The Joint Commission

Pacific Coast Surgical Center
3720 W. Lomita Blvd., Suite 100
Torrance, CA 90505

Organization Identification Number: 556117

Program(s)	**Survey Date(s)**
Ambulatory Health Care Accreditation	03/17/2014-03/19/2014

Executive Summary

Ambulatory Health Care Accreditation :

As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Ambulatory Health Care Accreditation Program	
Standards:	EC.02.01.01	EP8
	IC.02.02.01	EP2
	MM.03.01.01	EP2,EP9

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Ambulatory Health Care Accreditation Program	
Standards:	EC.02.03.05	EP15
	EM.03.01.03	EP1
	IC.02.04.01	EP1
	LD.03.05.01	EP4
	LD.04.04.01	EP1,EP16
	LS.03.01.10	EP6,EP9
	LS.03.01.20	EP17
	MM.01.01.03	EP1,EP2
	PI.02.01.01	EP8
	RI.01.05.01	EP4
	UP.01.03.01	EP2
	WT.04.01.01	EP2

CFC: §416.41 **Tag:** Q-0040 **Deficiency:** Standard

Corresponds to: AHC

Text: §416.41 Condition for Coverage: Governing Body and Management

The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that the facility policies and programs are administered so as to provide quality healthcare in a safe environment, and develops and maintains a disaster preparedness plan.

CFC Standard	Tag	Corresponds to	Deficiency
§416.41(c)(3)	Q-0043	AHC - EM.03.01.03/EP1	Standard

CFC: §416.42 **Tag:** Q-0060 **Deficiency:** Standard

Corresponds to: AHC - IC.02.02.01/EP2

Text: §416.42 Condition for Coverage: Surgical Services

Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC.

CFC: §416.43 **Tag:** Q-0080 **Deficiency:** Standard

Corresponds to: AHC

Text: §416.43 Condition for Coverage: Quality Assessment and Performance Improvement

The ASC must develop, implement and maintain an ongoing, data-driven quality assessment and performance improvement (QAPI) program.

CFC Standard	Tag	Corresponds to	Deficiency
§416.43(e)(5)	Q-0084	AHC - LD.03.05.01/EP4	Standard
§416.43(b)(2)(ii)	Q-0082	AHC - PI.02.01.01/EP8	Standard
§416.43(e)(2)	Q-0084	AHC - LD.03.05.01/EP4, LD.04.04.01/EP1	Standard

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CFC: §416.44 **Tag:** Q-0100 **Deficiency:** Standard

Corresponds to: AHC

Text: §416.44 Conditions for Coverage: Environment

The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.

CFC Standard	Tag	Corresponds to	Deficiency
§416.44(b)	Q-0104	AHC - LS.03.01.10/EP6	Standard
§416.44(b)(3)	Q-0104	AHC - EC.02.03.05/EP15, LS.03.01.10/EP9	Standard
§416.44(b)(4)	Q-0104	AHC - LS.03.01.20/EP17	Standard

CFC: §416.48 **Tag:** Q-0180 **Deficiency:** Standard

Corresponds to: AHC - MM.03.01.01/EP2, EP9

Text: §416.48 Condition for Coverage: Pharmaceutical Services

The ASC must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services.

CFC: §416.51 **Tag:** Q-0240 **Deficiency:** Standard

Corresponds to: AHC

Text: §416.51 Condition for Coverage – Infection control

The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases.

CFC Standard	Tag	Corresponds to	Deficiency
§416.51(b)(2)	Q-0244	AHC - LD.04.04.01/EP16	Standard

CFC: §416.50 **Tag:** Q-0219 **Deficiency:** Standard

Corresponds to: AHC

Text: §416.50 Condition for coverage - Patient Rights

The ASC must inform the patient or the patient's representative or surrogate of the patient's rights and must protect and promote the exercise of these rights, as set forth in this section. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable.

CFC Standard	Tag	Corresponds to	Deficiency
§416.50(c)(1)	Q-0224	AHC - RI.01.05.01/EP4	Standard

Chapter: Emergency Management

Program: Ambulatory Health Care Accreditation

Standard: EM.03.01.03 ESC 60 days

Standard Text: The organization evaluates the effectiveness of its Emergency Management Plan.

Primary Priority Focus Area: Communication

Element(s) of Performance:

1. As an emergency response exercise, the organization activates its Emergency Management Plan twice a year at each site included in the plan. 4
Note 1: If the organization activates its Emergency Management Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.
Note 2: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code *) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.
Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.
Footnote *: The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2000 for occupancy classifications.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§416.41(c)(3) - (Q-0043) - (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.
This Standard is NOT MET as evidenced by:
Observed in Emergency Management Session at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the emergency management session, it was noted that there was no evidence of any disaster drills in 2013.

Chapter: Environment of Care

Program: Ambulatory Health Care Accreditation

Standard: EC.02.01.01 ESC 45 days

Standard Text: The organization manages safety and security risks.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

8. The organization controls access to and from areas it identifies as security sensitive.

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

EP 8
Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site.
During the environment of care tracer, it was noted that the rear door to the facility was secured from the outside with a keypad lock; however, there was no automatic closure for that door which prevented this door from not being secured with the locking mechanism.

Chapter: Environment of Care

Program: Ambulatory Health Care Accreditation

Standard: EC.02.03.05

ESC 60 days

Standard Text: The organization maintains fire safety equipment and fire safety building features.
Note: This standard does not require organizations to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

15. At least monthly, the organization inspects portable fire extinguishers. The completion dates of the inspections are documented.
Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory.
Note 2 : Inspections involve a visual check for the presence and correct type of extinguisher, broken parts, full charge, and ease of access.
Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10, Standard for Portable Fire Extinguishers, 1998 edition (Sections 1-6, 4-3, and 4-4).

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 15
§416.44(b)(3) - (Q-0104) - (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the building tour, it was noted that there was no documentation of the required monthly inspections of the fire extinguishers for extinguisher #1.

Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the building tour, it was noted that there was no documentation of the required monthly inspections of the fire extinguishers for extinguisher #2.

Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the building tour, it was noted that there was no documentation of the required monthly inspections of the fire extinguishers for extinguisher #3.

Chapter: Infection Prevention and Control

Program: Ambulatory Health Care Accreditation

Standard: IC.02.02.01 ESC 45 days

Standard Text: The organization reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

2. The organization implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4)
Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.
Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§416.42 - (Q-0060) - §416.42 Condition for Coverage: Surgical Services
This Standard is NOT MET as evidenced by:
Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the infection control tracer, it was noted that there was a mixture of lot numbers being used for quality control for the spore testing for the sterilizers.

Chapter: Infection Prevention and Control

Program: Ambulatory Health Care Accreditation

Standard: IC.02.04.01 ESC 60 days

Standard Text: The organization offers vaccination against influenza to licensed independent practitioners and staff.
Note: This standard is applicable to staff and licensed independent practitioners only when care, treatment, or services are provided on site. When care, treatment, or services are provided off site, such as with telemedicine or telephone consultation, this standard is not applicable to off-site staff and licensed independent practitioners.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

1. The organization establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Credentialing and Privileging at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site.
During the competency and privileging sessions, it was noted that the organization did not have an influenza program in place.

Chapter: Leadership

Program: Ambulatory Health Care Accreditation

Standard: LD.03.05.01 ESC 60 days

Standard Text: Leaders implement changes in existing processes to improve the performance of the organization.

Primary Priority Focus Area: Quality Improvement Expertise/Activities

Element(s) of Performance:

4. Leaders provide the resources required for performance improvement and change management, including sufficient staff, access to information, and training.

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§416.43(e)(5) - (Q-0084) - (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.
This Standard is NOT MET as evidenced by:
Observed in Data Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the data tracer, it was noted that the clinical leaders need additional training to learn to analyze and display data in the QI program. The organization will benefit from having trained individuals to provide leadership, direction and focus to the quality improvement program.

§416.43(e)(2) - (Q-0084) - (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness.
This Standard is NOT MET as evidenced by:
Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the infection control tracer, it was noted that the individuals responsible for implementing the infection control program had not been exposed to extra training in infection control. The needed training will provide the opportunity for the organization to adequately direct the IC program.

Chapter:	Leadership
Program:	Ambulatory Health Care Accreditation
Standard:	LD.04.04.01 ESC 60 days
Standard Text:	Leaders establish priorities for performance improvement. (Refer to the 'Performance Improvement' [PI] chapter.)
Primary Priority Focus Area:	Quality Improvement Expertise/Activities

Element(s) of Performance:

16. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The infection control program is an integral part of the ambulatory surgical center's quality assessment and performance improvement program.

Scoring
Category : A
Score : Insufficient Compliance

1. Leaders set priorities for performance improvement activities and patient health outcomes. (See also PI.01.01.01, EPs 1 and 3)

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§416.43(e)(2) - (Q-0084) - (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness.
This Standard is NOT MET as evidenced by:
Observed in Environment of Care Session at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the environment of care session, it was noted that leadership had not provided sufficient direction for the staff as it related to monitoring the environment. Appropriate monitoring of: annual generator testing, monthly and annual monitoring of the egress lights were not being completed to provide assurance of a safe environment.

EP 16
§416.51(b)(2) - (Q-0244) - (2) An integral part of the ASC's quality assessment and performance improvement program; and
This Standard is NOT MET as evidenced by:
Observed in Infection Control System Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
The organization had not included surgeons in its study of hand hygiene compliance, therefore, the available information on hand hygiene compliance did not
accurately reflect the organization's compliance levels.

Chapter: Life Safety
Program: Ambulatory Health Care Accreditation
Standard: LS.03.01.10

ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.
Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.
Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.
Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

6. Doors required to be fire-rated for 3/4 hour, 1 hour, or 1 1/2 hours have functioning hardware, including positive latching and self-closing or automatic-closing devices. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. (See also LS.03.01.30, EPs 3 and 6) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1 and 8.2.3.2.1; NFPA 80-1999: 2-4.4.3, 2-4.5, 2-3.1.7, 1 -11.4)

Scoring Category : C
Score : Partial Compliance

9. The space around pipes, conduits, bus ducts, cables/wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are filled with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 6
§416.44(b) - (Q-0104) - §416.44(b) Standard: Safety From Fire
This Standard is NOT MET as evidenced by:
Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the infection control tracer, it was noted that the exit door of the sterile hallway, which led to the rear exit of the building, was not activated by a "self closure" device, hence when the rear door was opened, the sterile hallway's air was compromised by unfiltered, external air.

Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
Small sample size. One rear exit applicable.

EP 9
§416.44(b)(3) - (Q-0104) - (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.
This Standard is NOT MET as evidenced by:
Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the building tour, it was noted that there were multiple penetrations in the fire wall, on the east end of the sterile corridor.

Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the building tour, it was noted that there were multiple penetrations in the fire wall, on the west end of the sterile corridor.

Chapter:	Life Safety
Program:	Ambulatory Health Care Accreditation
Standard:	LS.03.01.20 (ESC 60 days)
Standard Text:	The organization maintains the integrity of the means of egress. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).
Primary Priority Focus Area:	Physical Environment

Element(s) of Performance:

17. Illumination in the means of egress, including exit discharge, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness. (For full text and any exceptions, refer to NFPA 101-2000: 7.8.1.4)

Scoring
Category : C
Score : Insufficient Compliance

Observation(s):

EP 17
§416.44(b)(4) - (Q-0104) - (4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006.
This Standard is NOT MET as evidenced by:
Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the EOC tracer, it was noted that the "Frog Lights" over the rear exit door were not operative, when manually activated.

Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the EOC tracer, it was noted that the "Frog Lights" over the sterile hallway exit door were not operative, when manually activated.

Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the EOC tracer, it was noted that the "Frog Lights" in the operating room #1, did not operate when manually activated.

Chapter: Medication Management

Program: Ambulatory Health Care Accreditation

Standard: MM.01.01.03 (ESC 60 days)

Standard Text: The organization safely manages high-alert and hazardous medications.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

1. The organization identifies, in writing, its high-alert and hazardous medications. * (See also EC.02.02.01, EP 8)
Footnote *: For a list of high-alert medications, see http://www.ismp.org. For a list of hazardous medications, see http://www.cdc.gov/niosh/docs/2012-150/.

Scoring Category : A
Score : Insufficient Compliance

2. The organization has a process for managing high-alert and hazardous medications. (See also EC.02.02.01, EP 8; MM.03.01.01, EP 9)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site.
During the medication management tracer, it was noted that the organizaiton did not posses a list of their high alert medications.

EP 2
Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site.
During the medication management tracer, it was noted that the organizaiton had not developed a storage process to help the staff avoid potential medication errors.

Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site.
During the medication management tracer, it was noted that the emergency cart contained 50% Magnesium Sulfate stored in the cart, adjacent to two vials of Narcan, which was packaged similarly.

Chapter: Medication Management
Program: Ambulatory Health Care Accreditation
Standard: MM.03.01.01 (ESC 45 days)
Standard Text: The organization safely stores medications.
Primary Priority Focus Area: Medication Management

Element(s) of Performance:

2. The organization stores medications according to the manufacturers' recommendations.

Scoring Category : C
Score : Insufficient Compliance

9. The organization keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

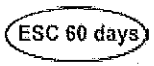
EP 2
§416.48 - (Q-0180) - §416.48 Condition for Coverage: Pharmaceutical Services
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the medication management tracer, it was noted that the one vial of Succinylcholine was located in each of the anesthesia carts without "do not use beyond" date.

Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the medication management tracer, it was noted that the two vials of Rocuronium were located in each of the anesthesia carts without a "do not use beyond" date.

Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the medication management tracer, it was noted that a vial of Lidocaine was located in one of the anesthesia carts, with an opening date but no "do not use beyond" date.

EP 9
§416.48 - (Q-0180) - §416.48 Condition for Coverage: Pharmaceutical Services
This Standard is NOT MET as evidenced by:
Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the medication management tracer, it was noted that two vials of 50% Magnesium Sulfate were located in the emergency cart, without any precautions to help reduce the possibility of medication errors.

Chapter: National Patient Safety Goals
Program: Ambulatory Health Care Accreditation
Standard: UP.01.03.01



Standard Text: A time-out is performed before the procedure.
Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

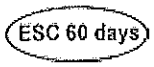
2. The time-out has the following characteristics:
- It is standardized, as defined by the organization.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Individual Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site.
During an individual patient tracer, it was noted that the "time out" process did not include verbal agreement by all of the members of the surgical team.

Chapter: Performance Improvement
Program: Ambulatory Health Care Accreditation
Standard: PI.02.01.01



Standard Text: The organization compiles and analyzes data.
Primary Priority Focus Area: Quality Improvement Expertise/Activities

Element(s) of Performance:

8. The organization uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5; PI.03.01.01, EP 1)

Scoring
Category : A
Score : Insufficient Compliance

Observation(s):

EP 8
§416.43(b)(2)(ii) - (Q-0082) - (ii) Identify opportunities that could lead to improvements and changes in its patient care.
This Standard is NOT MET as evidenced by:
Observed in Data Session at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the data session, it was noted that the organization had collected data on: The timeliness of Ancef infusion; however, the clinical leadership had not received training in the analysis and display of the data.

Chapter: Rights and Responsibilities of the Individual
Program: Ambulatory Health Care Accreditation

Standard: RI.01.05.01 ESC 60 days

Standard Text: The organization addresses patient decisions about care, treatment, or services received at the end of life.

Primary Priority Focus Area: Communication

Element(s) of Performance:

4. The organization's written policies specify whether the organization will honor advance directives.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
§416.50(c)(1) - (Q-0224) - (1) Provide the patient or, as appropriate, the patient's representative prior to the start of the surgical procedure with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service.
During the document review, it was noted that the organization had a process to ask patients if they possessed an advance directive; However, there was no evidence that the patients were informed of the office policy to not honor DNR, advance directives.

Chapter: Waived Testing

Program: Ambulatory Health Care Accreditation

Standard: WT.04.01.01 ESC 60 days

Standard Text: The organization performs quality control checks for waived testing on each procedure. Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

2. The documented quality control rationale for waived testing is based on the following:
- How the test is used
- Reagent stability
- Manufacturers' recommendations
- The organization's experience with the test
- Currently accepted guidelines

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Infection Control System Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site.
During the infection control system tracer, it was noted that the organization performed the QC on their glucometer on a weekly basis regardless of the number of anticipated tests during that week.

Pacific Coast Surgical Center

Organization ID: 556117

3720 W. Lomita Blvd., Suite 100 Torrance, CA 90505

Accreditation Activity - 45-day Evidence of Standards Compliance Form

Due Date: 5/9/2014

AHC Standard EC.02.01.01 The organization manages safety and security risks.

Findings: EP 8 Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site. During the environment of care tracer, it was noted that the rear door to the facility was secured from the outside with a keypad lock; however, there was no automatic closure for that door which prevented this door from not being secured with the locking mechanism.

Elements of Performance:

8. The organization controls access to and from areas it identifies as security sensitive.

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for the overall and on going compliance. Our facility assessed the issue and promptly fixed the door by adding an automatic closure device. This ensures that the door closes on its own and locks automatically. Locking mechanism is enabled after every opening of the door due to automatic device. Correction was overseen by DON.

WHAT:

Issue was brought to the Safety officer and was added to the Safety Check. All automatic door closure devices will be monitored on a monthly bases by the Safety officer. Safety officer will open the doors with automatic devices and check to make sure doors close and latched as intended.

WHEN:

Appointment was made to install automatic closure device on 3/21/14. Jose Montoya arrived on 3/31/14 and installed automatic door closures devices. Devices were assessed by DON on 3/31/14 to ensure proper installment of devices.

HOW:

Safety Officer is to check all automatic door closure devices in monthly walks. Safety Officer will check doors by opening all automatic doors and ensuring the closure and latching of the doors. This will be documented on their monthly safety walk.

AHC Standard IC.02.02.01 The organization reduces the risk of infections associated with medical equipment, devices, and supplies.

Findings: EP 2 §416.42 - (Q-0060) - §416.42 Condition for Coverage: Surgical Services This Standard is NOT MET as evidenced by: Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the infection control tracer, it was noted that there was a mixture of lot numbers being used for quality control for the spore testing for the sterilizers.

Elements of Performance:

2. The organization implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies. * (See also EC.02.04.03, EP 4) Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes. Footnote *: For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).

Scoring Category: A

Corrective Action Taken:

WHO:

The Materials Manager is ultimately responsible for ensuring the corrective action and for overall and ongoing compliance.

WHAT:

Techs were trained in the proper way to test and use controls by the Materials Manager. The manor in which attest are processed has been changed to ensure that the same lot numbers are used for controls and sterilizers. If any attest is without a control or without a test it will be thrown out and test rerun. Only one box and lot number will be used at one time.

WHEN:

Change to how attest are controlled were made on 3/20/14. Training for the techs was done on 3/21/14.

HOW:

Attest will be double checked by Materials Manager to ensure that the training set for is implemented on a daily basis.

AHC Standard MM.03.01.01 The organization safely stores medications.

Findings: EP 2 §416.48 - (Q-0180) - §416.48 Condition for Coverage: Pharmaceutical Services This Standard is NOT MET as evidenced by: Observed in Individual Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the medication management tracer, it was noted that the one vial of Succinylcholine was located in each of the anesthesia carts without "do not use beyond" date. Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the medication management tracer, it was noted that the two vials of Rocuronium were located in each of the anesthesia carts without a "do not use beyond" date. Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the medication management tracer, it was noted that a vial of Lidocaine was located in one of the anesthesia carts, with an opening date but no "do not use beyond" date. EP 9 §416.48 - (Q-0180) - §416.48 Condition for Coverage: Pharmaceutical Services This Standard is NOT MET as evidenced by: Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the medication management tracer, it was noted that two vials of 50% Magnesium Sulfate were located in the emergency cart, without any precautions to help reduce the possibility of medication errors.

Elements of Performance:

2. The organization stores medications according to the manufacturers' recommendations.

Scoring Category: C

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance of the staff.

WHAT:

Situation was assessed by the DON, policy was reviewed and was determined that is was accurate. It was determined that policy needed to be reviewed again by all staff member including Anesthesia. Medication policy regarding expiration dates were posted on all medication cabinets, including the fridge where meds are kept and anesthesia cart. Meetings were held to revisit policy. After every shift, the RN in that room then audits the the anesthesia cart and medication cabinets. Staff was reeducated on the policy. Regarding medication held in crash cart, it was determined by DON that leaving Magnesium Sulfate in crash cart in a bag would not be enough. The change was made to moving medication into a specimen cup with labels on specimens cup within the crash cart.

WHEN:

Policy was reviewed on 3/20/14 and meeting was held in regards to expiration dates on meds on the same day. Meeting was held to reeducate the staff on how to write the expiration dates. Policy was placed around all areas that have that have medications to remind them of the policy. Meeting was held on 3/20/14 and again on 4/11/14. Magnesium Sulfate was placed and noted on specimen bottle, High Alert, specimen bottles were used to make it less likely for wrong drug use. Staff was educated on the change of Magnesium

Sulfate.

HOW:

Crash cart is checked daily and maintained in the way that it was set up by DON. Crash cart is monitored by RN monthly and report is given to DON and DON does quality control on a monthly basis. This maintains that Magnesium sulfate will always be in a specimen container making it harder for a drug mistake to occur. This is done by the closing nurses. All anesthesia carts and mediation cabinets are checked daily for multi dose drugs without expiration dates. As well as the nurses cabinets in the OR room by a designated RN on a daily basis.The DON then audits the OR cabinets on a daily basis. If medication lacks expiration date it is promptly thrown out and a new bottle is put in its place. For medication that require refrigeration, they are dated as soon as they leave the fridge. These medications are also checked daily by a closing nurse.

Evaluation Method: 1. Medication expiration dates will be monitored weekly for four consecutive months. 2. DON will be doing sporadic monitoring of nurses ensuring expiration date are used for all opened and fridge medications. 4. When nurse/lVN is restocking meds in anesthesia cart for that day they much check all meds in drawer for expiration dates. 5. Nurses not following the policy will be reeducated and further steps will be taken to ensure compliance. 6. If it is determined that the same nurse is not in compliance the verbal warning will be given, then if still no compliance a write up will be given, and by the third time of non compliance termination will be given to that nurse

Measure of Success Goal (%): 100

9. The organization keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The Medication Policy was reviewed by The DON and determined that no consequence was active in controlling possible medication that were not labeled with new expiration dates. Education of all RNs seemed fit and reminders of policy were posted by every location where meds are kept and used .The education of all physicians and staff member were completed via staff meetings and physicians with a mini meeting with each individual staff member.

WHEN:

The Medication Policy was review for any flaws on 3/20/14. It was found to have no consequence for any actions regarding the wrong expiration dates on meds. This was revised on 3/20/14. A meeting was held with all RNs and they were educated on the new stipulation of the Medication Policy and also on how to properly date the meds after a multi dose vial is opened. This was done on 3/20/14. Magnesium Sulfate was place in a container with high alert labels all over it to ensure there would be no confusion of medications this was done on 3/19/14.

HOW:

The DON designates one RN to check the every medication cart or cabinet daily. Cabinets/carts are checked for expiration date due to bottle being open.IF medication was not labeled then medication is thrown out and a new bottle is put in its place. The DON then double checks to make sure all meds are in compliance and if not the DON has implemented a new stipulation of the policy, stating that if an RN does not comply with the policy then by the third medication without new expiration date, that RN will be terminated. DON made sure that from 3/19/14 on the Magnesium Sulfate will be kept in the container in the Crash Cart.

Pacific Coast Surgical Center

Organization ID: 556117

3720 W. Lomita Blvd., Suite 100 Torrance, CA 90505

Accreditation Activity - 60-day Evidence of Standards Compliance Form

Due Date: 5/24/2014

AHC Standard EC.02.03.05	**The organization maintains fire safety equipment and fire safety building features. Note: This standard does not require organizations to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.**

Findings: EP 15 §416.44(b)(3) - (Q-0104) - (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. This Standard is NOT MET as evidenced by: Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the building tour, it was noted that there was no documentation of the required monthly inspections of the fire extinguishers for extinguisher #1. Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the building tour, it was noted that there was no documentation of the required monthly inspections of the fire extinguishers for extinguisher #2. Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the building tour, it was noted that there was no documentation of the required monthly inspections of the fire extinguishers for extinguisher #3.

Elements of Performance:

15. At least monthly, the organization inspects portable fire extinguishers. The completion dates of the inspections are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2 : Inspections involve a visual check for the presence and correct type of extinguisher, broken parts, full charge, and ease of access. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10, Standard for Portable Fire Extinguishers, 1998 edition (Sections 1-6, 4-3, and 4-4).

Scoring Category: C

Corrective Action Taken:

WHO:

The Materials Manager is ultimately responsible for the corrective action and for the overall and on going compliance.

WHAT:

This area was reviewed and determined that upon the safety walk, the extinguishers were inspected and documented on the safety walk form instead of in the tag on the extinguishers. This action has been changed and safety officer now documents the inspection of each extinguisher on the tag located on the extinguisher. This portion of documenting the inspection of the extinguisher has been taken off the safety walk documentation.

WHEN:

The action of changing the safety walk documentation was done on 3/31/14. The action of documenting on the extinguisher tag was done on 3/18/14. The safety officer has been notified of the change on 3/20/14.

HOW:

The safety officer has been educated, that upon monthly inspection the documentation of the extinguisher will be documented on the tag located on the extinguisher. This action will be performed on a monthly basis.

Evaluation Method: 1. Safety Officer will do regular inspections monthly. 2. Materials Manager will monitor the inspections for 4 consecutive months. 3. The documentation on all the tag will be checked by the Materials Manager. 4. Results will be reported to Materials Manager . Since the safety walk is done solely by the Safety Officer, no further action is needed to be taken. In the absence of the safety officer the Materials Manager will conduct the safety walk.

Measure of Success Goal (%): 100

AHC Standard EM.03.01.03 The organization evaluates the effectiveness of its Emergency Management Plan.

Findings: EP 1 §416.41(c)(3) - (Q-0043) - (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. This Standard is NOT MET as evidenced by: Observed in Emergency Management Session at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the emergency management session, it was noted that there was no evidence of any disaster drills in 2013.

Elements of Performance:

1. As an emergency response exercise, the organization activates its Emergency Management Plan twice a year at each site included in the plan. Note 1: If the organization activates its Emergency Management Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Note 2: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety

Code *) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually. Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises. Footnote *: The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2000 for occupancy classifications.

Scoring Category: A

Corrective Action Taken:

WHO:

The Material Manager is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

Emergency Preparedness (Disaster) Plan Policy Chapter 8 page 2 was reviewed and determined that a Disaster plan was previously put in place. The Safety Officer updated the disaster policy and was approved by the governing board. Disaster plan now will be done quarterly and be ran by the Safety Officer. The education of all employees and physicians were completed via staff meetings and physician newsletter.

WHEN:

Emergency Preparedness (Disaster) Plan Policy Chapter 8 page 2 was revised to include new disaster plans on 4/7/14. The policy was approved on 4/7/14 by the governing body. Education of all physicians and staff was provided via staff meetings on 4/10/14 and physician newsletter was sent out and completed on 4/10/14

HOW:

Safety officer has taken up the primary role of conducting Disaster drills. The Safety officer gave the Materials Manager a list of all the date that drills will be conducted and Manager approved. So every year the Safety Officer will pick dates at random to have disaster drill and these dates will be approved by DON or Materials Manager.

AHC Standard IC.02.04.01 **The organization offers vaccination against influenza to licensed independent practitioners and staff. Note: This standard is applicable to staff and licensed independent practitioners only when care, treatment, or services are provided on site. When care, treatment, or services are provided off site, such as with telemedicine or telephone consultation, this standard is not applicable to off-site staff and licensed independent practitioners.**

Findings: EP 1 Observed in Credentialing and Privileging at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site. During the competency and privileging sessions, it was noted that the organization did not have an influenza program in place.

Elements of Performance:

1. The organization establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff.

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

Facility is ordering Vaccine 6/1/14 or when the vaccine becomes available. All staff will be able to get the flu shot in our facility and if they refuse they must sign a waiver stating their noncompliance.

WHEN:

This issue was reviewed on 3/20/14 by the DON. DON determined that the vaccine would be carried in this facility. DON will order vaccine on their first day it will become available or on 6/1/14. Waiver was created on 3/20/14 for noncompliant employees.

HOW:

The DON will check every employee will either have the flu shot or waiver as well as Physicians. This will be done on an ongoing basis and done when season starts to maintain compliance.

AHC Standard LD.03.05.01 Leaders implement changes in existing processes to improve the performance of the organization.

Findings: EP 4 §416.43(e)(5) - (Q-0084) - (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. This Standard is NOT MET as evidenced by: Observed in Data Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the data tracer, it was noted that the clinical leaders need additional training to learn to analyze and display data in the QI program. The organization will benefit from having trained individuals to provide leadership, direction and focus to the quality improvement program. §416.43(e)(2) - (Q-0084) - (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. This Standard is NOT MET as evidenced by: Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the infection control tracer, it was noted that the individuals responsible for implementing the infection control program had not been exposed to extra training in infection control. The needed training will provide the opportunity for the organization to adequately direct the IC program.

Elements of Performance:

4. Leaders provide the resources required for performance improvement and change

management, including sufficient staff, access to information, and training.

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

A new Infection Control Nurse was appointed to maintain the education of all employees of Infection control. There is now a once a year 3 part course that all employees are mandated to take. We also implemented a new unannounced tracer done by the new Infection Control Nurse. This will be done randomly and without notice. The Infection Control Nurse will monitor any potential for infection control and report back to the DON about finding and recommend areas that need fixing. The DON is then responsible for making sure all suggested infection control methods are changed and taken care of.

WHEN:

The DON completed the new training manual for infection control on 4/15/14. The Infection Control Nurse was appointed on 4/17/14. And the Implementation of the new training program will be start on 5/1/14. Unannounced tracer will be done periodically so no date is set for those.

HOW:

The Infection Control Nurse will be performing and education class for all employee and doctors. As well as, conducting unannounced tracers monitoring all potential infection controls. ICN will then report to the DON on areas that need improvement and issues that may arise. The DON will then take a plan of action and reeducation for all employees or doctors that need it.

AHC Standard LD.04.04.01 **Leaders establish priorities for performance improvement. (Refer to the 'Performance Improvement' [PI] chapter.)**

Findings: EP 1 §416.43(e)(2) - (Q-0084) - (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. This Standard is NOT MET as evidenced by: Observed in Environment of Care Session at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the environment of care session, it was noted that leadership had not provided sufficient direction for the staff as it related to monitoring the environment. Appropriate monitoring of: annual generator testing, monthly and annual monitoring of the egress lights were not being completed to provide assurance of a safe environment. EP 16 §416.51(b)(2) - (Q-0244) - (2) An integral part of the ASC's quality assessment and performance improvement program; and This Standard is NOT MET as evidenced by: Observed in Infection Control System Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. The organization had not included surgeons in its study of

hand hygiene compliance, therefore, the available information on hand hygiene compliance did not accurately reflect the organization's compliance levels.

Elements of Performance:

1. Leaders set priorities for performance improvement activities and patient health outcomes. (See also PI.01.01.01, EPs 1 and 3)

Scoring Category: A

Corrective Action Taken:

WHO:

The Materials Manager is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The Materials Manager educated the Safety Officer on the proper way to monitor the egress lights and the generator. The materials manager also included the proper length of times on the safety walk form and the generator survey. The Safety officer is now checking the generator and egress light for the appropriate time for each. The safety officer was educated on the appropriate lengths of time to check these things and for how often they need to be checked. The information will me documented on the hazard/Safety walk survey and the Generator Survey.

WHEN:

The Safety Officer was appointed to check the generator and the egress lights on 3/31/14. Safety officer was educated on the length of times to check the generator and the egress lights, as well as how often to check them.

HOW:

The Safety Officer will perform a monthly check on the generator and egress lights for 30 sec, 1 year check for 1 hour, and 3 year check for 4 hours for the generator. On the egress lights they will be checked on a monthly basis by pressing the check button for 30sec and checked again at 1 year for 1hour. This paper work is then given to the Materials Manager. The Materials Manager then walks through the safety walk with the safety officer. All items that are needed to be taken care of are noted by the materials manager and taken care of promptly. The materials manager then signs off on the safety walk after the walk is completed with the Safety Officer.

16. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The infection control program is an integral part of the ambulatory surgical center's quality assessment and performance improvement program.

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

We looked into out Hand Hygiene Survey and noted that Doctors were not included in the survey. We changed out Hand Hygiene survey and updated how and who monitors the

compliance of Hand Hygiene. Now an RN is chosen at random and instructed to monitor staff/doctors regarding their hand hygiene. The RN then fill out a Survey that is then returned to the DON. The DON takes this information and informs all staff on the findings and gives suggestions on how to fix the issue. All the Staff and Doctors were educated on the proper way to wash hands and the the proper time to wash hands.

WHEN:

Hand Hygiene Survey was looked at on 3/19/14 and was revised to include doctors on 3/19/14. Education of staff and doctors were done on 3/20/14.

HOW:

The RN, chosen to conduct the survey will be chosen at random. This random selection of an RN will be done on a monthly basis and will include the supervision of 10 doctors and 6 staff member per survey. The findings will be reported to the DON and the DON will take further steps to educate all members who are non compliant. If non compliance is persistent by the same individuals the further action will be taken to ensure 100% compliance.

AHC Standard LS.03.01.10

Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Findings: EP 6 §416.44(b) - (Q-0104) - §416.44(b) Standard: Safety From Fire This Standard is NOT MET as evidenced by: Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the infection control tracer, it was noted that the exit door of the sterile hallway, which led to the rear exit of the building, was not activated by a "self closure" device, hence when the rear door was opened, the sterile hallway's air was compromised by unfiltered, external air. Observed in Infection Control Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. Small sample size. One rear exit applicable. EP 9 §416.44(b)(3) - (Q-0104) - (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. This Standard is NOT MET as evidenced by: Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed

service. During the building tour, it was noted that there were multiple penetrations in the fire wall, on the east end of the sterile corridor. Observed in Building Tour at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the building tour, it was noted that there were multiple penetrations in the fire wall, on the west end of the sterile corridor.

Elements of Performance:

6. Doors required to be fire-rated for 3/4 hour, 1 hour, or 1 1/2 hours have functioning hardware, including positive latching and self-closing or automatic-closing devices. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. (See also LS.03.01.30, EPs 3 and 6) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1 and 8.2.3.2.1; NFPA 80-1999: 2-4.4.3, 2-4.5, 2-3.1.7, 1-11.4)

Scoring Category: C

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

Issue was brought to the Safety officer and was added to the Safety Check. All automatic door closure devices will be monitored on a monthly bases by the Safety officer. Safety officer will open the doors with automatic devices and check to make sure doors close and latched as intended.

WHEN:

An Appointment was made to attached and automatic closure device to the doors on 3/21/14. Jose Montoya our handyman installed the automatic closure device on 3/31/14. All of the doors were inspected by The DON.

HOW:

The inspection of the doors will be done by the Safety officer and reported on the safety walk. If any problems should arise and they would also be reported to the DON immediately. The DON will, in a timely manner, resolve the issues and help render the problem solved.

9. The space around pipes, conduits, bus ducts, cables/wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are filled with an approved fire-rated material. Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2)

Scoring Category: C

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

We quickly looked at all penetrations and searched for a company to come and seal up the penetrations. We called the company Service One and Kevin Herrera came out to look at what we needed. His company provides a service of plumbing but we asked him if they could assist us in sealing the penetrations. He agree and the next day he scheduled his fellow employees to come and seal up all the penetrations in the fire walls.

WHEN:

We called Service One to come in on 4/3/14. Kevin came in same day and fixed our plumbing issues and was scheduled to come in on 4/4/14. All of the issuers of penetrations were fixed on 4/4/14 by Service One company.

HOW:

The DON will ensure that any further construction to this facility will entitle the contracting company to repair or replace the firewall if damaged or penetrated in anyway.

AHC	**Standard LS.03.01.20**	**The organization maintains the integrity of the means of egress. Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization. Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable. Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).**

Findings: EP 17 §416.44(b)(4) - (Q-0104) - (4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006. This Standard is NOT MET as evidenced by: Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the EOC tracer, it was noted that the "Frog Lights" over the rear exit door were not operative, when manually activated. Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the EOC tracer, it was noted that the "Frog Lights" over the sterile hallway exit door were not operative, when manually activated. Observed in EOC Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the EOC tracer, it was noted that the "Frog Lights" in the operating room #1, did not operate when manually activated.

Elements of Performance:

17. Illumination in the means of egress, including exit discharge, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness. (For full text and any exceptions, refer to NFPA 101-2000: 7.8.1.4)

Scoring Category: C

Corrective Action Taken:

WHO:

The Materials Manager is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

We sent an appointment with an electrician to come out and check all the Frog Lights. Jimmy Palma Came out and checked all Frog lights and determined that the light bulbs were burnt out and that some batteries needed to be changed out. He then changed out all light bulbs in question and changed out old batteries for new ones and tested Frog light to ensure their proper use. The Materials Manager then did a walk through with the electrician and ensured the proper operation of the Frog lights. The Materials Manager bought a broom stick to make it easier for the Safety Officer to check the Frog Lights.

WHEN:

The appointment was made with Jimmy Palma on 4/3/14. Jimmy Palma then fixed all the Frog lights on 4/9/14. The walkthrough was done on 4/9/14 with the Materials Manager and the Electrician. Materials Manager bought broom stick on 4/9/14.

HOW:

The Safety Officer will check Frog lights on the monthly safety inspection. If a problem during the inspections arrises with the Frog lights not working, the Safety Officer will notify the Materials Manager immediately and the Materials Manager will call the electrician to fix the problem as soon as possible.

AHC Standard MM.01.01.03 The organization safely manages high-alert and hazardous medications.

Findings: EP 1 Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site. During the medication management tracer, it was noted that the organizaiton did not posses a list of their high alert medications. EP 2 Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site. During the medication management tracer, it was noted that the organizaiton had not developed a storage process to help the staff avoid potential medication errors. Observed in Medication Management Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site. During the medication management tracer, it was noted that the emergency cart contained 50% Magnesium Sulfate stored in the cart, adjacent to two vials of Narcan, which was packaged similarly.

Elements of Performance:

1. The organization identifies, in writing, its high-alert and hazardous medications. * (See also EC.02.02.01, EP 8) Footnote *: For a list of high-alert medications, see http://www.ismp.org. For a list of hazardous medications, see http://www.cdc.gov/niosh/docs/2012-150/.

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

This issue was under review by the DON and was quickly fixed when inspector pointed it out. High alert medications now labeled in cabinets as high alert via a sticker that states high alert. This was done every location that contains a high alert medication. All high alert medications were changed to the color red for their labeling. The list of Hazardous Medications is located in the Overstock cabinet and RN have already been educated on the location of the list. RN come in contact with this list on a daily basis because of medications needing to be restocked daily.

WHEN:

This was reviewed by DON on 3/19/14 and was changed by the DON on 3/19/14. All RN were educated on the labeling of medications with High alert labels on 3/20/14.

HOW:

The DON monitors the cabinets that contains all high alert medications. It is checked by the DON on a daily basis and again when a high alert shipment is received.

2. The organization has a process for managing high-alert and hazardous medications. (See also EC.02.02.01, EP 8; MM.03.01.01, EP 9)

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

High alert medications now labeled in cabinets as high alert via a sticker that states high alert. Magnesium Sulfate was transferred into a container and labeled as High Alert with the Name of the medication labeled on the outside in bold. The DON held a meeting informing all staff of the change to the medication. The medication will be kept in this container from now on to make it more difficult to mistake Magnesium Sulfate from any other medication that it may look like.

WHEN:

Magnesium Sulfate was placed in the container on 3/18/14 and labeled at the same time. The staff was notified of the change on 3/20/14 via a company meeting.

HOW:

The DON or RN performing monthly check of the crash cart will also check and make sure that the Magnesium Sulfate is still in it's container. This is documented on the crash cart

log.

AHC Standard PI.02.01.01 The organization compiles and analyzes data.

Findings: EP 8 §416.43(b)(2)(ii) - (Q-0082) - (ii) Identify opportunities that could lead to improvements and changes in its patient care. This Standard is NOT MET as evidenced by: Observed in Data Session at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the data session, it was noted that the organization had collected data on: The timeliness of Ancef infusion; however, the clinical leadership had not received training in the analysis and display of the data.

Elements of Performance:

8. The organization uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5; PI.03.01.01, EP 1)

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The DON research on the internet and educated herself and with the assistance of the medical director and pharmacist, the DON then reviewed the practice of administration of antibiotics currently at our facility and changed the facility's standards. A new document was created that tracts what antibiotic as given, what time it was given, and how it was introduced to the patient. This will be checked by the DON and logged on a chart that maps the administration time of the antibiotics. If it is seen that a trend of patients have not received the antibiotic in the allowed time then procedure will be reevaluated and changed accordingly.

WHEN:

The DON was educated on the antibiotic administration by the medical director and the pharmacist on 3/19/14. Administration of antibiotics was reviewed on 3/19/14. The industry standard was also looked at on 3/19/14. On 3/20/14 the document of Administration of Antibiotic Log was created. Practice was implemented 4/15/14 and will continue to be tracked for every case.

HOW:

The DON will perform check for every patient who receives antibiotics before the surgery. If DON is not available then DON will delegate to another person employee to complete the Study. This will be done on a daily basis.

AHC Standard RI.01.05.01 The organization addresses patient decisions about

care, treatment, or services received at the end of life.

Findings: EP 4 §416.50(c)(1) - (Q-0224) - (1) Provide the patient or, as appropriate, the patient's representative prior to the start of the surgical procedure with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms. This Standard is NOT MET as evidenced by: Observed in Document Review at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site for the Ambulatory Surgical Center deemed service. During the document review, it was noted that the organization had a process to ask patients if they possessed an advance directive; However, there was no evidence that the patients were informed of the office policy to not honor DNR, advance directives.

Elements of Performance:

4. The organization's written policies specify whether the organization will honor advance directives.

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

The DON met with LVN that is doing pre-op calls and changed the manor in which the Advanced Directive is handled in the pre-op calls. Now the pre-op call document has been changed to document that if there is an advanced directive, pre-op nurse needs to check yes or no if the patient is notified that we do not acknowledge and Advanced Directive.

WHEN:

The education was done on 3/19/14 with the LVN.

HOW:

The RN who is auditing the chart will check all charts to ensure that if the patient has an Advanced Directive was notified that we do not acknowledge the advanced directive.

AHC Standard UP.01.03.01 A time-out is performed before the procedure.

Findings: EP 2 Observed in Individual Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site. During an individual patient tracer, it was noted that the "time out" process did not include verbal agreement by all of the members of the surgical team.

Elements of Performance:

2. The time-out has the following characteristics: - It is standardized, as defined by the organization. - It is initiated by a designated member of the team. - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

DON has educated all employees via employee meeting on all parties located in or to agree or disagree with consent in the time out period. Every employee was told that all must give their opinion about consent and to make it verbal. RN is responsible during the case to ensure that everyone could hear the consent be read and ensure that all agree to the consent.

WHEN:

This actions of education of employees was done on 3/20/14.

HOW:

The DON is doing daily checks to ensure that all are in compliance. DON also can choose to follow a patient through the whole process from check in to check out. This will be done without notice and without any staff member knowing what the DON is doing or looking at.

AHC Standard WT.04.01.01 **The organization performs quality control checks for waived testing on each procedure. Note: Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.**

Findings: EP 2 Observed in Infection Control System Tracer at Pacific Coast Surgical Center (3720 W. Lomita Blvd, Suite 100, Torrance, CA) site. During the infection control system tracer, it was noted that the organization performed the QC on their glucometer on a weekly basis regardless of the number of anticipated tests during that week.

Elements of Performance:

2. The documented quality control rationale for waived testing is based on the following: - How the test is used - Reagent stability - Manufacturers' recommendations - The organization's experience with the test - Currently accepted guidelines

Scoring Category: A

Corrective Action Taken:

WHO:

The DON is ultimately responsive for the corrective action and for overall and ongoing compliance.

WHAT:

The DON delegated the Materials Manager to create a new document in which a control is done within 24 hours of glucose testing.This Log contains the patient sticker and a log of the control results, as well as the ranges of what the glucose should be. It is now the new standard for pre-op nurses upon preparing the charts for next day to perform test when it is seen that doctors ordered due to patient being diabetic.

WHEN:

The document was created on 4/11/14 and a meeting educating all RNs and LVNs was held to notify them of the changes made to how glucose control was tested.

HOW:

The DON has given pre-op nurse the logs. To ensure that it is done on every patient by placing a patient sticker on the log. DON will check the Log on a monthly basis and if no patients in need of glucose check that month then there will be no need for a control checks.