PRINTED: 09/16/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT O AND PLAN OF	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31C0001023	B. WING	;	a sakaba aka saka ana ana ana ana ana ana ana ana ana	08/	04/2021
·	ROVIDER OR SUPPLIER	BERY			STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
Q 000 I	NITIAL COMMENT	rs	Q	000			
	Survey date: Augu	st 4, 2021					
F 5 C C C F 7 C C C C C C C C C C C C C C C	Federal Focused In State Re-licensure compliance with Fe CFR Part 416, Con Ambulatory Surgica requirements under	n level Federal Recertification, ifection Control Survey, and Survey. The facility is not in ideral requirements under 42 ditions of Coverage for al Centers and State r Title 8, Chapter 43A, Manual censing of Ambulatory Care					
Q 083 F	of compliance: 416.51 Infection Co	ition was determined to be out ontrol MPROVEMENT PROJECTS	Qí	083	3		
i ii r		cts conducted annually must nd complexity of the ASC's					
h n ii	peing conducted. I	document the projects that are The documentation, at a lude the reason(s) for roject, and a description of the					
c e ii c	Based on staff inte documents, it was of the consure quality assemprovement (QAP on the needs of the patient health outco	s not met as evidenced by: rview and review of facility determined the facility failed to ssment and performance I) projects are selected based facility and the belief that omes and safety will improve. DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE	and the same and the	(X6) DATE

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

ROVIDER OR SUPPLIER	31C0001023	B. WING _		201	
		·		08/0	04/2021
BERGEN-PASSAIC EYE SURGERY			STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	BE	(X5) COMPLETION DATE
Continued From pa	ge 1	Q 08	3		
identified him/herse for the facility's QAF asked to describe the project(s) the facility He/she stated, "We falls." A request was the facility's data concernment of the facility's data concern the facility has asked the facility has asked why the facility has a sked why t	If as the person responsible PI program. Staff #2 was the performance improvement was currently conducting. Just completed a project on a made to Staff #2 regarding ellection related to the wement project and the peroject was suggested. The facility has had a stient falls. Staff #2 confirmed the facility selected a wement project on falls if that of the facility. He/she stated,				
corporate partner at the corporate group was one of the projegroup did." N.J.A.C. 8:43A - 18 ADMINISTRATION CFR(s): 416.48(a) Drugs must be prepaccording to establistandards of practic	nd there were a lot of falls in but not necessarily us. Falls ects that everyone in the .2(f) OF DRUGS pared and administered shed policies and acceptable se.	Q 18	1		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa Findings include: 1. Upon interview or identified him/herse for the facility's QAF asked to describe the project(s) the facility. He/she stated, "We falls." A request was the facility's data coperformance improverationale for why the compensational of the project was asked why the performance improvement in the facility has #2 was asked why the performance improvement in the concern of the project was not a concern of the project was one of the project wa	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Findings include: 1. Upon interview on 8/3/21 at 1:40 PM, Staff #2 identified him/herself as the person responsible for the facility's QAPI program. Staff #2 was asked to describe the performance improvement project(s) the facility was currently conducting. He/she stated, "We just completed a project on falls." A request was made to Staff #2 regarding the facility's data collection related to the performance improvement project and the rationale for why the project was suggested. 2. Staff #2 was asked if the facility has had a recent issue with patient falls. Staff #2 confirmed that the facility has not had any patient falls. Staff #2 was asked why the facility selected a performance improvement project on falls if that was not a concern of the facility. He/she stated, "The falls project was chosen for us. We have a corporate partner and there were a lot of falls in the corporate group, but not necessarily us. Falls was one of the projects that everyone in the group did." N.J.A.C. 8:43A - 18.2(f) ADMINISTRATION OF DRUGS	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 1. Upon interview on 8/3/21 at 1:40 PM, Staff #2 identified him/herself as the person responsible for the facility's QAPI program. Staff #2 was asked to describe the performance improvement project(s) the facility was currently conducting. He/she stated, "We just completed a project on falls." A request was made to Staff #2 regarding the facility's data collection related to the performance improvement project and the rationale for why the project was suggested. 2. Staff #2 was asked if the facility has had a recent issue with patient falls. Staff #2 confirmed that the facility has not had any patient falls. Staff #2 was asked why the facility. He/she stated, "The falls project was chosen for us. We have a corporate partner and there were a lot of falls in the corporate group, but not necessarily us. Falls was one of the projects that everyone in the group did." N.J.A.C. 8:43A - 18.2(f) ADMINISTRATION OF DRUGS CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Continued Fram Pa	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Findings include: 1. Upon interview on 8/3/21 at 1:40 PM, Staff #2 identified him/herself as the person responsible for the facility's QAPI program. Staff #2 was asked to describe the performance improvement project on falls." A request was made to Staff #2 regarding the facility data collection related to the performance improvement project and the rationale for why the project was suggested. 2. Staff #2 was asked if the facility has had a recent issue with patient falls. Staff #2 confirmed that the facility has not had any patient falls. Staff #2 was asked why the facility. He/she stated, "The falls project was chosen for us. We have a corporate group, but not necessarily us. Falls was one of the projects that everyone in the group did." N.J.A.C. 8:43A - 18.2(f) ADMINISTRATION OF DRUGS CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING			08/	04/2021	
		GERY		STREET ADDRESS, CITY, STATE, ZIF 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	, CODE			
PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFI TAG		ON SHOULD HE APPROPE	BE	(X5) COMPLETION DATE	
Q 181	A. Based on obsermanufacturer's pacinterview, it was deensure medications manufacturer's instructions. Findings include: Reference: Manufa Proparacaine Hydrous states, " Stodegrees Celsius (30). 1. On 8/4/21 at 10:0 (1) - fifteen (15) mil Proparacaine Hydrous was found stotemperature, not remanufacturer. 2. Staff #2 confirmed at 10:00 AM. N.J.A.C. 8:43A-9.5 B. Based on observe was of facility failed to are removed from in Findings include: Reference: Facility Drugs and Syringes of medications will Discontinued, outdamedications are of the state	vation, review of the kage insert, and staff termined the facility failed to a are stored in accordance with ructions. cturer's package insert for ochloride Ophthalmic Solution ore between 2 degrees to 8 to 46 degrees Fahrenheit)." On AM, in Exam Room # one liliter (ml) bottle of ochloride Ophthalmic Solution ored in a cabinet at room frigerated as required by the ed the above finding on 8/4/21 (b) vation, staff interviews, and cuments, it was determined ensure expired medications inventory. policy, "Storage and Control of 5" states, " Expiration dates be checked monthly ated, and short-dated	Q 1	181				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION			E SURVEY PLETED
		31C0001023	B. WING			08/0	04/2021
	PROVIDER OR SUPPLIER	GERY		STREET ADDRESS, CITY, STATE, Z 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD	BE	(X5) COMPLETION DATE
Q 181	the following expire the code cart locate a. Four (4) - one (1) Phenylephrine 10 n expiration date of 7 b. Three (3) - five (5) Jelly 2% with an ex c. One (1) - thirty (3) Jelly 2% with an ex 2. On 8/4/21 betwee the following expire the code cart locate Unit: a. Two (2) - five (5) Jelly 2% with an ex 3. Staff #19 confirm 8/4/21 at 11:30 AM. N.J.A.C. 8:43A-9.5 C. Based on observe the code cart locate Unit: at 11:30 AM. N.J.A.C. 8:43A-9.5 C. Based on observe we facility pole determined that the single use medicati patient and that mulare opened are label opened, and discar by the expiration date. Reference: Facility	d medications were found in ed in the set in	Q 1				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		31C0001023	B. WING			08/	04/2021
	PROVIDER OR SUPPLIER	BERY		-	STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
Q 181	must be prepared a established guidelir medications intended manufacturer for medication and dated discarded after 28 core manufacturer's medication vials lat single patient or sinfor one single patient. 1. On 8/4/21 at 10:0 (2) - 118 milliliter (medication vials lat single patient or sinfor one single patient. 1. On 8/4/21 at 10:0 (2) - 118 milliliter (medication vials lat single patient. 2. On 8/4/21 at 10:0 opened and partiall use. The manufacture eyewash was "Singuia. Staff #2 confirmed at 10:05 AM. b. Upon interview of stated the single used is discarded after a single used is carded and undate available for patient. 2. On 8/4/21 at 10:0 following multi-use opened and undate available for patient. 3. One (1) - 15 ml coophthalmic Solution. 5. One (1) - 2.5 ml coophthalmic Solution. 6. Upon interview of stated Exam Room.	and administered according to nes Any multi-dose vials of sed and designed by the ultiple uses will be opened, with the date opened, and days, or by the expiration date, ecommendation if sooner All beled by the manufacturer for agle dose use will be used only not or one single dose" OO AM, in Exam Room # two not bottles of Purified Water Solution Eyewash were found by filled, available for patient urer's label stated that the le Use." and the above finding on 8/4/21 on 8/4/21 at 12:40 PM, Staff #9 are eyewash should have been angle use. IO AM, in Exam Room # the ophthalmic drops were founded, stored in a drawer, and the use: container of Tropicamide on 1% container of Flurbiprofen	Q 1	181			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING			08/0	04/2021
	PROVIDER OR SUPPLIER I-PASSAIC EYE SURC	GERY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 8-01 POLLITT DRIVE, SUITE 4 AIR LAWN, NJ 07410	A	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 181	d. Staff #2 confirmed 10:15 AM. 3. On 8/4/21 at 10:3 multi-use ophthalm a cart. The following were opened, undatuse: a. One (1) - 2.5 ml conditions of the	and the expiration dates nined. In ad this finding on 8/4/21 at a so AM, in Operating Room ic drops were found stored in granulti-use ophthalmic drops ted, and available for patient a container of Flurbiprofen a Solution 0.03% antainers of Levobunolol chalmic Solution 0.5% antainer of Tobramycin in 0.3% antainer of Timolol Maleate in 0.5% antainers of Prednisolone a Suspension 1% antainer of Pilocarpine thalmic Solution 1% antainer of Brimonidine Tartrate in 0.2% antainer of Ofloxacin in 0.3% antainer of Ofloxacin in 0.3% antainer of Ofloxacin in 0.3% antainer of Dilocarpine thalmic Solution 1% antainer of Dilocarpine thalmic Sol	Q 1	181			

	OF DEFICIENCIES OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING			08/	04/2021	
	PROVIDER OR SUPPLIER	SERY		18-	REET ADDRESS, CITY, STATE, ZIP CODE -01 POLLITT DRIVE, SUITE 4 			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
Q 181	was unable to dete the opened ophthal k. Staff #19 confirm 8/4/21 at 10:30 AM 4. On 8/4/21, staff of facility's procedure and storage of multipacility staff provide reconcile with the faabove. Upon intervindicated: a. At 10:15 AM, Stasure of the process use and dating of mb. At 10:20 AM, Staophthalmic drops was pecific labels, usewere given to the properative day. c. At 10:35 AM, Staophthalmic drops was fourteen (14) day experience (14) day	in 8/4/21 at 10:35 AM, Staff #19 rmine the expiration dates of mic medications. Indeed the above findings on a were interviewed regarding the for use, beyond use dating, ti-use ophthalmic drops. Indeed information that did not acility's policy referenced in the facility following was a stated he/she was not the facility followed for the multi-use ophthalmic drops. In #9 stated multi-use were labeled with patient and atient at the end of the facility followed for the multi-use ophthalmic drops. In #19 stated multi-use were labeled with patient at the end of the first stated that multi-use were opened, labeled with a expiration date, and used for the first stated that multi-use were opened, labeled with a expiration date, and used for the first stated that multi-use were opened, labeled with a expiration date, and used for the first stated that multi-use were opened, labeled with a sexpiration date, and used for the first stated that multi-use were opened, labeled with a sexpiration date, and used for the first stated that multi-use were opened, labeled with a sexpiration date, and used for the first stated that multi-use were opened, labeled with a sexpiration date, and used for the first stated that multi-use were opened, labeled with a sexpiration date, and used for the first stated that multi-use were opened, labeled with a sexpiration date, and used for the first stated that multi-use were opened.	Q 1	81				
	was determined the	ew of policy and procedure, it facility failed to ensure all ringes are kept locked when		THE REAL PROPERTY OF THE PROPE				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS			E SURVEY PLETED
		31C0001023	B. WING			08/	04/2021
	PROVIDER OR SUPPLIER	GERY		18-01 PC	ADDRESS, CITY, STATE, ZIP CODE DLLITT DRIVE, SUITE 4 AWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
Q 181	Reference #1: Faci Services - Storage Syringes" states, "/- including eye drops controlled in compl Pharmacy Rules N drugs shall be store Drug storage areas in use 9. Syringe lock and key " Reference #2: New Pharmacy N.J.A.C. Storage and Secur made for adequate wherever they are a facility. 1) All drugs and protected again. On 8/3/21 at 11:50, the following. a. The anesthesia of and unattended with the cabinet was found syringes inside. 2. Staff #9 confirmed at 11:54 AM. 3. On 8/4/21 at 10: needles were found unlocked and unattended with the cabinet was found syringes inside.	and Control of Drugs and All syringes and medications, so, must be properly stored and iance with NJ State Board of JAC 13:39 Procedure: 1. All ed in locked storage areas. It will be kept locked when not es will be maintained under and Jarsey State Board of 13:39-9.23 states, " ity a) Provisions shall be a safe storage of drugs stored in the health care shall be secured for safe use not illicit diversion" 54 AM, in the NJ Exec Order 26.461 NJ Executed the medications inside. ctly adjacent to the anesthesia unlocked and unattended with ed the above findings on 8/3/21 10 AM, in Exam Room # JE at a drawer that was distored in a drawer that was	Q 1	81			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31C0001023	B. WING			08/0	4/2021
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PROVIDER OR SUPPLIER	BERY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 8-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 181	two (2) open metal and syringes were a cart, unattended.	40 AM, in Operating Room # baskets containing needles found on top of the anesthesia	Q 1	181			
Q 225	8/4/21 at 10:40 AM N.J.A.C. 8:43A-9.30 N.J.A.C. 8:43A-9.30	(a) (b)6 INVESTIGATION OF	Qź	225			
	for documenting the investigation, and do or verbal grievance criteria must be me (1) The grievance p	ablish a grievance procedure e existence, submission, lisposition of a patient's written to the ASC. The following et: brocess must specify ew of the grievance and the					
	provisions of a resp (2) The ASC, in res must investigate all the patient's repres	ponse. ponding to the grievance, grievances made by a patient, entative, or the patient's g treatment or care that is (or					
	was addressed, as patient's representation with written notice of must contain the national statement of the	document how the grievance well as provide the patient, the ative, or the patient's surrogate of its decision. The decision ame of an ASC contact person, nvestigate the grievance, the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		E SURVEY PLETED
		31C0001023	B. WING		A LANGE FOR TOPOLOGY TOPOLOGY	08/	04/2021
	PROVIDER OR SUPPLIER	BERY		18-	01 POLLITT DRIVE, SUITE 4	.,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
Q 225	result of the grievar grievance process. This STANDARD is Based on review or records (#21, #22, serview of facility dot the facility failed to by patients receive. Findings include: Reference: Facility and Grievances" strinstances of patient in consultation with members, will attensatisfactorily on an cannot be accompliwill be considered a provide the patient written response with grievance." 1. Review of the facility on 8/3/21 reveau a. Patient #21 had a facility on Section labeled "Co" Patient states, 'This told to arrive at 6:30 10:30 AM to the OF NJ Exec Order 26.41 office suggested pawith NJ Exec Order 26.41 office suggest	roce process and the date the was completed. Is not met as evidenced by: If three (3) of three (3) medical #23), staff interviews, and cuments, it was determined ensure all grievances lodged a follow-up written response. Policy, "Patient Complaints ates, " Procedure: 1. In all the complaints, the Administrator, other appropriate staff appropriate s	Q 2	225			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		E CONSTRUCTION	COMPLETED		
		31C0001023	B. WING			08/0	4/2021	
	PROVIDER OR SUPPLIER	GERY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 8-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIÖN DATE	
Q 225	was resolved inform (ii) There was no evin the medical recopatient with a writte complaint within this. b. Patient #22 had facility or present the complaint within this. b. Patient #22 had facility or present the complaint within labeled "Complaint within this was no evin the medical recopatient with a writte complaint within this c. Patient #23 had facility on present with a writte complaint within this c. Patient #23 had facility on present with a writte complaint within this was no evin the medical recopatient with a writte complaint within this c. Patient #23 had facility on present the complaint within this was no evin the present the complaint within this was no evin the called back 1.	vidence in the complaint log or red that the facility provided the en response to his/her rty (30) days. a procedure performed at the en the NJ Exec Order 26.4b1 NJ Exec Order	Q	225				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING		08/	04/2021	
	PROVIDER OR SUPPLIER	BERY		STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
Q 225	in the medical recorpation with a writte complaint within thin 2. Staff #1, Staff #2 above findings on 8	ridence in the complaint log or rd that the facility provided the n response to his/her rty (30) days. , and Staff #3 confirmed the 1/4/21 at 2:45 PM.	Q 22	5			
Q 240	program that seeks communicable dise This CONDITION i Based on observat staff interviews, it w failed to ensure the	ntain an infection control to minimize infections and ases. s not met as evidenced by: ion, document review, and as determined the facility maintenance of an infection t minimizes infections and	Q 24	0			
	Findings include: 1. The facility failed policies and procedures 2. The facility failed stored to maintain s Association for the Anstrumentation (AA to Tag Q-0242) 3. The facility failed detergents are used	to ensure implementation of ures for cleaning in between control of the control o					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED			
		31C0001023	B. WING		**************************************	08/04/2021	
	PROVIDER OR SUPPLIER	SERY		18-	REET ADDRESS, CITY, STATE, ZIP CODE 01 POLLITT DRIVE, SUITE 4 IR LAWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	C. C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 240	program is under the and qualified profes	to ensure its infection control le direction of a designated ssional with training in infection	Q 2	40			
Q 241	wipes manufacture Refer to Tag Q-024 SANITARY ENVIRO CFR(s): 416.51(a) The ASC must provenvironment for the	to ensure follow disinfectant r's instructions for use. (Cross 2) DNMENT vide a functional and sanitary provision of surgical services essionally acceptable	Q 2	41			
	A. Based on obser turnover cleaning, s nationally recognize determined the faci medication prepara	s not met as evidenced by: vation of post procedure room staff interview, and review of ed guidelines, it was lity failed to ensure the tion area is cleaned and ch surgical procedure.					
	Findings include:						
	Registered Nurses; Recommended Prastates, "Recommer environment should patient is transferre Operating and productions."	(Association of PeriOperative Perioperative Standards and actices, 2019 edition, pg. 180 addition III A clean be reestablished after the different from the area III.c. edure rooms must be cleaned III.c.3. Items that are used should be cleaned and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED	
		31C0001023	B. WING		aga ay ay ay a san a	08/04/2021	
	PROVIDER OR SUPPLIER	BERY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 8-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE:	(X5) COMPLETION DATE
Q 241	anesthesia carts and anesthesia carts and anesthesia carts and area, was not clear patient was transfed. a. The anesthesia carea, was not clear patient was transfed. 2. Upon interview, scart is supposed to anesthesiologists. N.J.A.C. 8:43 A-14. B. Based on randor interview, it was deensure all equipmed. Findings include: 1. During a tour of AM, tape was observendering the surfact at 11:06 AM. 3. On 8/4/21 at 11:3 area, three (3) found stored in a cart had a paper sign section, sticky, narrow device, rendering the surfact at 11:06 AM.	ch patient use, including and equipment" Vation of NJ Exec Order 26.4b1, in 8/4/2021 at 11:06 AM, Staff cleaning Operating Room cart, a medication preparation and and disinfected after the red out of the room. Staff #2 stated the anesthesia be cleaned by the .3(a) m observation and staff termined the facility failed to ent is clean. OR #4 on 8/4/2021 at 11:06 erved on the anesthesia cart,	Q2	241			

PRINTED: 09/16/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31C0001023	B. WING			08/04/2021	
	PROVIDER OR SUPPLIER	GERY		1	TREET ADDRESS, CITY, STATE, ZIP CODE 8-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 241	N.J.A.C. 8:43 A - 14 C. Based on randor and review of nation was determined the ventilation standard. Findings include: Reference #1: ANS ventilation and air oparameters states, should identify which ANSI/ASHRAE/ASI when the HVAC systast upgraded. The establish and implementation for ider variances within row where sterile proce. Reference #2: 2014 Table 7.1 Design P. Recirculation by Metalon 1. On 8/4/2021 at 9 conference, Staff # Infection Control proguidelines. 2. During a tour con AM, in the presence room air handling ubeing used within the presence of the process of the presence of the prese	4.2(b) m observation, staff interviews, nally recognized guidelines, it e facility failed to ensure its are maintained at all times. 6.1/AAMI ST79 3.3.5.5 Heating, conditioning (HVAC) operating "The health care organization th version of HE 170 will be used based on stem was initially installed or health care facility should ement systemic processes for erformance parameters and a ntifying and resolving oms throughout the facility	Q	241			

Facility ID: NJ31C0001023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING	B. WING		08/	04/2021
	PROVIDER OR SUPPLIER	GERY	STREET ADDRESS, CITY, STATE, ZIP CO 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		POLLITT DRIVE, SUITE 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 241	(i) Staff #2 stated to use as supplemental workroom. 3. Staff #2 and Stafinding on 8/4/21 and N.J.A.C. 8:43A-19. D. Based on rando and review of Center Prevention (CDC) the facility failed to guidelines regarding. Findings include: Reference #1: CDC Precautions: Preventions: Preventions: Preventions Agents in (http://www.cdc.go.go.go.go.go.go.go.go.go.go.go.go.go.	the handling unit was installed ental air cooling for the clean of #3 confirmed the above to 2:45 PM. 1(a) If #3 confirmed the above to 2:45 PM. 1(a) If was determined to an ensure staff adheres to CDC and hand hygiene and glove use. C 2007 Guideline for Isolation enting Transmission of the Healthcare Settings which pac/pdf/isolation/Isolation2. 51 states, " Gloves that are will prevent hand the hygiene following glove sures that the hands will not fectious material that might arough unrecognized tears or mate the hands during glove C, Morbidity and Mortality MWR), Recommendations and for Hand Hygiene in gs, October 25, 2002, Vol. 51,	Q 2	41			

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING			08/04/2021	
	PROVIDER OR SUPPLIER			18	TREET ADDRESS, CITY, STATE, ZIP CODE B-01 POLLITT DRIVE, SUITE 4 AIR LAWN, NJ 07410		
(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 APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
Q 241	gloves for the care do not wash gloves patients." 1. Upon entry into AM, the following varients are dentrance wearing graph of the surveyor at the surveyor a	the facility on 8/3/21 at 10:05 was observed: the survey team at the facility gloves. While wearing gloves, survey staff for survey staff for survey team at filling out a 1½ questionnaire for each nen left the area to notify the of the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's d to the entrance area wearing plied hand sanitizer to his/her over to the survey team's	Q2	241			
	Reference #1: Proc states, " Descript are multi-purpose of	duct Label for CaviWipes 1 ion Disinfecting Towelettes disinfectant/decontaminant					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CON	(X3) DATE SURVEY COMPLETED			
		31C0001023	B. WING			08/0	04/2021
	PROVIDER OR SUPPLIER	BERY		18-01 P	ADDRESS, CITY, STATE, ZIP CODE OLLITT DRIVE, SUITE 4 AWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 241	inanimate surfaces When not in use, ke prevent solution los Reference #2: Cent Prevention, "Guidel Sterilization in Heal https://www.cdc.gor sinfection/index.htn Disinfecting Enviror Healthcare Facilitie instructions for prop detergent) products 1. On 8/3/21 at 11:0 NJ Exec Order 26.4b1 a. On a supply cart doors to the NJ Exe	ters for Disease Control and ine for Disinfection and thcare Facilities (2008) winfectioncontrol/guidelines/dinl" states, " 5. Cleaning and mental Surfaces in s 5.c. Follow manufacturer's per use of disinfecting (or	Q 2	41			
Q 242	2. Staff #1 and Staffindings on 8/3/21 a N.J.A.C 8:43A-14.3 INFECTION CONT CFR(s): 416.51(b) The ASC must mai designed to preven infections and com addition, the infection program must include in the control of the c	8(a)	Q2	42			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`′		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31C0001023	B. WING	·		08/04/2021	
	PROVIDER OR SUPPLIER	GERY			STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 242		nge 18 ed infection control guidelines.	Q	242			
	A. Based on obser review of manufact (IFUs) for NECO Order 20 determined the faci use germicidal wipe manufacturer's inst	s not met as evidenced by: vation, staff interviews, and urer's instructions for use Germicidal Wipes, it was lity failed to ensure all staff es in accordance with tructions for use.					
		pes Germicidal Wipes, ruction for use states, 1) minute."	MANAGORAN ANTANAN				
	cleaning in OR # a observed cleaning observed cleaning Germic questioned regarding	vation of room turnover at 10:54 AM, Staff #13 was the OR mattress using idal Wipes. He/she was ng the contact time of the nd stated it was three (3) minutes.					
	11:08 AM, Staff #12 the contact time for	the NJ Exec Order 26.4b1 on Room at 2 was questioned regarding the NJ Execonder 26.4b1 s Germicidal ed the contact time was two					
		er's instructions for week and were reviewed with Staff #2 contact time is one (1) minute.					
	staff interview, and	vation of the substerile area, review of nationally n control guidelines, it was					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		31C0001023	B. WING	B. WING		08/04/2021	
	PROVIDER OR SUPPLIER	GERY		1	STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Q 242	determined the fac	age 19 ility failed to ensure sterile a manner that maintains	Q	242			
	Practice, 2016 edit pages 838-839 sta	Guidelines For Perioperative ion Recommendation XV tes, "Sterilized materials and stored in a manner to					
	8/3/2021, Staff #2	nce conference conducted on confirmed the facility follows Centers for Disease Control idelines.					
		the substerile area on 8/4/2021 Illowing was observed:					
	a. Nine (9) crushed	d sterile packages of ^{to blee one} nts					
	b. Twelve (12) crus packaged forceps	shed sterile packages of sterile					
	sterile packaged in of one another, wit	etic storage drawers containing instruments were stored on top in the weight of the instruments bromising the sterility of the					
	3. Staff #2 confirm at 2:45 PM.	ed the above findings on 8/4/21					
	N.J.A.C. 8:43 A-17	(b)					
		om observation, staff interviews, ufacturer's instructions for use,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED			
	31C0001023	B. WING	*		08/0	08/04/2021	
	BERY						
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
it was determined to manufacturer's insticleaner are followed: Findings include: Reference: Manufa for SuperNova enzy. 25 oz (one quarter 1. On 8/4/2021 at 1 water and an enzyr the NJ Exec Order 26.4b1 a. The water level wark. b. Upon interview, with 2.5 gallons of of NJ Exec Order 20.4b1 enzy c. Staff #4 stated th was approximately correct concentration was not in accordal instructions for use 2. Staff #1 and Staffindings on 8/4/21 at N.J.A.C. 8:43 A-14. D. Based on review	the facility failed to ensure the ructions for the enzymatic d. cturer's Instructions for Use (matic states " concentration ounce) per gallon of water" 2:01 PM, a sink filled with natic solution was observed in area. was below the 2 1/2 gallon Staff #4 stated they fill the sink distilled water and add 0.62 oz matic. The amount of water in the sink 2 gallons and confirmed the on of the enzymatic cleaner ince with the manufacturer's of #2 confirmed the above at 2:45 PM. 4(a)	Q 2	***************************************				
determined the faci documentation of	lity failed to ensure	National Landing Conference on the Conference on					
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa it was determined the manufacturer's insticleaner are follower Findings include: Reference: Manufa for SuperNova enzy. 25 oz (one quarter 1. On 8/4/2021 at 1 water and an enzynthe MEXIC Corder 26.4b1) a. The water level water and an enzynthe MEXIC Spallons of coff of MEXIC Corder 26.4b1) a. The water level wark. b. Upon interview, Swith 2.5 gallons of coff MEXIC Corder 26.4b1) c. Staff #4 stated the was approximately correct concentration was not in accordate instructions for use 2. Staff #1 and Staffindings on 8/4/21 at N.J.A.C. 8:43 A-14. D. Based on review employee health file and review of facility determined the facility determined the facility documentation of Mexicological contents of the facility determined the facility determined the facility documentation of Mexicological contents of the facility determined the facility documentation of Mexicological contents of the facility documentation of the facility documentation	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 it was determined the facility failed to ensure the manufacturer's instructions for the enzymatic cleaner are followed. Findings include: Reference: Manufacturer's Instructions for Use for SuperNova enzymatic states " concentration .25 oz (one quarter ounce) per gallon of water" 1. On 8/4/2021 at 12:01 PM, a sink filled with water and an enzymatic solution was observed in the NJ Exec Order 26.451*** area. a. The water level was below the 2 1/2 gallon	PROVIDER OR SUPPLIER JACOUO1023 B. WING PROVIDER OR SUPPLIER JACOUO1023 B. WING PROVIDER OR SUPPLIER JACOUO1023 B. WING JACOUO1023 JACOUO102	A BUILDING 31C0001023 B. WING STREET ADDRESS, CITY, STATE, 2 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410 SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 It was determined the facility failed to ensure the manufacturer's instructions for the enzymatic cleaner are followed. Findings include: Reference: Manufacturer's Instructions for Use for SuperNova enzymatic states " concentration concentration 25 oz (one quarter ounce) per gallon of water" 1. On 8/4/2021 at 12:01 PM, a sink filled with water and an enzymatic solution was observed in the state of st	PROVIDER OR SUPPLIER LPASSAIC EYE SURGERY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 (Loss and the facility falled to ensure the manufacturer's instructions for the enzymatic cleaner are followed. Findings include: Reference: Manufacturer's Instructions for Use for SuperNova enzymatic states " concentration 25 oz (one quarter ounce) per gallon of water" 1. On 84/2021 at 12:01 PM, a sink filled with water and an enzymatic solution was observed in the face of supernova enzymatic. a. The water level was below the 2 1/2 gallon mark. b. Upon interview, Staff #4 stated they fill the sink with 1.5 gallons of distilled water and add 0.62 oz of provided the correct concentration of the enzymatic cleaner was not in accordance with the manufacturer's instructions for use. 2. Staff #1 and Staff #2 confirmed the correct concentration of the enzymatic cleaner was not in accordance with the manufacturer's instructions for use. 2. Staff #1 and Staff #2 confirmed the above findings on 8/4/21 at 2:45 PM. N.J.A.C. 8:43 A-14.4(a) D. Based on review of two (2) of seven (7) employee health files (#6, #12), staff interviews, and review of facility policy and procedure, it was determined the facility falled to ensure documentation of NJE Exce Order 26.4-11	A BUILDING 31CONTINENT OF DETICIENCIES SUMMARY STATEMENT OF DETICIENCIES (EACH DETICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 20 it was determined the facility failed to ensure the manufacturer's instructions for the enzymatic cleaner are followed. Findings include: Reference: Manufacturer's instructions for Use for SuperNova enzymatic states " concentration 2.5 oz (one quarter ounce) per gallon of water" 1. On 8/4/2021 at 12:01 PM, a sink filled with water and an enzymatic solution was observed in the manufacturer's instructions for Use for SuperNova enzymatic states " concentration area. a. The water level was below the 2 1/2 gallon mark. b. Upon interview, Staff #4 stated they fill the sink with 2.5 gallons of distilled water and add 0.62 oz of mark and an enzymatic cleaner was not in accordance with the manufacturer's instructions for use. 2. Staff #4 stated the amount of water in the sink was approximately 2 gallons and confirmed the correct concentration of the enzymatic cleaner was not in accordance with the manufacturer's instructions for use. 2. Staff #1 and Staff #2 confirmed the above findings on 8/4/21 at 2:45 PM. N.J.A.C. 8:43 A-14.4(a) D. Based on review of two (2) of seven (7) employee health files (#6, #12), staff interviews, and review of facility policy and procedure, it was determined the facility policy and procedure, it was determined the facility policy and procedure, it was determined the facility failed to ensure documentation of [M] J Exec Order 26.441	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
		31C0001023	B. WING			08/04/2021		
	PROVIDER OR SUPPLIER	BERY		18	TREET ADDRESS, CITY, STATE, ZIP CODE 8-01 POLLITT DRIVE, SUITE 4 AIR LAWN, NJ 07410			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
Q 242	Reference: Facility Testing" states, " member who cannot previous rubella scrubella scrubella scrubella scrubella scrubella scrubella scrubella screening to application to the statement of the scrube scrube (rubeola) semployees upon erupon application to communicated in w	policy, "Rubella and Rubeola Each employee and/or staff of document the results of a reening test shall be given a est, upon employment or taff 2. Employees/Staff 957 or later will be given a screening test including new imployment or staff members the staff Results will be writing to the employee/staff mented in the employee staff	Q 2	242				
Q 266	and Staff #12 lacked screening to screening	e, and Staff #3 confirmed the 3/4/21 at 2:45 PM. 7(b) 7(c) DER	Q2	266				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	DING		COMPLETED			
		31C0001023	B. WING		0	08/04/2021		
	PROVIDER OR SUPPLIER	BERY		STREET ADDRESS, CITY, STATE, ZIP CO 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	DDE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE		
Q 266	reviewed for NJ Exe NJ Exec Order 26.4 interviews, and revi procedure, it was densure the post-op Findings include: Reference: Facility Medical Record Enterviews in complete, legible, as close to contempossible, dated, and the entry." 1. Review of Medic PM revealed the following boxes were in Diet ii. Discontinue salin iii. Activity iv. Medications v. Discharge home b. The area indicative return to the doctor blank.	policy, "Medical Services, tries and Orders" states, "1. the medical record will be writing poraneously to the event as d signed by the person making al Record #1 on 8/4/21 at 2:12 flowing:	Q	266				

New Jersey Department of Health
STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		24208	B. WING		08/0	4/2021
NAME OF E	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00,0-	
18-01 PO		LITT DRIVE				
BERGEN	-PASSAIC EYE SUR	4PRY	N, NJ 07410			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	8:43A-9.3(b)(9) PH POLICIES & PROCE The facility's policie administration, con medications shall in policies and proced limitation of use of This REQUIREMED by: Based on observation of facility policy and the facility failed to are not available for Findings include: Reference: Facility states, "The facilid drugs" 1. On 8/4/21 at 10: seven (7) - 1.5 mill lubricant eye drops Resale" were found a. This finding was 8/4/21 at 10:05 AM 2. On 8/4/21 at 10: two (2) boxes cont Solution labeled "Page 1. The facilid rugs and the facility states are found as 1. This finding was 8/4/21 at 10:05 AM 2. On 8/4/21 at 10: 50 AM 2. On 8/4/21 at 10: 50 AM 3. On 8/4/21 at 10: 50 AM 4. On 8/4/21 at 10: 50 AM 4. On 8/4/21 at 10: 50 AM 5. On 8/4/21 at 10: 50 AM 5. On 8/4/21 at 10: 50 AM 6. On 8/4/21 at 10: 50 AM 7. On 8/4/21 at 10: 50 AM	ARMACEUTICAL SVCS: CEDURES It is and procedures for the trol, and storage of include, but not be limited to, dures for the control and drugs marked "sample." In it is not met as evidenced ion, staff interview, and review if procedure, it was determined ensure sample medications in use in the facility. In it is not met as evidenced ion, staff interview, and review if procedure, it was determined ensure sample medications in use in the facility. In it is not met as evidenced ion, staff interview, and review if procedure, it was determined ensure sample medications in the facility.	A2334			
	b. Staff #19 confirm 8/4/21 at 10:48 AM	ned the above findings on I.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 09/16/2021 FORM APPROVED

(X3) DATE SURVEY

New Jersey Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		24208	B. WING		08/04	4/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A3224	Emergency equipm room in a surgical sidifficult airway containmediately available. The emergency equipmediated to, resustations.	JRG & ANES SVCS: SURG IP The ent available to the operating service shall include, at least, a sainer or cart which shall be pole for handling emergencies. Suipment shall include, but not citation equipment, and and maintain an airway.	A3224			
A4532	by: Based on observatidetermined the faciairway kit or cart is emergencies. Findings include: 1. On 8/4/21 at 2:20 facility did not have immediately availables: 8:43A-16.1(b) PT FPROCEDURES		A4532			
	education concerning policies and process and process annually and as particular this REQUIREME by: Based on review of	ility shall receive in-service ng the implementation of dures regarding patient rights rt of new employee orientation. NT is not met as evidenced f seven (7) of seven (7) staff #4, #6, #7, #8, #12, #18) and				

(X2) MULTIPLE CONSTRUCTION

New Jersey Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING 08/04/2021 24208 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 18-01 POLLITT DRIVE, SUITE 4 BERGEN-PASSAIC EYE SURGERY FAIR LAWN, NJ 07410 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) A4532 A4532 Continued From page 2 staff interview, it was determined the facility failed to ensure all staff receive in-service training on patient rights annually and upon hire. Findings include: 1. Staff education files for Staff #2, Staff #4, Staff #6, Staff #7, Staff #8, Staff #12, and Staff #18, lacked evidence of in-service training on patient rights. 2. Upon interview on 8/4/21 at 2:15 PM, Staff #2 confirmed the facility does not provide staff in-service training on patient rights.

Bergen-Passaic Eye Surgery Center Provider ID Number 31C0001023

18-01 Pollitt Dr., Suite 4, Fair Lawn, NJ 07410

Date Survey Completed: 08/04/2021 Date of Re-Survey: 10/18/2021

PLAN OF CORRECTION

This Plan of Correction (POC) addresses the deficiencies noted during the revisit to the facility on October 18, 2021, of the original survey on August 3-4, 2021. The deficiencies have been addressed, and the Board and management of Bergen-Passaic Cataract Laser and Surgery Center LLC, dba Bergen-Passaic Eye Surgery Center are committed to complying with all Standards and Conditions for Coverage of the Medicare program.

ID Prefix Tag	Deficiency	Details of Correction	Monitoring Mechanism (Responsible Person)	Date of Implementation
Q240	INFECTION CONTROL CFR(s): 416.51			
	The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases.			
	This CONDITION is not met as evidenced by: Based on document review and staff interviews, it was determined the facility failed to ensure that staff education and monitoring regarding infection control practices, is implemented.	Immediate Action Taken: The Core Leadership Management Team (CLT), which includes the Administrator (CEO), Director of Nursing (DON), Infection Control/Regulatory Compliance RN (ICRN) met with the NJDOH CMS Surveyor to review the Plan of Correction (POC) implementation of education and monitoring regarding infection control practices.		
		The CLT submitted the deficiency letter and results of the Conditional Revisit survey conducted on October 18, 2021, to the Board.	The Core Leadership Management Team (CLT), under supervision of the Board, is responsible for correcting these deficiencies.	The Board was notified on October 22, 2021
		Systemic Change: The CLT took action to address the Condition-level deficiencies in Q240 416.51 Findings 1 through 8 to ensure that staff education and monitoring regarding	The Board and the CLT took responsibility for the CONDITION-level deficiency described in Q 240 following and is ensuring correction.	The corrective actions in Q 240 will be reported to the Board through the facility's Clinical



Page 2 of 18

Q240	Continued From page 1			
		infection control practices are implemented as per the PoC and to ensure an adequate an Infection Control Program consistent with CMS Conditions of Participation.		Operations Committee (COC) as noted.
		See Tags Q240 - Q242 for details of actions taken to correct deficiencies noted in these Tags. Facility Policies and Procedures, inservices and ongoing checks and rounds will be implemented to ensure systemic changes.	See each individual deficiency Q240 - Q242 following, for a description of monitoring mechanisms for complying with these components of the Q 240 Condition-level deficiency. The COC and Board as described in individual deficiencies will receive reports from the CLT in order to monitor compliance and correction of all deficiencies.	The corrective actions in Q240 - Q242 will be reported to the Board through the facility's Clinical Operations Committee as noted.
Q240	Findings 1 & 2:	Findings 1 & 2: Immediate Action Taken: The Core Leadership Team, CEO, DON, and ICRN, took immediate action to address education on proper Operating Room (OR) cleaning and disinfection		
		Systemic Change: A comprehensive education and in-service process, including documentation of same will be developed and instituted for proper Operating Room (OR) cleaning and disinfection between cases.		
		A comprehensive monitoring process, including documentation of same will be developed and instituted for proper Operating Room (OR) cleaning and disinfection between cases.	NJ Exec Order 26.4b1	

Q240 | Continued From page 2

1. The facility failed to conduct staff education on proper Operating Room (OR) cleaning and disinfection between cases, as indicated on the facility's plan of correction (PoC).

2. The facility failed to monitor compliance with the proper cleaning and disinfection of the OR between cases, as indicated on the facility's PoC.

Findings 3 & 4:

1. The US FOIA (b)(6) and US FOIA (b)(6)

designee will ensure all clinical team members are educated and in-serviced on proper Operating Room (OR) cleaning and disinfection between cases; including that the proper dry time is observed.

2. The Director of Nursing (DON) and onsite Infection Control/Regulatory Compliance RN (ICRN) or designee will monitor compliance by bi-weekly visual observation of each OR cleaning and disinfection between cases (2 times per week for each OR). Documentation of the observation will be entered in the Room Turn Over Log.

Findings 3 & 4:

Immediate Action Taken:

Tape was removed from all equipment as of the prior survey on August 4, 2021. Newly installed glucometers were permanently identified for cleaning and monitoring after the prior survey on August 4, 2021.

Systemic Change:

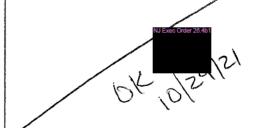
A comprehensive education and in-service process, including documentation of same will be developed and instituted for the use of tape on equipment in the facility and manufacturer's instructions for use (IFUs) for cleaning and disinfecting glucometers.

A comprehensive monitoring process,

- 1. The DON, ICRN or designee will monitor compliance by clinical team member signed education confirmation.
 100% of the eligible staff will be educated by October 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.
- 2. The DON, ICRN or designee will monitor compliance by random visual observation of each OR and document observations in the room turn over log. Once 100% compliance is achieved routine monitoring will continue for 6 months. Compliance will be reported to the COC, which will report to the Board quarterly.

1. Education of the eligible clinical team members will be completed by October 21, 2021.

2. Observation will begin on October 22, 2021. Initial audits will be no less than 6 months.



0040	C. di AF			
Q240	Continued From page 3			
		including documentation of same will be developed and instituted for the use of tape on equipment in the facility and manufacturer's instructions for use (IFUs) for cleaning and disinfecting glucometers.		
	3. The facility failed to conduct staff education on the use of tape on equipment and manufacturer's instructions for use (IFUs) for cleaning and disinfecting glucometers, as indicated on the facility's PoC	3a. The US FOIA (b)(6) site US FOIA (b)(6) US FOIA (b)(6) r their appointed designee will ensure all clinical team members are educated and in-serviced on the use of tape on equipment.	3a. The US FOIA (b)(6) or designee will monitor compliance by clinical team member signed education confirmation. 100% of the eligible staff will be educated by Oct 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.	3a. Education of the eligible clinical team members will be completed by October 21, 2021.
		3b. The US FOIA (b)(6) and onsite US FOIA (b)(6) US FOIA (b)(6) or their appointed designee will ensure all registered nurses (RNs) are educated and in-serviced on manufacturer's instructions for use (IFUs) the cleaning and disinfecting glucometers.	3b. The US FOIA (b)(6) r designee will monitor compliance by all registered nurses (RNs) signed education confirmation. 100% of the eligible RNs will be educated by October 21, 2021. All other RNs will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.	3b. Education of eligible RNs will be completed by October 21, 2021.
	4. The facility failed to monitor compliance with the use of tape on equipment, and cleaning and disinfecting glucometers, as indicated on the facility's PoC.	4. Compliance will be monitored by weekly random rounds of clinical areas for use of tape on equipment and cleaning and disinfecting glucometers. Observation findings will be documented.	4. The DON, ICRN or designee will monitor compliance by weekly visual observation of use of tape on equipment and cleaning and disinfecting glucometers. Documentation of the observation will be entered in the log. Once 100% compliance is achieved routine monitoring will continue for 6 months. Compliance will be reported to the COC, which will report to the Board quarterly.	4. Observation will begin on October 22, 2021. Initial audits will be no less than 6 months.
			i i i	129/21

0040	G-4:1P			
Q240	Continued From page 4			
	Findings 5 & 6:	Findings 5 & 6: Immediate Action Taken: The supplemental air-cooling system in the clean workroom was immediately disconnected and removed from use as of the prior survey on August 4, 2021.		
		The facility placed a work order with the Mechanical Engineering contractor to conduct removal of the unit as part of the Center's planned expansion project approved by NJ DOH and DCA functional review.		
		Systemic Change: A comprehensive education and in-service process, including documentation of same will be developed and instituted for the use of the supplemental air-cooling system in the clean workroom.		
		A comprehensive monitoring process, including documentation of same will be developed and instituted for the use of the supplemental air-cooling system in the clean workroom.		
	5. The facility failed to conduct staff education on the discontinued use of the supplemental air-cooling system in the clean workroom, as indicated on the facility's PoC.	5. The US FOIA (b)(6) and onsite US FOIA (b)(6) US FOIA (b)(6) or their appointed designee will ensure all clinical team members are educated on the discontinued use of the supplemental air-cooling system in the clean workroom.	5. The monitor compliance by clinical team member signed education confirmation. 100% of the eligible staff will be educated by October 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.	5. Education of the eligible clinical team members will be completed by October 21, 2021.

Page 6 of 18

Continued From page 5 O240 6. The facility failed to monitor 6. Compliance will be monitored by daily 6. The DON, ICRN or designee will 6. Observation will compliance with the discontinued use random rounds of clean workroom clinical monitor compliance by random weekly begin on October 22, of the supplemental air-cooling areas for discontinued use of the visual observation of the clean workroom 2021. Initial audits will system in the clean workroom, as supplemental air-cooling system. for discontinued use of the supplemental be no less than 6 indicated on the facility's PoC. Observation findings will be documented air-cooling system. Documentation of the months. observation will be entered in the log. Once 100% compliance is achieved routine monitoring will continue for 6 months. Compliance will be reported to the COC, which will report to the Board quarterly Findings 7 & 8: Findings 7 & 8 Immediate Action Taken: The Core Leadership Team, US FOIA (b)(6) took immediate action to address education on the guidelines and proper use of disinfection and sterilization of surfaces in the Center, relating to the contact time for germicidal wipes. Systemic Change: A comprehensive education and in-service process, including documentation of same will be developed and instituted for proper use of disinfection and sterilization of surfaces in the Center, relating to the contact time for CaviWipes germicidal wipes. A comprehensive monitoring process, including documentation of same will be developed and instituted for proper use of disinfection and sterilization of surfaces in the Center, relating to the contact time for CaviWipes germicidal wipes.

Continued From page 6 O240

7. The facility failed to conduct staff education on following the IFU for contact time for germicidal wipes, as indicated on the facility's PoC.

8. The facility failed to monitor compliance with the manufacturer's instructions for use for contact time when using germicidal wipes, as indicated on the facility's PoC.

SANITARY ENVIRONMENT CFR(s): 416.51(a)

O241

The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.

This STANDARD is not met as evidenced by:

7. The US FOIA (b)(6) site US FOIA (b)(6) and on-US FOIA (b)(6) or their appointed designee will ensure all clinical team members are educated on following the IFU for contact time for CaviWipes germicidal wipes.

8. Compliance will be monitored by weekly random rounds of the ORs and clinical areas observing and documenting that all clinical team members are following the IFU for contact time for CaviWipes germicidal wipes.

The Core Leadership Management Team met with the NJDOH CMS Surveyor to review the Plan of Correction (POC) implementation to provide a functional and sanitary environment for the provision of

7. The US FOIA (b)(6) or designee will monitor compliance by clinical team member signed education confirmation. 100% of the eligible staff will be educated by October 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.

8. The DON, ICRN or designee will monitor compliance by weekly random visual rounds of observing and documenting that all clinical team members are following the IFU for contact time for CaviWipes germicidal wipes. Documentation of the observation will be entered in the log. Once 100% compliance is achieved routine monitoring will continue for 6 months. Compliance will be reported to the COC, which will report to the Board quarterly.

7. Education of the eligible clinical team members will be completed by October 21, 2021.

8. Observation will begin on October 22, 2021. Initial audits will be no less than 6 months.

Immediate Action Taken:

Q241	Continued From page 7			
		surgical services by adhering to professionally acceptable standards of practice.		
		The CLT submitted the deficiency letter and results of the Conditional Revisit survey conducted on October 18, 2021, to the Board.	The CLT under supervision of the Board, is responsible for correcting these deficiencies.	The Board was notified on October 22, 2021
		Systemic Change: The standard-level deficiencies in Q241 416.51(a) A through F to ensure that staff education and monitoring concerning provision of a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice is implemented as per the PoC.	The Board and the CLT took responsibility for the Standard-level deficiency described in Q241416.51(a) A through F following and is ensuring correction. The corrective actions in Q241 will be reported to the Board through the facility's Clinical Operations Committee (COC) as noted.	The corrective actions in Q241 will be reported to the Board through the facility's COC as noted.
	education regarding proper OR cleaning and disinfection between cases, as indicated in the facility's Plan of Correction (PoC). Findings include:	A. The IS FOIA (b)(6) US FOIA (b)(6) or their appointed designee will ensure all clinical team members are educated and in-serviced on proper Operating Room (OR) cleaning and disinfection between cases; including that the proper dry time is observed	A. Thus Fola (b)(6) or designee will monitor compnance by clinical team member signed education confirmation. 100% of the eligible staff will be educated by October 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.	A. Education of the eligible clinical team members will be completed by October 21, 2021.
	1. The facility's PoC, dated 9/30/21, states, "Systemic Change: 1. The facility will ensure that all surfaces in the OR are properly cleaned and disinfected between cases The Director of Nursing (DON) will		OK 10/21/21	

the OR are properly cleaned and

Continued From page 8 O241 ensure that in-service education is completed, documented, and reported to the COC, which reports to the Board.... In-service education was completed as of August 31, 2021." 2. During the entrance conference at 10:00 AM, a request was made to Staff#1and Staff#2 for the staff education conducted regarding the cleaning and disinfection of the OR between cases. No staff education was provided. 3. Upon interview at 11:30 AM, Staff#3 confirmed that there was no evidence that staff education regarding the cleaning and disinfection of the OR between cases. was conducted. B. Based on document review and B. The DON, ICRN or designee will B. The Director of Nursing (DON) and on-B. Observation will staff interviews, it was determined site Infection Control/Regulatory monitor compliance by random visual begin on October 22, the facility failed to monitor Compliance RN (ICRN) or designee will observation of each OR and document 2021. Initial audits will compliance with the proper cleaning monitor compliance by bi-weekly visual observations in the room turn over log. be no less than 6 and disinfection of the OR between observation of each OR cleaning and Once 100% compliance is achieved routine months. cases, as indicated on the facility's disinfection between cases (2 times per monitoring will continue for 6 months. week for each OR). Documentation of the Compliance will be reported to the COC, PoC. observation will be entered in the Room which will report to the Board quarterly. Turn Over Log. Findings Include: 1. The facility's PoC, dated 9/30/21, states, "Systemic Change: 1. The facility will ensure that all surfaces in

O241

Continued From page 9

disinfected between cases... The

US FOIA (b)(6)

will monitor compliance by random visual observation of each OR and document the observation in the OR Log daily. ... Monitoring has been ongoing since the date of the survey August 4, 2021."

- 2. During the entrance conference at 10:00 AM, a request was made to Staff#1 and Staff#2 for the observations documented on the daily OR Logs beginningAugust4, 2021. The OR Logs provided did not include observations of the proper cleaning and disinfection of the OR between cases.
- 3. Upon interview at 11:30 AM, Staff#3 confirmed that the OR Logs did not include observations of the proper cleaning and disinfection of the OR between cases.
- C. Based on document review and staff interviews, it was determined the facility failed to conduct staff education on the use of tape on equipment and manufacturer's instructions for use (IFUs) for cleaning and disinfecting glucometers, as indicated on the facility's PoC.

C. Thus FOIA (b)(6) and on-US FOIA (b)(6) ppointed designee will ensure all clinical team members are educated and in-serviced on the use of tape on equipment. C. The US FOIA (b)(6) or designee will monitor compliance by clinical team member signed education confirmation. 100% of the eligible staff will be educated by Oct 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.

C. Education of the eligible clinical team members will be completed by October 21, 2021.

Continued From page 10 O241 us FOIA (b)(6), or designee will monitor The US FOIA (b)(6) and on-site Education of eligible compliance by all registered nurses (RNs) RNs will be completed signed education confirmation. 100% of the by October 21, 2021. ensure all registered nurses (RNs) are eligible RNs will be educated by October educated and in-serviced on manufacturer's 21, 2021. All other RNs will be educated instructions for use (IFUs) the cleaning and before their first shift. Education compliance will be reported to the COC, disinfecting glucometers. which will report to the Board quarterly. Findings include: 1. The facility's PoC, dated 9/30/21, states, "Immediate Action Taken: 1. Tape was removed off the anesthesia cart... Systemic Change: 1. All clinical staff have been re-educated about the use of tape in the facility. ...Immediate Action Taken:1. Three (3) new glucometers were purchased, and the older units were discarded, 2. All clinical personnel have received training on the units, a review of the manufacturer's instructions for use as well as cleaning and disinfection. ... The US FOIA (b)(6) ensure that in-service education is completed... In-service education was completed as ofAugust15, 2021." 2. During the entrance conference at 10:00 AM, a request was made to Staff#1and Staff#2 for staff education regarding the use of tape in the facility, and the staff education regarding the manufacturer's instructions for use for the cleaning and disinfection of glucometers. No staff education was provided.

- 3. Upon interview at 11:30 AM, Staff#3 confirmed that there was no evidence of staff education regarding the use of tape in the facility, or evidence of staff education regarding manufacturer's instructions for use for the cleaning and disinfection of glucometers.
- D. Based on document review and staff interviews, it was determined the facility failed to monitor compliance with the use of tape on equipment, and cleaning and disinfecting glucometers, as indicated on the facility's PoC.

Findings include:

1. The facility's PoC, dated 9/30/21, states, "Immediate Action Taken: 1. Tape was removed off the anesthesia cart... Systemic Change: 2. The

US FOIA (b)(6)^{and on-}atory

designee will monitor compliance by visual observation of the anesthesia carts and document the observation on the audit log. ... The US FOIA (b)(6) re responsible to monitor compliance of the systemic changes weekly... Monitoring has been ongoing since the date of the survey, August 4, 2021. ...Immediate Action Taken: 1. Three (3) new glucometers were

D. Compliance will be monitored by weekly random rounds of clinical areas for use of tape on equipment and cleaning and disinfecting glucometers. Observation findings will be documented D. The DON, ICRN or designee will monitor compliance by weekly visual observation of use of tape on equipment and cleaning and disinfecting glucometers. Documentation of the observation will be entered in the log. Once 100% compliance is achieved routine monitoring will continue for 6 months. Compliance will be reported to the COC, which will report to the Board quarterly.

D. Observation will begin on October 22, 2021. Initial audits will be no less than 6 months.

purchased, and the older units were discarded...2. Facility Policies and Procedures... and ongoing checks and rounds will be implemented to ensure systemic changes... The DON and ICRN are responsible to monitor compliance with the systemic changes at least monthly...

Monitoring has been ongoing since the date of the survey, August 4, 2021."

- 2. During the entrance conference at 10:00 AM, a request was made to Staff#1 and Staff#2 for the monthly monitoring rounds regarding the use of tape in the facility and the cleaning and disinfecting of glucometers. No evidence of monthly monitoring was provided.
- 3. Upon interview at 11:30 AM, Staff#3 confirmed that there was no evidence of monthly monitoring regarding the use of tape in the facility and the cleaning and disinfecting of glucometers.
- E. Based on document review and staff interviews, it was determined the facility failed to conduct staff education on the discontinued use of the supplemental air-cooling system in the clean workroom, as indicated on the facility's PoC.

E. The US FOIA (b)(6) and on-US FOIA (b)(6) ppointed designee will ensure all clinical team

designee will ensure all clinical team members are educated on the discontinued use of the supplemental air-cooling system in the clean workroom. E. The US FOIA (b)(6) or designee will monitor compliance by clinical team member signed education confirmation. 100% of the eligible staff will be educated by October 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.

E. Education of the eligible clinical team members will be completed by October 21, 2021.

Continued From page 13 O241 Findings include: 1. The facility's PoC, dated 9/30/21, states, "Immediate Action Taken: 1. The individual split room air handling unit that was observed and being used as a supplemental air cooling for the clean workroom was immediately disconnected and removed from use. ... Systemic Change... 3. All clinical staff have been educated about the discontinued use of the supplemental air cooling for the clean workroom." 2. During the entrance conference at 10:00 AM, a request was made to Staff#1and Staff#2 for staff education conducted regarding the discontinued use of the split room air handling unit. No staff education was provided. 3. Upon interview at 11:30 AM, Staff#3 confirmed that there was no evidence of staff education conducted regarding the discontinued use of the split room air handling unit. F. Based on document review and F. Compliance will be monitored by daily F. The DON, ICRN or designee will F. Observation will staff interviews, it was determined random rounds of clean workroom clinical monitor compliance by random weekly begin on October 22, the facility failed to monitor areas for discontinued use of the visual observation of the clean workroom 2021. Initial audits will compliance with the discontinued use supplemental air-cooling system. for discontinued use of the supplemental be no less than 6 of the supplemental air-cooling Observation findings will be documented. air-cooling system. Documentation of the months. system in the clean workroom, as observation will be entered in the log. Once indicated on the facility's PoC. 100% compliance is achieved routine monitoring will continue for 6 months.

Page 15 of 18

0241	Continued France 10	T	T	T
Q241	Continued From page 10			
	Pindings in the last			
	Findings include:			
	1. The facility's PoC, dated 9/30/21,			
	states, "Immediate Action Taken: 1.			
	The individual split room air			
	handling unit that was observed and			
	being used as a supplemental air			
	cooling for the clean workroom was			
	immediately disconnected and			
	removed from use The DON and			
	ICRN are responsible to monitor			
	compliance with the systemic change			
	daily and report to the COC which			
	will report to the Board			
	Monitoring began as of September			
	16, 2021."			1
	2. During the entrance conference at			
	10:00 AM, a request was made to			
	Staff#1and Staff#2 for evidence of			
	monitoring for compliance regarding			
	the discontinued use of the			
	supplemental air-cooling system in			
	the clean workroom. No evidence of			
	monitoring was provided.			
	monitoring was provided.			
	3. Upon interview at11:30 AM,			
	Staff#3 confirmed that there was no			
	evidence of monitoring regarding the			
	discontinued use of the supplemental			
	air-cooling system in the clean			
	workroom.			
	WOLKLOOM.			
Q242	INFECTION CONTROL			
Q242	•			
	PROGRAMCFR(s): 416.51(b)			
	The ACC mount maintain and are	Torono allindo Andino Mal		
	The ASC must maintain an ongoing	Immediate Action Taken:		
<u></u>	program designed to prevent, control,	The Core Leadership Management Team		

O242

Continued From page 15

and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.

This STANDARD is not met as evidenced by:

A. Based on document review and staff interviews, it was determined the facility failed to conduct staff education regarding adherence to manufacturer's instructions for use regarding contact time for germicidal wipes, as indicated on the facility's PoC.

1. The facility's PoC, dated 9/30/21, states, "Systemic Change... 2. All staff will be educated on following manufacturer's instructions for proper

met with the NJDOH CMS Surveyor to review the Plan of Correction (POC) implementation to maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases as per AAMI guidelines.

The CLT submitted the deficiency letter and results of the Conditional Revisit survey conducted on October 18, 2021, to the Board.

Systemic Change:

The USFOA(D)80 ok action to address the deficiencies in Q242 416.51(b) to ensure that staff education and monitoring is implemented as per the PoC, to prevent, control, and investigate infections and communicable diseases and to ensure a sanitary environment is in place as part of a comprehensive Infection Control program.

A. The US FOIA (b)(6) and on-US FOIA (b)(6) prointed

designee will ensure all clinical team members are educated on following the IFU for contact time for wipes.

The CLT under supervision of the Board, is responsible for correcting these deficiencies.

The Board and the CLT took responsibility for the Standard-level deficiency described in Q242 416.51(b) A through B following and is ensuring correction.

The corrective actions in Q242will be reported to the Board through the facility's Clinical Operations Committee (COC) as noted.

A. The or designee will monitor compliance by clinical team member signed education confirmation. 100% of the eligible staff will be educated by October 21, 2021. All other clinical team members will be educated before their first shift. Education compliance will be reported to the COC, which will report to the Board quarterly.

The Board was notified on October 22, 2021

The corrective actions in Q242 will be reported to the Board through the facility's COC as noted.

A. Education of the eligible clinical team members will be completed by October 21, 2021.

NJ Exec Order 28.4b1

states, "Systemic Change... 2. All staff will be educated on following

Continued From page 16 O242 use of NJ Exec Order 26.4b1 leaners, including dry time. ... Re-education was completed as of September 15, 2021." 2. During the entrance conference at 10:00 AM, a request was made to Staff#1and Staff#2 for evidence of staff education regarding following manufacturer's instructions for use for contact time for NJ Exec Order 26.4b germicidal wipes. No staff education was provided. Continued From page 12 3. Upon interview at 11:30 AM, Staff#3 confirmed that there was no evidence of staff education regarding following manufacturer's instructions for use for contact time for NJ Exec Order 26.4b1 ermicidal wipes. B. Based on document review and B. Compliance will be monitored by weekly B. The DON, ICRN or designee will B. Observation will staff interviews, it was determined random rounds of the ORs and clinical areas monitor compliance by weekly random begin on October 22, the facility failed to monitor observing and documenting that all clinical visual rounds of observing and documenting 2021. Initial audits will compliance with the manufacturer's team members are following the IFU for that all clinical team members are following be no less than 6 instructions for use for contact time contact time for CaviWipes germicidal the IFU for contact time for CaviWipes months. when using germicidal wipes. germicidal wipes. Documentation of the wipes, as indicated on the observation will be entered in the log. Once facility's PoC. 100% compliance is achieved routine monitoring will continue for 6 months. Compliance will be reported to the COC, which will report to the Board quarterly. Findings include: 1. The facility's PoC, dated 9/30/21,

Classified as Confidential

Page 18 of 18

Continued From page 16 Q242 manufacturer's instructions for proper use of leaners, including dry time. ... The CLT is responsible to monitor compliance with the systemic change by visual observation daily and report to the COC quarterly, which will report to the Board." 2. During the entrance conference at 10:00 AM, a request was made to Staff#1and Staff#2 for evidence of monitoring for compliance with following manufacturer's instructions for use for contact time when using Continued From page 13 germicidal wipes. No evidence of monitoring was provided. 3. Upon interview at 11:30 AM, Staff#3 confirmed that there was no evidence of monitoring for compliance with following manufacturer's instructions for use for contact time when using

NJ Exec Order 26.4b1

rmicidal wipes.

Bergen-Passaic Cataract Laser & Surgery Center, LLC dba Bergen-Passaic Eye Surgery Center

October 28, 2021

Date

Telephone (201) 414-5649

Classified as Confidential

PLAN OF CORRECTION

This Plan of Correction (POC) addresses the deficiencies noted during the visit to the facility on August 3-4, 2021. The deficiencies have been addressed, and the Governing Body and management of Bergen-Passaic Cataract Laser and Surgery Center LLC are committed to complying with all Standards and Conditions for Coverage of the Medicare program.

Deficiency	Details of Correction	Monitoring Mechanism (Responsible Person)	Date of Implementation
Q 240 CFR(s): 416.51 INFECTION CONTROL This CONDITION was not met because the facility failed to	Immediate Action Taken: 1. The Core Leadership Management Team (CLT),	See each individual finding in	The corrective actions in
ensure the maintenance of an infection control program.	which includes the Administrator (CEO), Director of Nursing (DON), Infection Control/Regulatory Compliance RN (ICRN) met with the NJDOH CMS Survey Team to review and understand all cited deficiencies in the survey and reported all deficiencies to the Board.	Q 240 - Q 243 following, for a description of monitoring mechanisms for complying with these components of the Q 240 Condition-level deficiency.	Q 240, Q 241, Q 242, and Q 243 will be reported to the Board through the facility's Clinical Operations Committee (COC).
	2. The CLT took immediate action to address the Condition-level deficiencies and ensure an adequate Sanitary Environment Program and an Infection Control Program consistent with CMS Conditions of Participation. See Tags Q 240 - Q 243 for details of actions taken to correct deficiencies noted in these Tags.	The Core Leadership Management Team (CLT), under supervision of the Board, is responsible for correcting these deficiencies. The COC and Board as described in	The Board, ownership and the CLT took responsibility for the CONDITION-level deficiency described in Q 240 following, as well as
	Systemic Change: 1. The facility will implement a comprehensive Sanitary Environment program to prevent the risk of infection and communicable disease, ensure a sanitary	individual deficiencies will receive reports from the CLT in order to monitor compliance and correction of all deficiencies.	all other deficiencies noted on the 2567, and is ensuring correction.
	environment is in place, as referenced in responses to Q240, Condition 416.51 which follows.		The COC was notified of the exit interview remarks at the meeting on August
	2. The facility will implement a comprehensive Infection Control program to prevent transmission of disease, ensure a sanitary environment is in place,		10, 2021. The information was presented to and discussed by the Board on
	including adequate medication management, as referenced in responses to Q240, Condition 416.51 which follows.		August 12, 2021.

Q 083 CFR(s): 416.43(d) PERFORMANCE IMPROVEMENT PROJECTS

This STANDARD was not met because the facility failed to ensure quality assessment and performance improvement (QAPI) projects were selected based on the needs of the facility.

- (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.
- (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results.

Immediate Action Taken:

Requirements for the criteria and selection of Quality Assessment and Performance Improvement (QAPI) projects were reviewed by the Core Leadership Management Team (CLT), which includes the Administrator (CEO), Director of Nursing (DON), Infection Control/Regulatory Compliance RN (ICRN), and the Business Office Manager (BOM), and the Clinical Operations Committee (COC).

Systemic Change:

- 1. The Clinical Operations Committee (COC) will appoint the Performance Improvement Project (PIP) Committee Chair with Board approval to present and discuss the quality data indicators or the identification of medical errors, which may identify quality issues, to be focused upon in the upcoming quarter. The number and scope of Performance Improvement projects will be determined by the ongoing collection and analysis of these quality indicator and performance measure data which identify quality issues within the facility.
- 2. The determination for undertaking each Performance Improvement Project (PIP) will be documented in the COC minutes and include the data to be collected, the manner by which it will be collected, how frequently it will be collected and analyzed, and the measurable impact to improve patient safety, health outcomes, or facility performance. This information and the results of the PIP will be presented to the COC by the PIP Chair.

At the COC meeting on August 10, 2021 the DON and the Medical Director discussed the issue of anesthesiology canceling, postponing, or rescheduling surgical cases and its impact on patient care. The COC jointly decided that a study will be conducted to track and review these cases to see what the causes are and if there is an opportunity to reduce the number of occurrences.

The Director of Nursing (DON) is responsible to document the CLT and COC review of the QAPI guidelines and requirements. The DON will present the documentation at the next quarterly COC meeting.

The (COC) will present the Performance Improvement Project (PIP) Committee Chair appointment for Board approval.

The COC will present the PIP Chair to the Board by November 16, 2021.

Review of the QAPI

completed by September

30, 2021. The results will

which reports to the Board.

be reported to the COC,

requirements were

The (PIP) Chair will present the quality data indicators and ongoing projects to the CLT quarterly and documented in the COC minutes and presented to the Board quarterly.

The DON is collecting the case data from August 1 through October 31, 2021, for retrospective review by the anesthesia and nursing directors.

The preliminary data will be presented at the next COC meeting on November 16, 2021. Q 181 CFR(s): 416.48(a) N.J.A.C. 8:43A- 18.2(f) ADMINISTRATIONOF DRUGS

This STANDARD was not met because:

- A. The facility failed to ensure medications are stored in accordance with manufacture instructions.
- One 15mm bottle of Proparacaine Hydrochloride Ophthalmic Solution was found stored in a cabinet at room temperature in Exam Room in temperature in Exam Room in the manufacturer.

N.J.A.C. 8:43A-9.5(b)

- B. The facility failed to ensure that expired medications are removed from inventory.
- The following expired medications were found in the code cart in the NUERCOORDERAGE TEACHER.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the code cart in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired medications were found in the NUERCOORDERAGE.

 The following expired

Immediate Action Taken:

 Because the Proparacaine Hydrochloride Ophthalmic Solution was not properly stored in the refrigerator, the contents were wasted and discarded.

Systemic Change:

- 1. The Director of Nursing (DON), and on-site Infection Control/Regulatory Compliance RN (ICRN) will work together to ensure that all clinical staff will be retrained on the facility's Medication policies and procedures, and in reading, understanding, and following Manufacturer's Instructions for Use (IFU), Storage and Disposal.
- 2. An RN will be assigned by the DON to monitor medication storage on a weekly basis. The weekly Medication storage audit will continue by quarter until 100% compliance is reached. Subsequent random monthly monitoring will continue afterward. Results of audits will be reported to the DON on an audit log. The DON will report the monitoring results to the COC, which reports to the Board.
- 3. The Center Contract Pharmacist will also perform a proper Medication storage audit quarterly and report the audit results to the DON.

Immediate Action Taken:

1. The expired medications were removed from inventory and the contents were wasted and discarded.

Systemic Change:

1. The US FOIA (b)(6) US FOIA (b)(6) and on-site

ensure that in-service education regarding medication policies and handling is presented to the clinical staff. The will report to the COC, which reports to the Board.

Weekly monitoring will be done by an RN assigned by the DON. Subsequent random monthly monitoring will be carried out by an RN appointed by the DON. Results of audits will be reported to the DON. The DON will report the monitoring results to the COC, which reports to the Board.

Results of the Contract Pharmacist's audit will be reported to the DON, who will report the results to the COC, which reports to the Board.

Review and retraining of the clinical staff will be documented and completed by Oct 15, 2021.

Weekly monitoring will begin October 4, 2021 The DON will report the monitoring results and the rare of compliance to the COC quarterly beginning November 2021.

Quarterly monitoring by the Contract Pharmacist will begin with the 3rd quarter 2021. The DON will report the monitoring results and the rate of compliance to the COC quarterly.

The will ensure that in-service education regarding medication policies

Review and retraining of the clinical staff will be

Q181 Continued from page 3

- a. Four (4) one (1) milliliter (ml) vials of Phenylephrine 10 milligram (mg)/ml with an expiration date of 7/21
- b. Three (3) five (5) ml containers of Lidocaine Jelly 2% with an expiration date of 7/21
- c. One (1) thirty (30) ml container of Lidocaine Jelly 2% with an expiration date of 7/21
- 2. The following expired medications were found in the code cart located in the NJ Exec Order 26.4b1 Jinit
- a. Two (2) five (5) ml containers of Lidocaine Jelly 2% with an expiration date of 7/21

N.J.A.C. 8:43A-9.5(f)

- C. The facility failed to ensure that single use medications are used solely for one patient and that multidose ophthalmic drops that are opened are labeled and dated with the date opened and discarded after twenty-eight days, by the expiration date or manufacturer's recommendation if sooner.
- 1. The following Single Use medications were found opened and partially filled, available for patient use in Exam Room #

will ensure that all clinical staff will be retrained on the facility's Medication policies and procedures, and in reading, understanding, and following Manufacturer's Instructions for Use (IFU), Storage and Disposal,

- An RN will be assigned by the DON to monitor expired medication storage on an ongoing monthly basis. Results of audits will be reported to the DON on an audit log. The DON will report the monitoring results to the COC, which reports to the Board
- 3. The Center Contract Pharmacist will also perform a Medication expiration audit quarterly and report the audit results to the DON.

Immediate Action Taken:

1. Because the open medications were labeled for "single use" the contents were wasted and discarded.

Systemic Change:

1. The US FOIA (b)(6) and on-site US FOIA (b)(6) US FOIA (b)(6)

all clinical staff will be retrained on the facility's Medication policies and procedures for single use medications.

2. The Director of Nursing (DON) and on-site Infection Control/Regulatory Compliance RN (ICRN) or their designee will visually monitor and report via audit log the OR and other patient care areas to ensure that safe administration of eye drops protocols are followed,

and handling is presented to the clinical will report to the COC, staff. The I which reports to the Board.

An RN will be assigned by the DON to monitor medication expiration monthly. Results of the monitoring be reported to the DON. The DON will report the monitoring results to the COC, which reports to the Board.

Results of the Contract Pharmacist's audit will be reported to the DON, who will report the results to the COC, which reports to the Board.

documented and completed by Oct 15, 2021.

Monitoring began September 1, 2021. The DON will report the monitoring results and the rare of compliance to the COC quarterly beginning November 2021.

Quarterly monitoring by the Contract Pharmacist has been ongoing. The DON reports the monitoring results and the rare of compliance to the COC quarterly.

The US FOIA (b)(6) will ensure that in-service education regarding single use medication policies and handling is presented to the clinical staff. The usfola will report to the COC, which reports to the Board

The DON and ICRN are responsible to monitor the rate of compliance with the systemic change weekly, and report rates of observed compliance to the COC which will report to the Board.

Review and retraining of the clinical staff will be documented and completed by Oct 15, 2021.

Weekly monitoring will begin October 4, 2021 and remain ongoing.

will ensure

Q181 Continued from page 4

- a. Two (2) 118 milliliter (ml) bottles of Purified Water 98.3% Ophthalmic Solution Eyewash
- 2. The following multi-use ophthalmic drops were found in Exam Room ppened and undated, stored in a drawer, and available for patient use:
- a. One (1) 15 ml container of Tropicamide Ophthalmic Solution 1%
- b. One (1) 2.5 ml container of Flurbiprofen Sodium Ophthalmic Solution 0.03%
- 3. The following multi-use ophthalmic drops were found stored in a cart in Operating Room opened, undated, and available for patient use:
- a. One (1) 2.5 ml container of Flurbiprofen Sodium Ophthalmic Solution 0.03%
- b. Two (2) 5 ml containers of Levobunolol Hydrochloride Ophthalmic Solution 0.5%
- c. One (1) 5 ml container of Tobramycin Ophthalmic Solution 0.3%
- d. One (1) 5 ml container of Timolol Maleate Ophthalmic Solution 0.5%
- e. Two (2) 5 ml containers of Prednisolone Acetate Ophthalmic Suspension 1%

limiting all vials and bottles labeled for single patient use to use for one patient only.

Immediate Action Taken:

 Because the multi-use medications were open and unlabeled without the date opened and discard date information the contents were wasted and discarded.

Systemic Change:

1. The US FOIA (b)(6) and on-site US FOIA (b)(6) br designee will ensure all clinical staff are re-instructed and re-

will ensure all clinical staff are re-instructed and reoriented on the facility's Medication policies and procedures for multi-use medication bottles and vials.

2. The Director of Nursing (DON) and on-site Infection Control/Regulatory Compliance RN (ICRN) or their designee will monitor the OR and other patient care areas to ensure that safe administration of eye drops protocols are followed, labeling all multi-use vials with the date opened and proper discard date; after twentyeight days, by the expiration date or manufacturer's recommendation if sooner. The US FOIA (b)(6) will ensure that in-service education regarding multi-use medication policies and handling is presented to the clinical staff. The will report to the COC, which reports to the Board

The DON and ICRN are responsible to monitor compliance with the systemic change weekly until 100% compliance is achieved. Rates of observed compliance will be reported to the COC which will report to the Board.

Review and retraining of the clinical staff will be documented and completed by Oct 15, 2021.

Weekly monitoring will begin October 4, 2021 and remain ongoing.



Q181 Continued from page 5

f. One (1) - 15 ml container of Pilocarpine Hydrochloride Ophthalmic Solution 1%

g. One (1) - 5 ml container of Brimonidine Tartrate Ophthalmic Solution 0.2%

h. One (1) - 5 ml container of Ofloxacin Ophthalmic Solution 0.3%

i. One (1) - 3.5 gram tube of Erythromycin Ophthalmic Ointment .5%

N.J.A.C. 8:43A-9.5(f)

- D. Based on observation, staff interview, review of New Jersey State Board of Pharmacy guidelines, and review of policy and procedure, it was determined the facility failed to ensure all medications and syringes are kept locked when not in use.
- 1.In the NJ Exec Order 26.4b1 Area, the following was observed:
- a. The anesthesia cabinet was found unlocked and unattended with medications inside.
- b. The cabinet directly adjacent to the anesthesia cabinet was found unlocked and unattended with syringes inside

Immediate Action Taken:

All anesthesia carts and cabinets containing medications and/or syringes were immediately locked.

Systemic Change:

1. All members of the Anesthesia staff will be instructed on the facility's policies and procedures regarding medication security measures. They will be re-instructed that all medications and syringes must be secured at all times, either in a locked cart or in the

The US FOIA (b)(6) will assist the Anesthesia Director in preparing instruction for all anesthesia staff members regarding medication safety and security. The Anesthesia Director will meet with members of the

Corrective in-service on medication safety and security information will be presented to the anesthesia staff no later than October 15, 2021.... Q181 Continued from page 6 anesthesia staff, individually or as a personal possession and control of the anesthesia group, and present corrective provider. information on medication safety and security. The Anesthesia Director will document when the anesthesia staff has completed the in-service and report to the COC, who will inform the Board. Weekly monitoring will The DON and Anesthesia Director are 2. The DON and Anesthesia Director or their designee responsible to monitor compliance with begin October 4, 2021 and will visually monitor and physically verify to ensure that medications and syringes in the anesthesia carts remain the systemic change weekly until 100% remain ongoing. compliance is achieved. Rates of secure at all times. Results will be reported via audit observed compliance will be reported to log. the COC which will report to the Board. Corrective in-service on The Director of Nursing (DON) will 3. In Exam Room #2 needles ensure that in-service education medication safety and were found stored in a drawer regarding medication security policies security information will all clinical staff are re-instructed and re-oriented on the that was unlocked and and procedures is presented to the be presented to the clinical facility's Medication and syringe security policies and unattended staff no later than October clinical staff. The DON will report procedures. completion to the COC, which reports to 15, 2021. the Board 4. In Operating Room Weekly monitoring will 4. The Director of Nursing (DON) and on-site Infection The DON and ICRN are responsible to begin October 4, 2021 and two (2) open metal baskets Control/Regulatory Compliance RN (ICRN) or designee monitor compliance with the systemic containing needles and syringes will visually monitor and physically verify to ensure that change weekly, and report rates of remain ongoing were found on top of the observed compliance to the COC which medications and syringes in the OR and other patient anesthesia cart, unattended. care areas remain secure at all times. Results will be will report to the Board reported via audit log. Q225 N.J.A.C. 8:43A-9.3(a) N. J.A.C. 8:43A-9.3(b)6 SUBMISSION AND INVESTIGATION OF GRIEVANCES CFR(s): 416.50(d)(4),(5),&(6) The ASC must establish a Immediate Action Taken: The Grievance policy criteria were researched and grievance procedure reviewed by the Core Leadership Team (CLT). for documenting the existence,

Q225	Continue	d from	page	7
------	----------	--------	------	---

submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. The following criteria must be met:

- (1) The grievance process must specify time frames for review of the grievance and the provisions of a response.
- (2) The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished.
- (3) The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the result of the grievance process and the date the grievance process was completed.

This STANDARD is not met as evidenced by: Based on review of three (3) of three (3) medical records (#21,

Systemic Change:

- 1. The grievance policy will be reviewed including the criteria for identifying a grievance. The procures for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance against the Center, care, or any other matter as per CFR(s): 416.50(d).
- 2. The time frame for investigating and resolving a grievance is 30 days. Documentation of the how the grievance was addressed and/or resolved will be kept in a central location, the Grievance log, as well as being provided to the patient in writing. The Center Administrator is listed as the ASC contact person.
- 3. All Center personnel will receive a copy of the policy and in-service re-education on the policy.
- 4. The Administrator (CEO) and on-site Infection Control/Regulatory Compliance RN (ICRN) or designee will monitor Grievances and the Grievance log to ensure compliance.

The Administrator (CEO) will submit the grievance policy to the Board for approval if there are any required updates to the policy.

In-service education regarding the Grievance policy will be presented to the staff by October 15, 2021.

The CEO and ICRN are responsible to monitor compliance weekly for the first quarter and monthly thereafter. Rates of compliance will be reported to the COC which will report to the Board.

The policy was approved on September 27, 2021

In-service education on the Grievance Policy will be presented to the staff no later than October 15, 2021.

Weekly monitoring will begin in October, 2021.



Q225 Continued from page 8

#22, #23), staff interviews, and review of facility documents, it was determined the facility failed to ensure all grievances lodged by patients receive a follow-up written response.

N.J.A.C. 8:43A- 16.1(a) Q 240 1INFECTION CONTROL CFR(s): 416.51

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

This CONDITION is not met as evidenced by:

Based on observation, document review, and staff interviews, it was determined the facility failed to ensure the maintenance of an infection control program that minimizes infections and communicable diseases.

Findings include:

- The facility failed to ensure implementation of policies and procedures for cleaning in between surgical procedures. (Cross Refer to Tag Q-0241)
- The facility failed to ensure sterilized items are stored to maintain sterility, in accordance with the Association for the Advancement of Medical Instrumentation (AAMI)

Immediate Action Taken:

 The Core Leadership Team, CEO, DON, and ICRN, took immediate action to address the Condition-level deficiencies. See Tags Q 241, Q 242, and Q 243 for details of Immediate Actions taken to correct deficiencies noted in these Tags.

Systemic Change:

- Facility Policies and Procedures, in-services and ongoing visually checks and rounds will be implemented to ensure systemic changes.
- 2. See Tags Q 241, Q 242, and Q 243 for details of changes taken to correct deficiencies noted in these Tags.

The DON and ICRN are responsible to monitor compliance and report rates of observed compliance to the COC which will report to the Board

rius FOIA (b)(6) will ensure that in-service education is completed, documented, and reported to the COC, which reports to the Board.

Monitoring has been ongoing since the date of the survey August 4, 2021.

In-service education was completed as of August 31, 2021.



Q240 Continued From page 9			
guidelines. (Cross Refer			
to Tag Q-0242)			
3. The facility failed to ensure			
the enzymatic detergents are			
used in accordance with the			
manufacturer's instructions for			
use. (Cross Refer to Tag Q- 0242)			
·			
The facility failed to ensure its infection control program is			
under the direction of a			
designated and qualified			
professional with training in			
infection control. (Cross Refer to Tag Q-0243)			
5. The facility failed to ensure follow disinfectant wipes			
manufacturer's instructions for			
use. (Cross Refer to Tag Q-			
0242)			
Q 241 SANITARY			
ENVIRONMENT			
CFR(s): 416.51(a)			
The ASC must provide a			
functional and sanitary			
environment for the provision of surgical services by adhering to			
professionally acceptable			
standards of practice.			
This STANDARD is not met as			
evidenced by:	Immediate Action Taken:		
A. Based on observation of post	1. The anesthesia cart, a medication preparation	NJ Exec Order 26.4b1	
procedure room turnover	area, was cleaned and disinfected.		
cleaning, staff interview, and	2. OR #3 personnel were reeducated on the post		
review of nationally recognized	procedure room turnover cleaning.	1× /3x	
		V.0/5 /	

guidelines, it was determined the facility failed to ensure the medication preparation area is cleaned and disinfected after each surgical procedure.

Findings include: Reference: AORN (Association of Perioperative Registered Nurses) Perioperative

Standards and Recommended Practices, 2019 edition, pg. 180 states, "Recommendation III... A clean environment should be established after the patient is transferred from the area... III.c. Operating and procedure rooms must be cleaned after each patient... III.c.3. Items that are used during patientcare should be cleaned and disinfected after each patient use, including anesthesia carts and equipment."

1. During an observation of

NJ Exec Order 26.4b1

cleaning on 8/4/2021at 11:06 AM, Staff #15 was observed cleaning Operating Room (OR)

a. The anesthesia cart, a medication preparation area, was not cleaned and disinfected after the patient was transferred out of the room.

Systemic Change:

1. The facility will ensure that all surfaces in the OR are properly cleaned and disinfected between cases, and that the proper dry time is observed. The Director of Nursing (DON) and on-site Infection Control/Regulatory Compliance RN (ICRN) or designee will monitor compliance by random visual observation of each OR and document the observation in the OR Log daily.

2. Facility Policies and Procedures, in-services and ongoing checks and rounds will be implemented to ensure systemic changes. The Director of Nursing (DON) and on-site Infection Control/Regulatory Compliance RN (ICRN) or designee will monitor compliance by random visual observation of each OR and document the observation in the OR Log daily.

The DON and ICRN are responsible to monitor compliance with the systemic changes weekly, and report rates of observed compliance to the COC which will report to the Board

ThUS FOIA (b)(6) will ensure that in-service education is completed, documented, and reported to the COC, which reports to the Board.

The DON and ICRN are responsible to monitor compliance with the systemic changes weekly, and report rates of observed compliance to the COC which will report to the Board Monitoring has been ongoing since the date of the survey August 4, 2021.

In-service education was completed as of August 31, 2021.

Monitoring has been ongoing since the date of the survey August 4, 2021.



2. Upon interview, Staff #2 stated the anesthesia cart is supposed to be cleaned by the anesthesiologists.

N.J.A.C. 8:43A-14.3(a)

B. Based on random observation and staff interview, it was determined the facility failed to ensure all equipment is clean.

Findings include:

1. During a tour of OR #3 on 8/4/2021at 11:06 AM, tape was observed on the anesthesia cart, rendering the surface uncleanable,

3. On 8/4/21 at 11:30 AM, in the Preoperative area, three (3)

N Exec Order 26:491 glucometers were found stored in a cabinet. The glucometers each had a paper sign secured with multiple pieces of clear, sticky, narrow tape on the back of the device, rendering the surface uncleanable.

Immediate Action Taken:

1. Tape was removed off the anesthesia cart, a medication preparation area, and the cart was cleaned and disinfected.

Systemic Change:

1.All clinical staff have been re-educated about the use of tape in the facility.

2. Facility Policies and Procedures, in-services and ongoing checks and rounds will be implemented to ensure systemic changes. The Director of Nursing (DON) and on-site Infection Control/Regulatory Compliance RN (ICRN) or designee will monitor compliance by visual observation of the anesthesia carts and document the observation on the audit log.

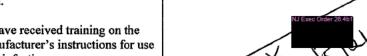
Immediate Action Taken:

- 1. Three (3) new glucometers were purchased, and the older units were discarded.
- 2. All clinical personnel have received training on the units, a review of the manufacturer's instructions for use as well as cleaning and disinfection.

The US FOIA (b)(6) will ensure that in-service education is completed, documented, and reported to the COC, which reports to the Board.

The DON and ICRN are responsible to monitor compliance of the systemic changes weekly, and report rates of observed compliance to the COC which will report to the Board In-service education was completed as of August 15, 2021

Monitoring has been ongoing since the date of the survey, August 4, 2021



Q241 Continued From page 12			
Q241 Continued From page 12	Each unit was permanently marked with an indelible identification number, which is able to be cleaned and disinfected.		•
	Systemic Change: 1.All clinical staff have been re-educated about the use of tape in the facility.	The US FOIA (b)(6) will ensure that in-service education is completed, documented, and reported to the COC, which reports to the Board.	In-service education was completed as of August 15, 2021.
	Facility Policies and Procedures, in-services and ongoing checks and rounds will be implemented to ensure systemic changes .	The DON and ICRN are responsible to monitor compliance with the systemic changes at least monthly, and report rates of observed compliance to the COC which will report to the Board	Monitoring has been ongoing since the date of the survey, August 4, 2021
N.J.A.C. 8:43A - 14.2(b)			
C. Based on random observation, Staff interviews, and review of nationally recognized guidelines, it was determined the facility failed to ensure ventilation standards are maintained at all times.	Immediate Action Taken: 1. The individual split room air handling unit that was observed and being used as a supplemental air cooling for the clean workroom was immediately disconnected and removed from use.	The DON and ICRN are responsible to monitor compliance with ANSI/AAMIST79 daily, and report compliance to the COC which will report to the Board	Monitoring began as of September 16, 2021.
Findings include:	2. The facility has placed a work order with the Mechanical Engineering contractor to remove the unit.	The CEO is responsible to monitor the expansion project and report to the Board.	Monitoring began as of September 13, 2021 Estimated date of removal is November 26, 2021
Reference#1: ANSI/AAMIST79 3.3.5.5 Heating, ventilation and air conditioning (HVAC) operating parameters states, "The healthcare organization should identify which version of	Systemic Change: 1. The facility's mechanical engineering contractor will conduct removal of the unit as part of the Center's planned expansion project approved by NJ DOH and DCA functional review.	The CEO is responsible to monitor the expansion project and report to the Board.	Monitoring began as of September 13, 2021
ANSI/ASHRAE/ASHE 170 will be used based on when the HVAC system was initially installed or last upgraded. The	Construction of new Sterile Processing and Decontamination areas occurs during Phase 1A of the project.		
healthcare facility should establish and implement systemic processes for monitoring HVAC performance	3.All clinical staff have been educated about the discontinued use of the supplemental air cooling for the clean workroom.	The DON and ICRN are responsible to monitor compliance with the systemic change daily and report to the COC which will report to the Board	Monitoring began as of September 16, 2021

Page 14 of 28

Q241 Continued From page 13		
parameters and mechanism for		
identifying and resolving		
variances within rooms		
throughout the facility where		
sterile processing occurs." Reference #2: 2014		
ANSI/ASHRAE/ASHE 170		
Table 7.1 Design Parameters-		
prohibits Air Recirculation by		
Means of Room Units.		
1. On 8/4/2021at 9:45 AM,		
during the entrance		
conference, Staff #1 confirmed		
Q241 Continued From page 13		
the facility's Infection Control		
program adheres to AAMI		
guidelines.		
2. During a tour conducted on		
8/4/21at 10:30 AM, in the		
presence of Staff #2, an		
individual split room air handling unit was observed installed and		
being used within the clean		
workroom.		
a The split unit air-handler is a		
NJ Exec Order 26.4b1		
air.		
(i) Staff #2 stated the handling		
unit was installed to use as		
supplemental air cooling for the		
clean workroom.		

N.J.A.C. 8:43A-19.1(a)

D. Based on random observation, staff interviews, and review of Centers for Disease Control and Prevention (CDC) guidelines, it was determined the facility failed to ensure staff adheres to CDC guidelines regarding hand hygiene and glove use.

Findings include: Reference #1: CDC 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (http://www.cdc.gov/hicpac/pdf/ isolation/Isolation2007.pdf pages 50-51states, "... Gloves that are removed properly will prevent hand contamination. Hand hygiene following glove removal further ensures that the hands will not carry potentially infectious material that might have penetrated through unrecognized tears or that could contaminate the hands during glove removal."

Reference #2: CDC, Morbidity and Mortality Weekly Report (MMWR), Recommendations and Reports, Guideline for Hand Hygiene in Health-Care Settings, October 25, 2002, Vol. 51, No. RR-16, pg. 33 states, "... Recommendations...D. Remove gloves after caring for a patient.

Immediate Action Taken:

1. CDC guidelines regarding hand hygiene and glove use were reviewed with Staff #5.

Systemic Change:

1.All staff members have been re-educated on CDC guidelines regarding hand hygiene and glove use.

2. Participation in external and internal hand hygiene studies will continue to document and ensure compliance.

The US FOIA (b)(6) will ensure that in-service education is completed, documented, and reported to

the COC, which reports to the Board.

The ICRN is responsible to monitor hand hygiene weekly for both internal and external studies until 100% compliance is achieved. Afterward random observation no less than monthly will ensue. Reporting to the COC by the ICRN and up to the Board

Re-education was complete as of September 1, 2021

Weekly monitoring has been in place and will continue as of August 31, 2021.

N Exec Order 28, 491

Page 16 of 28

Q241 Continued From page 15		
Do not wear the same pair of		
gloves for the care of more than		
one patient, and do not wash		
gloves between uses with		
different patients,"		
Upon entry into the facility on		
8/3/21at 10:05 AM, the following		
was observed:		
Staff #5		
a. Staff #5 greeted the survey team at the facility entrance		
wearing gloves. While wearing		
gloves. Staff #5.5Execorder 26.451		
survey staff for		
performing a temperature reneck		
and ming out		
screening questionnaire for		
each surveyor. He/she then left		
the area to notify the US FOIA (b)(6) US FOIA (b)(6) the survey		
OSTOIA (b)(o)I the survey		
isan sama.		
b. Staff #5 returned to the		
entrance area wearing gloves.		
Staff #5 applied hand sanitizer		
to his/her gloves and walked over to the NJ Exec Order 26.4b1		
screening area wearing the		:
same gloves.		
N.J.A.C. 8:43A- 14.3(a)5		
N.J.A.C. 8:43A- 14.3(a)7		
E. Based on observation, staff		
interviews, review of		
manufacturer's instructions for		
use, and review of CDC		1
guidelines, it was determined		
the facility failed to ensure all containers of CaviWipes		
cleaners are closed when not in		
oldariors are closed when not in		

Page 17 of 28

Q241 Continued From page 16 use. Findings include: Immediate Action Taken: Reference#1: Product Label for All CaviWipes containers were immediately closed. CaviWipes1 states, "... Description... Disinfecting Towelettes are multi-purpose disinfectant/decontaminant cleaning wipes for use on hard. non-porous inanimate surfaces. ... To Dispense Towelettes... When not in use, keep center cap closed to prevent solution loss....." Reference #2: Centers for Systemic Change: 1. All staff will be educated on CDC guidelines and Disease Control and The CLT is responsible to monitor Re-education was Prevention, "Guideline for proper use of disinfection and sterilization of surfaces in compliance with the systemic complete as of September Disinfection and the Center. change daily by visual observation and 15, 2021 Sterilization in Healthcare report to the COC quarterly, which will Facilities (2008) report to the Board https://www.cdc. 2. All staff will be educated on following manufacturer's gov/infection control/guidelines/ instructions for proper use of CaviWipes cleaners, disinfection/index.html" including dry time. states,"... 5. Cleaning and Disinfecting Environmental Surfaces in Healthcare Facilities ... 5.c. Follow manufacturer's instructions for proper use of disinfecting (or detergent) products ...: ' 1. On 8/3/21at 11:04 AM, during a tour of the NJ Exec Order 26.4b1 the following was observed: a. On a supply cart located outside of the glass doors to the observed with the lid open.

Q 242 Continued From page 17 b. In the NJ Exec Order 26.4b1 both the first and second patient care bays 'containers of NJ Exec Order 26.4b1 vere observed with the ilds open. N.J.A.C 8:43A-14.3(a) Q 242 INFECTION CONTROL PROGRAM CFR(s): 416.51(b) The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Immediate Action Taken: A. Based on observation, staff 1. Staff members #12 and #13 were immediately reinterviews, and review of educated on the manufacturer's instructions for use manufacturer's instructions for use (IFUs) for Number of Communication (IFUs) for Numb regarding Germicidal Wipes, including dry. time. failed to ensure all staff use germicidal wipes in accordance with manufacturer's instructions for use Findings include Reference: Germicidal Wipes, manuracturer's instruction for use states, "Disinfectsinone (1) minute."

1. During an observation of NJ Exec Order 26.4b1 OR at 10:54AM, Staff #13 was observed cleaning the OR mattress using NJ Exec Order 28.4b1 Germicidal Wipes. He/she was questioned regarding the contact time of the germicidal wipes and stated it was three (3) minutes to five (5) minutes.

2. During a tour of the NJ Exec Order 26.4b1_{at}

11:08 AM, Staff #12 was questioned regarding the contact time for the

contact time for the University Execution 20.451 Germicidal Wipes. He/sne stated the contact time was two (2) minutes.

- 3. The manufacturer's instructions for Germicidal Wipes were reviewed with Staff#2 and confirmed the contact time is one (1) minute.
- B. Based on observation of the substerile area, staff interview, and review of nationally recognized infection control guidelines, it was determined the facility failed to ensure sterile items are stored in a manner that maintains sterility.

Findings include:

Systemic Change:

 All staff will be educated on CDC guidelines and proper use of disinfection and sterilization of surfaces in the Center.

2. All staff will be educated on following manufacturer's instructions for proper use of including dry time.

The CLT is responsible to monitor compliance with the systemic change by visual observation daily and report to the COC quarterly, which will report to the Board

Re-education was complete as of September 15, 2021

Reference: AORN Guidelines For Perioperative Practice, 2016 edition Recommendation XV pages 838-839 states, "Sterilized materials should be labeled and stored in a manner to ensure stability...."

- During the entrance conference conducted on 8/3/2021, Staff #2 confirmed the facility follows AORN and CDC (Centers for Disease Control and Prevention) guidelines.
- 2. During a tour of the area on 8/4/2021 at 11:37AM, the following was observed:
- Nine (9) crushed sterile packages of Sharp Westcott instruments
- Twelve (12) crushed sterile packages of sterile packaged forceps
- c. Twelve (12) plastic storage drawers containing sterile packaged instruments were stored on top of one another, with the weight of the instruments crushing and compromising the sterility of the packages.

N.J.A.C. 8:43A-17(b)

C. Based on random observation, staff interviews and review of manufacturer's instructions for use it was determined the facility failed to ensure the

Immediate Action Taken:

 All crushed sterile packages were immediately removed from the substerile area and returned to Sterile Processing and Decontamination areas to be reprocessed.

Systemic Change:

- 1. All clinical staff have been re-educated about the proper storage processes to ensure the integrity of the sterile packaging.
- 2. Varying and smaller sizes of sterile packaging are being sought for the smaller instruments.
- 3. Ongoing checks and rounds will be implemented to ensure changes. The Director of Nursing (DON) and onsite Infection Control/Regulatory Compliance RN (ICRN) or designee will monitor compliance by random visual observation and document the observation in the audit log.

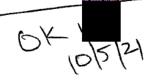
The ICRN met with all SPD staff and inserviced them immediately on the integrity and proper storge of sterile packages. In-service education is completed, documented, and reported to the COC, which reports to the Board

The staff and in-serviced them on the integrity and proper storge of sterile packages. Inservice education is completed, documented, and reported to the COC, which reports to the Board

The DON and ICRN are responsible to monitor compliance weekly and report rates of observed compliance to the COC which will report to the Board Re-education was complete as of August 10, 2021

Re-education was complete as of September 1, 2021

Monitoring has been ongoing since the date of the survey, August 4, 2021



manufacturer's instructions for the enzymatic cleaner are followed.

Findings include:

Reference: Manufacturer's Instructions for Use for SuperNova enzymatic states "... concentration .25 oz (one quarter ounce) per gallon of water...."

- 1. On 8/4/2021at 12:01 PM, a sink filled with water and an enzymatic solution was observed in the decontamination area.
- a. The water level was below the 2 1/2-gallon mark.
- b. Upon interview, Staff #4 stated they fill the sink with 2.5 gallons of distilled water and add 0.62 oz o enzymatic.
- c. Staff #4 stated the amount of water in the sink was approximately 2 gallons and confirmed the correct concentration of the enzymatic cleaner was not in accordance with the manufacturer's instructions for use.

N.J.A.C. 8:43A-14.4(a)

D. Based on review of two (2) of seven (7) employee health files

Immediate Action Taken:

The enzymatic cleaner was emptied and refilled according to manufacturer's instructions for use

Systemic Change:

- All SPD clinical personnel received an in-service on the enzymatic manufacturer's instructions for use as well as the proper amounts of enzymatic solution and water. Any concentration or level issues will be relayed to the ICRN.
- 2. US FOIA (b)(6) were re-instructed to verify proper flutu amounts were reached by using the "fill-line". Random observational monitoring by CLT personnel will occur weekly and be documented in the audit log.

US FOIA (b)(6)

education is completed, documented, and reported to the COC, which reports to the Board.

The ICRN is responsible to monitor compliance weekly and report rates of observed compliance to the COC which will report to the Board Re-education was complete as of August 10, 2021

Monitoring has been ongoing since the date of the survey, September 1, 2021.

(#6, #12), staff interviews, and review of facility policy and procedure, it was determined the facility failed to ensure documentation of the facility failed to ensure documentation of the facility failed to ensure and the facility failed to ensure the failed to ensure the facility failed to ensure the failed to ens

Findings include:

Reference: Facility policy, Rubella and Rubeola Testing" states, "... Each employee and/or staff member who cannot document the results of a previous rubella screening test shall be given a rubella screening test, upon employment or application to the staff. ... 2. Employees/Staff members born in 1957or later will be given a measles (rubeola) screening test including new employees upon employment or staff members upon application to the staff. ... Results will be communicated in writing to the employee/staff member and documented in the employee staff record"

Review of the employee
health files for Staff #6 and Staff
#12 lacked evidence of a
or *** Creening test.**

**Test of the employee

**Test of th

N.J.A.C. 8:43A- 3.7(b) N.J.A.C. 8:43A- 3.7(c) Q 266 DISCHARGE - ORDER CFR(s): 416.52(c)(2) Immediate Action Taken:

reening test results were requested of staff # 6 and #12. Results will be communicated in writing to the employees and documented in the staff record.

Systemic Change:

1. All employee / staff files will be reviewed for compliance with the facility staff health policy. Staff who are not in compliance will be informed in writing and results obtained and documented.

The Administrator (CEO) will obtain and document the results.

Requests were made by September 1, 2021, and will be complete by October 15, 2021

The Administrator (CEO) is responsible for staff compliance with the facility staff health policy. Any delinquent files will be brought into compliance by October 15, 2021. Compliance will be reported to the COC and the Board.

Staff compliance will be complete by October 15, 2021.

The ASC must ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy.

This STANDARD is not met as evidenced by:

Based on (1) of three (3) medical records reviewed for NJ Exec Order 26.4b1

orders

(#1), staff interviews, and review of facility policy and procedure, it was determined the facility failed to ensure the ensure the IN Execution 25 project form is complete.

Findings include:

Reference: Facility policy,
"Medical Services, Medical
Record Entries and Orders"
states, "1 Physician entries in
the medical record will be
complete, legible, and clear.
They will be writing as close to
contemporaneously to the event
as possible, dated, and signed
by the person making the entry."

- 1. Review of Medical Record #1 on 8/4/21at 2:12 PM revealed the following:
- In the section labeled

NJ Exec On

Immediate Action Taken:

- 1. Staff was alerted to screen all Post-op Orders on the medical record for completeness.
- 2. For any non-complete post-op orders it will be brought to the surgeon's attention prior to discharging the patient.

Systemic Change:

1. All staff have been re-educated about the proper completion the post-op order form. The US FOIA (b)(6) US FOIA (b)(6) responsible to oversee monitoring of the form use, which will include reporting by the Medical records, nursing, and business departments.

In addition The will add monitoring for completeness of the post-op orders to the Monthly nursing chart audit.

The US FOIA (b)(6) will ensure that in-service education is completed, documented, and reported to the COC, which reports to the Board

The DON and ICRN are responsible to monitor compliance weekly and report rates of observed compliance to the COC which will report to the Board Review and retraining of the staff will be documented and completed by Oct 15, 2021.

Weekly monitoring will begin October 4, 2021 Q 266 Continued From page 23 Orders," the following boxes 2. The facility's post-op order form will be changed as part Development of the new The Business Office Manager (BOM) is were left blank: of the annual review to include an area for the surgeon's responsible to ensure that the post-op form is ongoing i. Diet signature, date, and time. The revised form will be order form is amended to include the presented to the COC and the Board for review and ii. Discontinue saline lock surgeon's signature, date, and time. approval. Our surgeons' offices will be contacted to ensure iii. Activity that they are using only the newly revised post-op order iv. Medications The BOM is responsible to re-educate v. Discharge home form. They will be asked to discard any older forms. staff and the surgeons' offices about the new form. b. The area indicating when the patient should return to the doctor for follow-up care was left blank.

A2334 8:43A-9.3(b)(9) PHARMACEUTICAL SVCS: POLICIES & PROCEDURES A2334

The facility's policies and procedures for the administration, control, and storage of medications shall include, but not be limited to, policies and procedures for the control and limitation of use of drugs marked "sample.

This REQUIREMENT is not met as evidenced by

Based on observation, staff interview, and review of facility policy and procedure, it was determined the facility failed to ensure sample medications are not available for use in the facility.

Findings include: Reference: Facility policy, "Medication Policies" states, "...The facility does not use sample drugs...."

- 1. On 8/4/21at 10:05AM, in Exam Room #1, seven (7) 1.5 milliliter(ml) bottles of Systane lubricant eye drops labeled "Sample-Not for Resale" were found stored in the cabinet.
- 2. On 8/4/21at 10:48 AM, in Operating Room #1, two (2) boxes containing Omidria Ophthalmic Solution labeled "Professional Trial Product-Not for Sale" were

Immediate Action Taken:

- 1. The seven (7) 1.5 milliliter (mI) bottles of Systane lubricant eye drops in Exam Room #1 were immediately wasted and discarded.
- 2. The two (2) boxes containing Omidria Ophthalmic Solution were removed from OR #1 and the pharmaceutical rep contacted to pick up the product.

Systemic Change:

- 1. The COC and Board were immediately notified by the CEO and DON re the samples on site. The facility will adhere to its policy of not using sample drugs.
- 2. The Medical Director will contact the Medical Staff to remind the surgeons of the Center's policy to not use sample drugs.

The Director of Nursing (DON), and on-site Infection Control/Regulatory Compliance RN (ICRN) will work together to ensure that all clinical staff will be retrained on the facility's Medication sample policy and procedures. Weekly monitoring by visual checks and rounds and documentation in the audit log will be implemented to ensure systemic changes.

The CEO will be responsible for informing any pharmaceutical rep that samples are not allowed in the Center.

The Medical Director will contact the Medical staff in writing by October 1, 2021, to remind them of our policy to not use sample drugs at the Center.

The DON is responsible to monitor compliance weekly and report rates of observed compliance to the COC which will report to the Board

Monitoring has been ongoing since the date of the survey August 16,

2021.

The center has been in compliance with no sample drugs being used in the Center as of August 15, 2021



found stored in a medication A3224 8:43A-12.9(a)(3) SURG & ANES SVCS: SURG SVC EMERGEQUIP A3224 Emergency equipment available Immediate Action Taken: The Director of Anesthesia will ensure Anticipated delivery by 1. The Center is pursuing the purchase a difficult airway kit to the operating room in a October 25, 2021. that in-service education is completed, surgical service shall include, at as chosen by the Anesthesia Director. documented, and reported to the COC, least, a difficult airway container which reports to the Board or cart which shall be immediately available for Systemic Change: Implementation is 1. The Anesthesia Director will be responsible for handling emergencies. November 1, 2021 The emergency equipment shall training appropriate personnel in use of the difficult airway kit as well as documenting training and include, but not be limited to, resuscitation equipment, and maintenance. equipment to open and maintain an airway. This REQUIREMENT is not met as evidenced by Based on observation and staff interview, it was determined the facility failed to ensure a difficult airway kit or cart is immediately available for emergencies. Findings include: 1. On 8/4/21at 2:20 PM, Staff #3 confirmed the facility did not have a difficult airway kit or cart immediately available for emergencies.

A4532 8:43A-16.1(b) PT RIGHTS: POL & PROCEDURES A4532

The staff of the facility shall receive in-service education concerning the implementation of policies and procedures regarding patient rights annually and as part of new employee orientation.

This REQUIREMENT is not met as evidenced by

Based on review of seven (7) of seven (7) staff education files (#2, #4, #6, #7, #8, #12, #18) and staff interview, it was determined the facility failed to ensure all staff receive inservice training on patient rights annually and upon hire.

Findings include:

- Staff education files for Staff #2, Staff #1, Staff #6, Staff #7, Staff #8, Staff #12, and Staff #18, lacked evidence of inservice training on patient rights
- 2. Upon interview on 8/4/21at2:15 PM, Staff #2 confirmed the facility does not provide staff in-service training on patient rights.

Immediate Action Taken:

1. Employee training is provided by an online portal. All employees missing training modules including Patient Rights were given time to complete the modules.

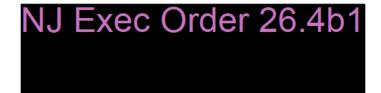
Systemic Change:

- The ICRN will maintain a report documenting that the patient rights training modules have been completed for each employee.
- Employees who have delinquent courses are notified by the online portal directly as well as by their immediate supervisor.

The Infection Control Regulatory Nurse (ICRN) will ensure that the patient rights education and training modules are completed, documented, and reported to the COC, which reports to the Board.

The patient rights education courses will be complete as of October, 15, 2021





September 30, 2021 Date

Bergen-Passaic Cataract Laser & Surgery Center, LLC Telephone (201) 414-5649

PRINTED: 08/20/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		31C0001023	B. WING _				⋜ 18/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	10/	10/2021
DEDCEN	DASSAIC EVE SUBCED	,		18	3-01 POLLITT DRIVE, SUITE 4		
DERGEN-	PASSAIC EYE SURGERY	•		FA	AIR LAWN, NJ 07410		
(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 000}	INITIAL COMMENTS		{Q 0	00}			
	October 18, 2021. Th	FR Part 416, Conditions for					
{Q 240}	416.51 Infection Con INFECTION CONTRO CFR(s): 416.51		{Q 2	40}			
		ain an infection control ominimize infections and ses.					
	Based on document it was determined the	not met as evidenced by: review and staff interviews, facility failed to ensure that conitoring regarding infection inplemented.					
	Findings include:						
	proper Operating Roo	cases, as indicated on the					
	the proper cleaning a	o monitor compliance with nd disinfection of the OR dicated on the facility's PoC.					
	the use of tape on eq instructions for use (II	o conduct staff education on uipment and manufacturer's FUs) for cleaning and ers, as indicated on the					
	4. The facility failed to	o monitor compliance with					
ARODATORY	DIRECTOR'S OR PROVIDERS	SLIPPLIER REPRESENTATIVE'S SIGNATUR			TITI F		(X6) DATE

10/28/2021

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

Facility ID: NJ31C0001023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		31C0001023	B. WING			l	₹ 49/2024
NAME OF P	ROVIDER OR SUPPLIER	0.0000.020		_	STREET ADDRESS, CITY, STATE, ZIP CODE	10/	18/2021
	10112211 011 001 1 21211				18-01 POLLITT DRIVE, SUITE 4		
BERGEN-	PASSAIC EYE SURGER	(l	FAIR LAWN, NJ 07410		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{Q 240}	the use of tape on eq	e 1 uipment, and cleaning and ers, as indicated on the	{Q 2	240	}		
	following the IFU for o	o conduct staff education on contact time for ^[U Execution 20,437] ndicated on the facility's					
{Q 241}	_	ty's PoC.	{Q 2	241]	}		
	A. Based on docume interviews, it was dete conduct staff educatio cleaning and disinfect	not met as evidenced by: int review and staff ermined the facility failed to on regarding proper OR tion between cases, as y's Plan of Correction (PoC).					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	l \ /	(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING			R 1 0/18/2021	
	ROVIDER OR SUPPLIER PASSAIC EYE SURGER	RY		STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		10/10/2021	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{Q 241}	Continued From pag	ge 2	{Q 24	1}			
	Findings include:						
	"Systemic Change: all surfaces in the O disinfected between will e education is comple reported to the COC In-service education and disinfection of the staff education cond and disinfection of the staff education was 3. Upon interview at that there was no even will surface in the condensation of the staff education was a surface in the condensation of the staff education was a surface in the condensation of the condensa	dated 9/30/21, states, 1. The facility will ensure that R are properly cleaned and cases The USFOIA (D)(6) ensure that in-service ted, documented, and which reports to the Board. on was completed as of ce conference at 10:00 AM, a co Staff #1 and Staff #2 for the ucted regarding the cleaning the OR between cases. No provided. 11:30 AM, Staff #3 confirmed didence that staff education and and disinfection of the OR					
	monitor compliance	ent review and staff termined the facility failed to with the proper cleaning and R between cases, as					
	The facility's PoC "Systemic Change: all surfaces in the O disinfected between	, dated 9/30/21, states, 1. The facility will ensure that R are properly cleaned and cases The US FOJA (b)(6) or r compliance by random					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING _			R 10/18/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	I	10/16/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{Q 241}	observation in the Chas been ongoing stages August 4, 2021." 2. During the entrar request was made to observations documbeginning August 4 did not include observations and disinfercases. 3. Upon interview at that the OR Logs did the proper cleaning between cases. C. Based on documinterviews, it was deconduct staff educate equipment and marruse (IFUs) for clear glucometers, as independent and the facility of the anesthesia of the clinical staff have been facility and the older units of the manufacture of the manufactur	of each OR and document the DR Log daily Monitoring ince the date of the survey are conference at 10:00 AM, a so Staff #1 and Staff #2 for the mented on the daily OR Logs at 2021. The OR Logs provided ervations of the proper action of the OR between at 11:30 AM, Staff #3 confirmed do not include observations of and disinfection of the OR tent review and staff attermined the facility failed to tion on the use of tape on aufacturer's instructions for	{Q 2-	41)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING		R 10/18/2021		
	ROVIDER OR SUPPLIER PASSAIC EYE SURGER	RY		STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	10/10/2021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
{Q 241}	education was comp 2. During the entran request was made to staff education regardicility, and the staff manufacturer's instructeaning and disinfe education was provious. Upon interview at that there was no evergarding the use of evidence of staff edumanufacturer's instructeaning and disinfe. D. Based on documinaterviews, it was demonitor compliance equipment, and clear glucometers, as individed in the subsequence of the anesthesia can the US FOIA (b) or designee visual observation of document the obserus of the symptomic of	ce conference at 10:00 AM, a co Staff #1 and Staff #2 for reding the use of tape in the education regarding the uctions for use for the ction of glucometers. No staff ded. 11:30 AM, Staff #3 confirmed ridence of staff education tape in the facility, or ucation regarding uctions for use for the ction of glucometers. ent review and staff etermined the facility failed to with the use of tape on uning and disinfecting cated on the facility's PoC.	{Q 24	1}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING			R 10/18/2021		
	ROVIDER OR SUPPLIER PASSAIC EYE SURGER	1	•	STREET ADDRESS, CITY, STATE, ZIP COL 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		10/10/2021		
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
{Q 241}	checks and rounds we systemic changes The responsible to monitor systemic changes at has been ongoing sin August 4, 2021." 2. During the entrance request was made to monthly monitoring rotape in the facility and disinfecting of glucommonthly monitoring were as a superior to the supplemental and clean workroom, as in PoC. Findings include: 1. The facility's PoC, "Immediate Action Taroom air handling unibeing used as a support clean workroom was and removed from use All clinical staff have at the system of the supplemental and clean workroom was and removed from use All clinical staff have at the system of the supplemental and clean workroom was and removed from use All clinical staff have	d Procedures and ongoing ill be implemented to ensure The US FOIA (b)(6) are or compliance with the least monthly Monitoring ince the date of the survey, e conference at 10:00 AM, a Staff #1 and Staff #2 for the bunds regarding the use of difference of the cleaning and inters. No evidence of as provided. 11:30 AM, Staff #3 confirmed dence of monthly monitoring tape in the facility and the ting of glucometers. Interview and staff ermined the facility failed to on on the discontinued use air cooling system in the indicated on the facility's dated 9/30/21, states, ken: 1. The individual split to that was observed and elemental air cooling for the immediately disconnected e Systemic Change 3. Seen educated about the ne supplemental air cooling	{Q 24	1}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING _			R 0/18/2021		
	ROVIDER OR SUPPLIER	ERY		STREET ADDRESS, CITY, STATE, ZIP O 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		0/10/2021		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
{Q 241}	2. During the entrarequest was made staff education co discontinued used unit. No staff education. No staff education conducted regard split room air hands. F. Based on documenterviews, it was monitor compliant the supplemental workroom, as individed as a supplemental workroom air handling being used as a suclean workroom wand removed from are responsible to systemic change of which will report to began as of Septemental was made evidence of monitor the discontinued of cooling system in evidence of monitor and the discontinued of the cooling system in evidence of monitor and the discontinued of the cooling system in evidence of monitor and the cooling syste	ance conference at 10:00 AM, a e to Staff #1 and Staff #2 for inducted regarding the of the split room air handling cation was provided. at 11:30 AM, Staff #3 confirmed evidence of staff education ing the discontinued use of the dling unit. ment review and staff determined the facility failed to be with the discontinued use of air cooling system in the clean cated on the facility's PoC. a Taken: 1. The individual split unit that was observed and upplemental air cooling for the was immediately disconnected in use The US FOIA (b)(6) of monitor compliance with the daily and report to the COC to the Board Monitoring	{Q 2	241}				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
						R		
		31C0001023	B. WING _			10/18/2021		
	ROVIDER OR SUPPLIER PASSAIC EYE SURGERY	,		STREET ADDRESS, CITY, STATE, ZIP CODI 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	Ξ			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
{Q 241}			{Q 24	41}				
{Q 242}	workroom.	ing system in the clean	{Q 24	423				
\Q Z+Z}	CFR(s): 416.51(b)		\ω 2-	721				
	program must include ASC has considered,	documentation that the selected, and implemented infection control guidelines.						
	A. Based on docume interviews, it was detected conduct staff education	ermined the facility failed to on regarding adherence to ctions for use regarding germicidal wipes, as						
	1. The facility's PoC, on "Systemic Change	2. All staff will be educated turer's instructions for cleaners, including dry was completed as of						
	request was made to evidence of staff educ manufacturer's instruc	e conference at 10:00 AM, a Staff #1 and Staff #2 for cation regarding following ctions for use for contact ermicidal wipes. No staff ed.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		31C0001023	B. WING			R 10/18/2021	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410	ı	10/10/2021	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{Q 242}	3. Upon interview at a that there was no evic regarding following muse for contact time for wipes. B. Based on documer interviews, it was determonitor compliance winstructions for use for germicidal facility's PoC. Findings include: 1. The facility's PoC, "Systemic Change on following manufactor proper use of time The sobservation daily and which will report to the compliance with the sobservation daily and which will report to the contact time when us wipes. No evidence of solutions at that there was no evic compliance with following manufacture contact time when us wipes. No evidence of solutions at that there was no evic compliance with following manufacture with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. No evidence of solutions with following manufacture contact time when us wipes. When the solutions with	dence of staff education anufacturer's instructions for or with the manufacturer's r contact time when using I wipes, as indicated on the dated 9/30/21, states, 2. All staff will be educated turer's instructions for cleaners, including dry sponsible to monitor systemic change by visual report to the COC quarterly, as Board." e conference at 10:00 AM, a Staff #1 and Staff #2 for g for compliance with er's instructions for use for ing 10 Excellents of the conference with er's instructions for use for ing 10 Excellents of the conference date of monitoring was provided. 11:30 AM, Staff #3 confirmed dence of monitoring for wing manufacturer's r contact time when using	{Q 2	42}			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVI	SIT
IDENTIFICATION NUMBER	A. Building				
31C0001023 _{Y1}	B. Wing		Y2	10/18/2021	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BERGEN-PASSAIC EYE SURG	BERY	18-01 POLLITT DRIVE, SUITE 4			
		FAIR LAWN, NJ 07410			

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	M	DATE	ITEM		DATE	ITEM			DAT	E
Y4		Y5	Y4		Y5	Y4			Y5	j
ID Prefix	Q0083	Correction	ID Prefix	Q0181	Correction	ID Prefix	Q0225		Corre	ection
Reg.#	416.43(d)	Completed	Reg.#	416.48(a)	Completed	Reg.#	416.50(d)(4),(5), &	(6)	Com	pleted
LSC		10/18/2021	LSC		10/18/2021	LSC	STEELEN AND A SECTION OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF T	NAME OF TAXABLE	10/18	/2021
ID Prefix	Q0266	Correction	ID Prefix		Correction	ID Prefix			Corre	ection
Reg.#	416.52(c)(2)	Completed	Reg. #		Completed	Reg.#			Com	pleted
LSC		10/18/2021	LSC			LSC				
					,					
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Corre	ection
Reg.#		Completed	Reg. #		Completed	Reg.#			Com	pleted
LSC			LSC			LSC				
· · · · · · · · · · · · · · · · · · ·	***************************************						· · · · · · · · · · · · · · · · · · ·			
ID Prefix	1444	Correction	ID Prefix		Correction	ID Prefix			Corre	ection
Reg.#		Completed	Reg. #		Completed	Reg.#			Com	pleted
LSC			LSC			LSC				
	· · · · · · · · · · · · · · · · · · ·						.,			
ID Prefix		Correction	ID Prefix		Correction	1D Prefix		,,,,	Corre	ection
Reg.#		Completed	Reg. #		Completed	Reg.#			Com	pleted
LSC			LSC			LSC				
REVIEWS		REVIEWED RECORDS	DATE	NJ Exec	Order 26	6.4b1		DATE \O\	22	21
REVIEWS CMS RO	ĒD BY □	REVIEWED BY (INITIALS)	DATE	TIT			[DATE		
FOLLOW 8/4/2021		COMPLETED ON		CK FOR ANY UNCORRECTED DEFICIENCE			UE EAGUITVO -	YE	s 🗆	NO

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 24208 Y1 B. Wing DATE OF REVISIT Y2 TO/18/2021 Y3 NAME OF FACILITY BERGEN-PASSAIC EYE SURGERY STATE FORM: REVISIT REPORT A. Building B. Wing DATE OF REVISIT Y2 TO/18/2021 Y3 STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410

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).

report to	1111).							
ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4	· · · · · · · · · · · · · · · · · · ·	Y5	Y4		Y5
ID Prefix		Correction	ID Prefix	A3224	Correction	ID Prefix	A4532	Correction
Reg.#	8:43A-9.3(b)(9)	Completed	Reg. #	8:43A-12.9(a)(3)	Completed	Reg.#	8:43A-16.1(b)	Completed
LSC		10/18/2021	LSC		10/18/2021	LSC		10/18/2021
ID Prefix		Correction	ID Prefix		Correction	ID Prefix	Av-A	Correction
Reg.#		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		monator ·	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#		Completed	Reg.#		Completed	Reg. #		Completed
LSC			LSC		Marine	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC		nousen	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#		Completed	Reg.#	mahan ayayan anayan ah ayaya a	Completed	Reg.#		Completed
LSC			LSC			LSC		
STATE AC		∕REVIEWED (Minimorder 26.40) (INITIALS)	DATE (O)23	NJ Exe	c Order 2	6.4b1	DATE	22/21
CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	Т			DATE	
FOLLOW 8/4/2021		Y COMPLETED ON		CK FOR ANY UNCORRED DRRECTED DEFICIENCE			IE EAOU ITVO	s 🗆 no

Page 1 of 1

EVENT ID:

4QF012

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT				
IDENTIFICATION NUMBER	A. Building						
31C0001023 _{Y1}	B. Wing	Y2	11/4/2021	Y3			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
BERGEN-PASSAIC EYE SURGER	RY	18-01 POLLITT DRIVE, SUITE 4					
		FAIR LAWN, NJ 07410					
This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments							

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

ITEM		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Q0240 Reg. # 416.51 LSC		Correction Completed 11/04/2021	ID Prefix Reg. # LSC	Q0241 416.51(a)	Correction Completed 11/04/2021	ID Prefix Reg. # LSC	Q0242 416.51(b)	Correction Completed 11/04/2021
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction
REVIEWED BY STATE AGENCY REVIEWED BY CMS RO FOLLOWUP TO S	URVEY CO	REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) OMPLETED ON	DATE DATE CHE	TITLE	CORRECTED DEFICIENCIES	I.	DATE DATE	
8/4/2021				CIENCIES (CMS-2567) SEN			s 🗌 no	

PRINTED: 08/20/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		31C0001023	B. WING _			08/	04/2021
NAME OF PROVIDER OR SUPPLIER BERGEN-PASSAIC EYE SURGERY				1	STREET ADDRESS, CITY, STATE, ZIP CODE 18-01 POLLITT DRIVE, SUITE 4 FAIR LAWN, NJ 07410		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROPROPRIES OF THE APPROPROPRIES OF THE APPROPRIES O			(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	This is a Federal Recertification Survey conducted on 8/4/2021.						
K 000	with Emergency Prep Condition for Coverag Centers (ASCs) for th Survey only.	Surgery is in compliance paredness regulation 416.54, ge for Ambulatory Surgical his Federal Recertification	V. 6	200			
K 000	INITIAL COMMENTS This is a Federal Rea		K	000			
	conducted on 8/4/2021.						
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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