Health Administration for the Advancement (AAMI), guidelines and 2. On 12/7/17 at 10:1 of the reprocessing at revealed: a. A soiled D&E tray Staff #9 confirmed the following instruments - 8 Cervical dilators - 2 Allis Clamps - 1 Tenaculum - 1 Sponge forcep - 2 Curettes - 1 Speculum	 (IFU) are followed for and Evacuation (D&E) (Association for the ical Instrumentation) Care Facilities, 2015 edition on 7.2.2 Manufacturers' The written IFU of the device always be followed." O AM during the entrance confirmed that the facility's gram is based on Center for C), Occupational Safety and (OSHA), and Association of Medical Instrumentation ad recommendations. I3 AM, a tour was conducted rea and the following was was being reprocessed. e D&E tray consist's of the 	Q	241		Š	S
	- 1 small basin				_) -
	(i) The manufacturer	's IFU were requested.			An	neri	cans
						40 44	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: NNPM11

Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED
		31C0001113	B. WING			12	/08/2017
NAME OF PI	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CHERRY I	HILL WOMENS CENTER				502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 241	 (ii) At 10:34 AM Staff IFU's for the D&E inst in the sterilization roo (iii) Staff #9 confirme posted on the outside reference for sterilization (iv) At 11:55 AM Staff remembers printing the instruments, however them at this time. The above finding rest Jeopardy which curtations The above finding rest Jeopardy which curtations The above finding rest Jeopardy which curtations Reference #2: AAMI Advancement of Med Sterilization in Health states in ST 79 sections States, "The cleaning written IFU should be Reference #3: Ergo-IEnzyme Detergent latistates, "Soaking: Add cleaner per 1 gallon temperature water). On 12/7/17 at 10:4 of the decontamination was revealed: 	 #9 confirmed there were no truments, available for use m. d he/she uses the signage of the sterilizer, as his/her tion parameters. #7 confirmed he/she he IFU's for the D&E he/she is unable to locate sulted in an Immediate iled this practice. The was removed on 12/8/17, ceptable plan of correction. (Association for the ical Instrumentation) Care Facilities, 2015 edition on 7.5.2 Cleaning agents, ag agent manufacturer's followed." Logistics One Cleaner bel Directions for Use d 1/4 to 1/2 ozOne of diluent (tepid warm ing: Add 1/4 ounceOneOneOidiluents(tepid to elevated 45 AM, a tour was conducted on area and the following 	Q	24		S.	S
		rved using Ergo-Logistics Detergent to clean and				ner	cans

Event ID: NNPM11

Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		31C0001113	B. WING			12/	08/2017
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY I	HILL WOMENS CENTER				02 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Q 241	 enzymatic, when mixinand water. (ii) Staff #8 confirmed twelve (12) pumps of one-half (1/2) to one of the sink and replied "labout one (1) gallon of with the sink and replied "labout here." (iv) Staff #8 confirmed sink nor is the water of gallon. (v) Staff #8 was observed of water. (vi) Staff #8 confirmed water. (vii) Staff #8 confirmed water. (vii) Staff #8 confirmed water. 2. The above finding #2. D. Based on observed review of nationally red determined that the factors. 	E tray. rved using several pumps of ing the enzyme detergent d he/she uses approximately enzyme detergent to (1) gallon of water." sked how he/she measures water, pointed to half-way up I usually fill the water to d there is no marking in the measured to exactly one erved using a measuring cup Cleaner Enzyme Detergent up and poured it into the sink ed that the measuring cup cup. ther measuring the water nor t correctly. was confirmed with Staff ation, staff interview, and ecognized guidelines, it was acility failed to ensure a	Q	241		S	ŝ
		y environment for the services by adhering to CDC Control and Prevention)			Ar	neri	cans

Event ID: NNPM11

Facility ID: NJ310001113



	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		31C0001113	B. WING		12/08/2017
	ROVIDER OR SUPPLIER		50	TREET ADDRESS, CITY, STATE, ZIP CC D2 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034	DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
Q 241	Advisory Committee) Findings include: Reference #1: Guide Health Care Settings Healthcare Infection Committee[HICPAC] HICPAC/SHEA/APIC Force, published in th Control and Preventi Weekly Report at MM page 32 states, "Recommendations: Handwashing and Ha are not visibly soiled, rub for routinely deco all other clinical situa 1C-J Alternatively, antimicrobial soap ar situations described hands after contact w mucous membranes dressings if hands ar Decontaminate hand 1. On 12/7/17 at 9:4 conference, Staff #2 Infection Control prop Disease Control (CD Health Administratior Advancement of Med guidelines and recon	e Infection Control Practices guidelines on hand hygiene. eline for Hand Hygiene in : Recommendation of the Control Practices Advisory and the //IDSA Hand Hygiene Task the CDC (Centers for Disease on) Morbidity and Mortality //WR 2002; 51 (No. RR-16) 1. Indications for and antisepsisB. If hands use an alcohol-based hand ontaminating hands in tions described in items wash hands with an nd water in all clinical in items G. Decontaminate with body fluids or excretions, nonintact skin, and wound e not visibly soiled J. s after removing gloves" 0 AM during the entrance confirmed that the facility's gram is based on Center for C), Occupational Safety and n (OSHA), Association for the dical Instrumentation (AAMI), mendations. 45 AM, in the m, Staff #8 was cleaning and ay.	Q 241		Americans
RM CMS-256	37(02-99) Previous Versions Ob	solete Event ID: NNP	M11 Fac	sility ID: NJ310001113	for Life

DEPARTMENT OF HEALTH AND HUMAN SERVICES



	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE	
		31C0001113	B. WING			12/	08/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
CHERRY H	HILL WOMENS CENTER			502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
Q 241	Staff #8 removed his/ perform hand hygiene decontamination room (i) The hand washing area was filled with ch alcohol-based hand m accessible. (ii) When asked how hands, Staff #10 repli sink out there" and po (iii) When asked if he hand rub, Staff #10 repli sink out there" and po (iii) When asked if he hand rub, Staff #10 repli of hand sanitizer that the decontamination of 3. At 11:16 AM, durin and disinfecting of Op between patients, the a. Staff #10 was usin green towel to clean a (i) Staff #10 then faile prior to exiting the OF can and mop. (ii) After obtaining the Staff #10 returned to gloves on, mopped th his/her gloves prior to watering can and mop (iii) Staff #10 then ref	disinfecting the D&E tray, her gloves and failed to a prior to exiting the n. g sink in the decontamination hux pads and the ub was not readily he/she washes his/her ed, "Sometimes I use the binted to the OR corridor. e/she uses alcohol-based eplied by pointing to a bottle was up high on a shelf in room. og an observation of cleaning berating Room (OR) #1, following was revealed: and disinfect the OR. ed to remove his/her gloves, R to obtain a green watering e watering can and mop, the OR, with the same he floor, and failed to remove o exiting the OR to return the p. moved his/her gloves and	Q 24	11		S	S
		d hygiene, prior to obtaining			An	neri	cans

Event ID: NNPM11

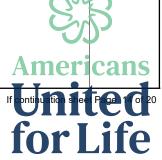
Facility ID: NJ310001113



		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		31C0001113	B. WING		12/	/08/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY H	HILL WOMENS CENTER			502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
Q 241	Continued From page	9 13	Q 24	.1		
	policy, it was determinensure that facility po	tion and review of facility ned that the facility failed to licy and CDC (Centers for lelines for hand hygiene				
	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."					
	Health Care Settings: Healthcare Infection (Committee[HICPAC] = HICPAC/SHEA/APIC/ Force, published in the Control and Prevention Weekly Report at MM states, "Recommenda Handwashing and Ha Decontaminate hands contact with patients after contact with a patient	(IDSA Hand Hygiene Task the CDC (Centers for Disease on) Morbidity and Mortality IWR 2002; 51 (No. RR-16) ations: 1. Indications for and antisepsis C. s before having direct F. Decontaminate hands				
	1. During an observat was revealed:	tion on 12/7/17, the following			S	Ω.
		oom at 10:26 AM, Staff #12 s, failed to perform hand iched Patient #1.		A	meri) cans
				T	T	

Event ID: NNPM11

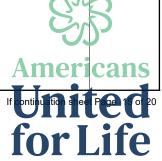
Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURV COMPLETED		
		31C0001113	B. WING _			12/	08/2017
NAME OF PF	ROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY H	HILL WOMENS CENTER				02 KINGS HIGHWAY NORTH HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Q 241	failed to perform hand Patient #1 to the Lab b. In the Consult Roo failed to perform hand a physical assessment c. In the Post Anesthe 12:25 PM, Staff #18 ter failed to perform hand medications from the area. F. Based on observative review of facility polic facility failed to ensure were followed in acco Findings include: Reference #1: Facility Administration; Contro "Procedure 7. Mult within 28 days of ope date when discarding Reference #2: United (USP) General Chapt multi-dose has been on needle-punctured) the discarded within 28 d specifies a different (st that opened vial."	 #12 doffed his/her gloves, d hygiene, and then escorted Room. m at 11:00 AM, Staff #14 d hygiene before performing nt on Patient #1. esia Care Unit (PACU) at entered the PACU from the) Suite already wearing n doffed his/her gloves, d hygiene, and obtained PACU medication storage tion, staff interview, and y, it was determined that the e safe injection practices ordance with its policies. y policy titled, Medication - ol and Storage of states, i use vials must be used ning. Do not use expiration 	Qź	241		Sa	3
		tion in the Post Anesthesia 12/7/17, at approximately			Ar	neri	cans

Event ID: NNPM11

Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		31C0001113	B. WING			12	/08/2017
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CHERRY I	HILL WOMENS CENTER				502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
Q 241 Q 242	12:35 PM, Staff #18 of Nubian from an open medication from the w ready to be administer a. During an interview the medication vial has the above medication no date of opening or G. Based on observa policy, it was determine ensure that staff follor Operating Room (OR Findings include: Reference: Facility por "Surgical caps must be areas of the operating must be covered." In the operating room approximately 11:55 of failed to contain all th surgical cap. INFECTION CONTRO CFR(s): 416.51(b) The ASC must mainta designed to prevent, infections and commu- addition, the infection program must include ASC has considered,	bbtained a multidose vial of box. Staff #18 withdrew the vial and confirmed that it was ered to the patient.		24		S.	S
					A	mer	cans
				-			

Event ID: NNPM11

Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES				-	FORM	APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTR			X3) DATE COMP	SURVEY
		31C0001113	B. WING				12/0	08/2017
NAME OF PF	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	-		
CHERRY H	HILL WOMENS CENTER				S HIGHWAY NORTH HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	E	(X5) COMPLETION DATE
Q 242	Continued From page	e 16	Q 24	12				
	A. Based on staff int review, it was determ ensure that the select	guidelines for infection						
	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."							
	a. Staff #2 confirmed and implemented the	that the facility has selected following guidelines:						
	Instrumentation (AAM - Occupational Safety (OSHA) regulations	Advancement of Medical II) and Health Administration Control and Prevention				1	S	S cans
	(CDC)							Calls

Event ID: NNPM11

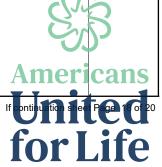
Facility ID: NJ310001113



	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		31C0001113	B. WING			12/	08/2017
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY H	ILL WOMENS CENTER				502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
Q 242	Continued From page b. The facility's Infect provided and reviewe guidelines were select documented evidence selected by the facility 2. The above finding B. Based on observa of facility policies and recognized guidelines determined that the fa ongoing Infection Cor OSHA regulations are Findings include: Reference #2: OSHA (3)(i) states, "Provisio occupational exposur provide, at no cost to personal protective ed limited to, gloves, gov shields or masks and mouthpieces, resusci or other ventilation de	tion Control Program was d. Although CDC and OSHA eted, there was no e that AAMI guidelines were y. was confirmed by Staff #2. tion, staff interview, review procedures, and nationally and regulations, it was acility failed to ensure an notrol program that adheres to a implemented. A 29 CFR part 1910.1030(d) n. When there is e, the employee, appropriate quipment such as, but not vns, laboratory coats, face eye protection, and tation bags, pocket masks, evices. Personal protective asidered "appropriate" only if		242	DEFICIENCY)		
	the employee's work undergarments, skin,					Su	
	conference, Staff #2 of	AM, during the entrance confirmed that the facility's ram is based on Center for			An	neri	cans

Event ID: NNPM11

Facility ID: NJ310001113



		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		31C0001113	B. WING			12	/08/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CHERRY	HILL WOMENS CENTER				502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
Q 242	Disease Control (CDC for the Advancement (AAMI), guidelines and 2. On 12/7/17 at 10:4 Decontamination area manually cleaning and Evacuation (D&E) tray a. Staff #8 was obset conception from a gla (i) Staff #8 was donn (ii) The Eclipse gown gown is a Level 2 per (iii) On 12/8/17, Staff were level 2 permeab b. The facility failed to Decontamination area Reference #3: OSHA (2)(xiii) states, "Speci potentially infectious r a container which pre collection, handling, p transport, or shipping Reference #4: Facilit Specimens" states, "F procedure is finished suction bottle and tak Room in preparation f Laboratory1. Dec transfer the speciment	 C), OSHA, and Association of Medical Instrumentation d recommendations. 40 AM, in the a, Staff #8 was observed d disinfecting a Dilation and y. rved pouring products of ss jar into a Styrofoam cup. ed in a blue surgical gown. a packaging indicates the meable gown. #7 confirmed the gowns le gowns. a ensure staff in the a wear impervious gowns. A 29 CFR part 1910.1030(d) mens of blood or other materials shall be placed in vents leakage during processing, storage, y policy titled, "Laboratory Policy:2Once the the specimen is kept in the en into the Decontamination 	Q	242		S. neri	Scans

Event ID: NNPM11

Facility ID: NJ310001113



CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		31C0001113	B. WING			12/08/2017	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY I	HILL WOMENS CENTER				502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Q 242	container. 3. The ste that the specimen tract the outside door of th Care Unit) closet to th laboratory technician, container and drop it 1. On 12/7/17 at 10:4 Decontamination area manually cleaning an Evacuation (D&E) tra a. Staff #8 was obsel conception from a gla with a lid. (i) Staff #8 placed on Styrofoam cup, a yell patients first name an (ii) Staff #8 then plac and transported the s	Be careful not to overload erilization technician will see insport container is taken to e PACU (Post Anesthesia he laboratory. 4. The will take the transport off at the laboratory." 0 AM, in the a, Staff #8 was observed d disinfecting a Dilation and y. rved pouring products of has jar into a Styrofoam cup	Q	242		Sameri	Scans
	7/02 00) Brovieus Versions Obs					10 11	Fod

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: NNPM11

Facility ID: NJ310001113



POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
31C0001113 _{Y1}	B. Wing	Y2	4/17/2018	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY HILL WOMENS CENTER	R	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).

ITE	м	DATE	ITEM			DATE	ITEM		DATE
Y4		Y5	Y4			Y5	Y4		Y5
ID Prefix	Q0081 416.43(a), 416.43	Correction	ID Prefix	Q0083 416.43(d)		Correction	ID Prefix	Q0181 416.48(a)	Correction
Reg. #		Completed	Reg. #			Completed	Reg. #		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	<u> </u>	Correction
Reg. #		Completed	Reg. #			Completed	Reg. #		Completed
LSC			LSC				LSC	-Ameri	cans
REVIEWE STATE AG		REVIEWED BY (INITIALS)	DATE	SIGI	NATURE OF SU	RVEYOR		Umit	ed
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	тіті	LE			fop ate	life
FOLLOW	JP TO SURVEY CO 7	DMPLETED ON				D DEFICIENCIES CMS-2567) SEN ⁻			s 🗌 no

NNPM12

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	



DEPART	FORM APPROVED								
CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		31C0001113	B. WING _	B. WING			12/08/2017		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
CHERRY	HILL WOMENS CENTER			50	2 KINGS HIGHWAY NORTH				
ONERRY				CH	HERRY HILL, NJ 08034				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	DATE			
IAG			TAG		DEFICIENCY)				
K 000	INITIAL COMMENTS		K 0	000					
	This was a Federal F	Recertification Survey							
	conducted on 12/08/1	-							
	This facility is not in s	ubstantial compliance with							
		ection Association's 2012							
		his Federal Recertification							
14 004	Survey.								
K 321	Hazardous Areas - Er CFR(s): NFPA 101	nciosure	K 3	521					
	CFR(S). NFFA 101								
	Hazardous Areas - Ei	nclosure							
	Hazardous areas mus	st meet one of the following:							
	*Contain 1 hour rated	l enclosure when							
	non-sprinklered								
	*Sprinkler protected v	vith smoke resistive							
	separation	ions 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 r								
	Based on observation and staff interview on								
		rmined the facility failed to e environment is maintained							
	for patients, staff and								
	Findings include:								
	1 During a tour conc	lucted at 10:30 AM, in the							
	•	the ceiling installed within							
	the basement was for								
		g tiles. This would allow the				Cur	\mathbf{R}		
	passage of smoke from one area to another					Cr	N		
	inside the building.								
	2. This finding was confirmed by Staff #7.				An	neri	cans		
		SUPPLIER REPRESENTATIVE'S SIGNATUF			TITLE		X6 PTF		
	DIRECTORS ON FROMDER/S	SOLI LILICITEI REGENTATIVE S SIGNATUR	.				03 12/2012		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is deter d 0 other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosa 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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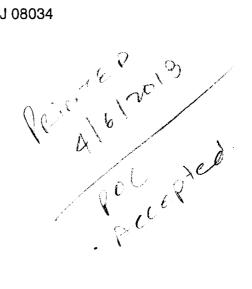
PRINTED: 02/27/2019

	-	ID HUMAN SERVICES			FORM	: 02/27/2019 APPROVED		
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG 01	(X3) DATE	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		31C0001113	B. WING _		12/(08/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	12/00/2017		
CHERRY	HILL WOMENS CENTER			502 KINGS HIGHWAY NORTH CHERRY HILL, NJ 08034				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE		
					S	2		
					S.	5		
					Ameri			
ORM CMS-25	67(02-99) Previous Versions Obs	solete Event ID: NN	PM21	Facility ID: NJ310001113	If continuation she			
				1	forL	life		



CHERRY HILL WOMEN'S CENTER

502 Kings Highway North ◆ Cherry Hill NJ 08034 (856) 667-5910 ◆ (800) 87∵-6331 Fax: (856) 667-8304



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, plt ase do not hesitate to reach out to me.

Sincerely,

Jenifer Groves, MEd, MBA Administrator Cherry Hill Women's Center





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. \checkmark
- 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.
- 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 material 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 starilization staff member.



Americans

- 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 Nurs ng 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 PcC 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 Porl is adhered to.
- 5. The corrective action will be completed on 4.13.18
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- 3. To ensure that compliance is maintained, the Director o 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 qualterly 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
- 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.
- 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 dc cumented 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 Canas Instrumentation (AAMI), Occupational Safety and Health Administration (OSA) and ited Centers for Disease Control and Prevention (CDC).

- b. Ensuring that staff in decontamination area wears 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 plan.
 - b. The facility's Deputy Administrator will update the facility's PPE policy to reflect this change and will provide staff with education for all personnel regarding this update.
 - c. The facility's Deputy Administrator will provide e-Jucation 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:
 - 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

