STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001220	A. BUILDING _____ B. WING _____	03/09/2021

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FELLOWSHIP SURGICAL CENTER LLC	715 FELLOWSHIP ROAD, SUITE A MOUNT LAUREL, NJ 08054

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Q 000	INITIAL COMMENTS This was a Federal Re-Certification Survey and a Federal COVID-19 Focused Infection Control Survey conducted at Fellowship Surgical Center on March 8 and 9, 2021, to determine compliance with 42 CFR Part 416 Conditions for Coverage for Ambulatory Surgical Centers. As a result of this survey, the following CfC (Condition for Coverage) was found to be out of compliance: 416.51 Infection Control	Q 000	COPY	
Q 181	ADMINISTRATION OF DRUGS CFR(s): 416.48(a) Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: A. Based on review of three (3) of three (3) medical records, staff interview and document review, it was determined that the facility failed to ensure that the type of [NJ E] ([NJ Ex Order 26.4(b)(1)]) [NJ Ex Order] to be administered preoperatively is specified. Findings include: Reference: Facility policy titled: "PACU (Post Anesthesia Care Unit) Pre-Printed Orders" states: "...The facility shall accept pre-printed orders for admission and/or discharge. The orders must have the physician original signature, the date written on them at the time patient is admitted to	Q 181		

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

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

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Q 181	Continued From page 1 PACU, and must be customized to the specific needs of the patient, i.e. checkbox choices must be marked or noted by the physician...." 1. Review of Medical Records #5, #6 and #20 on 3/8/2021 revealed the following: a. On the "Physician Orders Pain Management" preprinted order set, it states: "...[NJ Ex Order 26.4(b)(1)]: [NJ Ex Order 26.4(b)(1)] for all [NJ Ex Order 26.4(b)(1)] those with [NJ Ex Order 26.4(b)(1)]- [NJ Ex Order 26.4(b)(1)] OR [NJ Ex Order 26.4(b)(1)]: [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)]..." (i) In Medical Records #5, #6 and #20, only the words "[NJ Ex Order 26.4(b)(1)]" in that section were circled. (ii) Upon interview, Staff #2 confirmed that the physician orders were unclear and did not specify the type of [NJ Ex Order 26.4(b)(1)] be administered. B. Based on review of two (2) medical records (#2 and #4), staff interview and review of facility documents, it was determined that the facility failed to ensure that [NJ Ex Order 26.4(b)(1)] medications are administed upon the order of a physician. Findings include: Reference: Facility policy titled: "[NJ Ex Order 26.4(b)(1)] Administration" states: "..[NJ Ex O]s shall be started only upon physician orders. ..." 1. Review of Medical Record #2 and Medical Record #4 revealed the following: a. Patient #2 was admitted to the facility [NJ Ex Order 26.4] for a "[NJ Ex Order 26.4(b)(1)]	Q 181		

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Q 181	Continued From page 2 NJ Ex Order 26.4(b)(1) " (i) The Preoperative Assessment indicated that Patient #2 received NJ Ex Order 26.4(b)(1) at 0723 at NJ Ex Order 26.4(b)(1) during the preoperative stage. (ii) There was no evidence of a physician order for the NJ Ex Order 26.4(b)(1). b. Patient #4 was admitted to the facility on NJ Ex Order 26.4(b) for a "NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4 ". (i) The Preoperative Assessment indicated that Patient #4 received NJ Ex Order 26.4(b)(1) at 0700 at NJ Ex Order 26.4(b)(1) during the preoperative stage. (ii) There was no evidence of a physician order for the NJ Ex Order 26.4(b)(1). 2. Review of the preprinted physician order sheet titled: "Physician Admitting Orders" and the "Physician Orders NJ Ex Ord Management" states: [redacted] NJ Ex Order 26.4(b)(1)) for all NJ Ex Order 26.4(b)(1) and those with NJ Ex Order 26.4(b)(1) OR NJ Ex Order 26.4(b)(1) or all NJ Ex Order 26.4(b) patients..." a. Upon interview, Staff #1 stated that NJ Ex Order 26.4(b)(1)) are not performed on all patients to determine the appropriate NJ Ex Order 26.4(b)(1) be administered. b. Staff #1 and Staff #3 confirmed the above findings.	Q 181		
Q 240	INFECTION CONTROL	Q 240		

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Q 240	Continued From page 3 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, staff interview, document review, and a review of nationally recognized guidelines, it was determined that the facility failed to ensure an adequate infection control program that seeks to minimize infections and communicable diseases is maintained. Findings include: 1. The facility failed to ensure that a sanitary environment is maintained by adhering to professionally accepted standards of practice (Cross-refer to Tag Q 0241). 2. The facility failed to ensure qualification testing was conducted after a major repair of a steam sterilizer, in accordance with the Association for the Advancement of Medical Instrumentation (AAMI) guidelines (Cross-refer to Tag Q 0242). 3. The facility failed to ensure that sterilization for immediate use (IUSS) is conducted in an emergent situation only and not used as a substitute for insufficient instrumentation (Cross-refer to Tag Q 0242). 4. The facility failed to implement policies and procedures that all vendor loaner instruments are entered and tracked in the Vendor Loaner Instrumentation Log (Cross-refer to Tag Q 0242). 5. The facility failed to ensure that instruments	Q 240		

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Q 240	Continued From page 4 are cleaned and/or disinfected properly after use to prevent the formation of biofilm (Cross-refer to Tag Q 0242). 6. The facility failed to ensure that all hinged instruments are sterilized in an open position (Cross-refer to Tag Q 0242). 7. The facility failed to ensure that the medication preparation area is cleaned and disinfected after each surgical procedure when the patient is transferred out of the area (Cross-refer to Tag Q 0242).	Q 240		
Q 241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on one (1) of one (1) observation, staff interview, and review of nationally recognized guidelines, it was determined that the facility failed to ensure a sanitary environment by adhering to professionally accepted standards of practice. Findings include: Reference: AORN (Association of periOperative Registered Nurses) Guidelines for Perioperative Practice, 2017 edition states in Guideline for Environmental Cleaning Recommendation III "A clean environment should be reestablished after the patient is transferred from the area.	Q 241		

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Q 241	Continued From page 5 Reestablishing a clean environment after the patient leaves the area decreases the risk of cross-contamination and disease transmission. ..." 1. On 3/8/2021 at 9:45 AM, during the entrance conference, Staff #1 confirmed that the facility's Infection Control program is based on Association of periOperative Registered Nurses (AORN), Center for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), Association for the Advancement of Medical Instrumentation (AAMI), and the Association for Professionals in Infection Control (APIC) guidelines and recommendations. 2. During an observation of a post-procedure room turnover on 3/8/2021 at 11:34 AM in Operating Room (OR) #3, the following was identified: a. At 11:35 AM, Staff #11 cleaned and disinfected the mattress of the operative bed with the facility approved wipes. Staff #11 then placed a yellow positioning device that had been "used [redacted]" on the top surface of the cleaned mattress and then proceeded to clean and disinfect the yellow positioning device. Staff #11 did not re-clean or re-disinfect the top surface of the mattress. (i) Placing a contaminated device (yellow positioning device) on top of a cleaned surface (mattress) can re-contaminate the cleaned surfaces. b. Upon interview at 11:37 AM, Staff #11 stated that the C-arm (imaging scanner intensifier)was cleaned and disinfected when Patient #21 was	Q 241		

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Q 241	Continued From page 6 still present in OR #3 because he/she indicated "it doesn't touch the patient." 3. The above findings were confirmed on 3/8/21 at 3:15 PM by Staff #1, Staff #2, and Staff #3.	Q 241		
Q 242	INFECTION CONTROL PROGRAM CFR(s): 416.51(b) The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: A. Based on one (1) of one (1) observation, staff interview, and review of nationally recognized guidelines that the facility follows, it was determined that the facility failed to ensure that the medication preparation area is cleaned and disinfected after each surgical procedure when the patient is transferred out of the area. Findings include: Reference #1: The Center for Disease Control website <http://www.cdc.gov/HAI/settings/outpatient/basic-infection-control-prevention-plan-2011/standard-precautions-d-f.html> states: "Clean medication preparation areas when visibly soiled; if medication preparation takes place in the patient treatment area (outside a designated medication room), clean this area after each patient	Q 242		

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Q 242	Continued From page 7 encounter: Ensure the medication preparation area is free of any items contaminated with blood or body fluids (e.g., used equipment such as syringes, needles, IV tubing, blood collection tubes, and needle holders)." Reference #2: The AORN (Association of periOperative Registered Nurses) is the nationally recognized guideline that the facility has selected for its infection control program. AORN Perioperative Standards and Recommended Practices; "RP: Environmental Cleaning, Recommendation II." states: "A safe, clean environment should be reestablished after each surgical procedure. ... III A clean environment should be reestablished 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 patient care should be cleaned and disinfected after each patient use, including anesthesia carts and equipment... patient monitors..." 1. During an observation of a post procedure room turnover on 3/8/2021 at 11:32 AM, Staff #11 was observed cleaning the operating room table and the back table. a. Upon interview, Staff #11 stated that he/she only wiped "his/her work areas." Staff #11 stated that the anesthesia cart was cleaned by the anesthesiologists. b. Upon interview, Staff #3 stated that he/she prepared medications on top of the anesthesia cart and it was his/her dedicated medication preparation area. Staff #3 also stated that he/she cleaned his/her work surfaces while the patient was in the room but another staff member will	Q 242		

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Q 242	Continued From page 8 clean after the patient is transferred out of the room. (i) The medication preparation area was not cleaned and disinfected after the patient was transferred out of the room. 2. The above findings were confirmed by Staff #1 and Staff #2. B. Based on staff interview, review of facility documents, and a review of nationally recognized guidelines, it was determined that the facility failed to ensure that qualification testing is performed after a major repair of a steam sterilizer, in accordance with the Association for the Advancement of Medical Instrumentation (AAMI) guidelines. Findings include: Reference: "AAMI Comprehensive guide to steam sterilization and sterility assurance in health care facilities," 2017 edition, ST 79 section 13.8.1 states, " ... Qualification testing with a BI (Biological Indicator) PCD (Process Challenge Device) should be performed on all sterilizers after ... malfunctions, major repairs, sterilization process failures, or changes to the utilities ... Qualification testing should be ... For dynamic-air-removal sterilizers, three consecutive cycles should be run, one right after the other, with a PCD ..., yielding negative results from all test Bis [sic] ... In addition, three consecutive Bowie-Dick tests should be run, one right after the other with each test result demonstrating sufficient air removal ..." 1. On 3/8/2021 at 10:30 AM, during a tour of the	Q 242		

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Q 242	Continued From page 9 Sterilization Area, Staff #8 indicated that the NJ Ex Order 26.4(b)(1) Century V-120 Steam Sterilizer (Sterilizer #2) was a dynamic-air-removal sterilizer and underwent a major repair on 2/15/2021. a. When questioned about the qualification testing completed following the major repair of Sterilizer #2, Staff #8 stated that he/she conducted three consecutive test cycles with a PCD containing a BI and three consecutive Bowie-Dick tests. b. Review of the facility document titled: "Load List & Process Monitor Documentation System" dated, 2/15/21, indicated that three consecutive Bowie-Dick tests were conducted, followed by three consecutive test cycles with a PCD containing a BI. This was not in accordance with the above referenced AAMI guidelines. 2. The above findings were confirmed on 3/8/2021 at 3:15 PM by Staff #1, Staff #2, Staff #3. C. Based on staff interview, a review of facility documents and a review of nationally recognized guidelines, it was determined that the facility failed to ensure that sterilization for immediate use (IUSS) is conducted in an emergent situation only. Findings include: Reference #1: "AAMI Comprehensive guide to steam sterilization and sterility assurance in health care facilities," 2017 edition, ST 79 section 10.2.3 states: "IUSS should not be used ... as a substitute for sufficient instrumentation.	Q 242		

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Q 242	Continued From page 10 Instrument inventories should be sufficient to meet anticipated surgical volume and to ensure there is enough time to complete all critical elements of reprocessing. Immediate-use steam sterilization should be kept to a minimum and should be used only in urgent clinical situations. ..." Reference #2: Facility policy titled: "Sterilization For Immediate Use (IUSS)" states: " ... Policy: 1. Sterilization for immediate use will be restricted to those items needed in an emergent situation only. ..." 1. On 3/8/2021 at 1:30 PM, a review of the IUSS log was conducted with Staff #8. Review of the logs indicated that IUSS was performed on the following days: a. 2/16/2021, one (1) Hardware Removal Kit b. 2/25/2021, one (1) Spider Bar Set c. 3/2/2021, one (1) Plastic Set 2. Upon interview at 2:33 PM, Staff #8 stated that sterilization for immediate use was performed due to the facility not having enough inventory of the instruments that were utilized. 3. The above finding was confirmed on 3/8/2021 at 3:15 PM by Staff #1, Staff #2, Staff #3. D. Based on one (1) of one (1) observation, staff interview, and a review of facility documents, it was determined that the facility failed to ensure implementation of policies and procedures that all vendor loaner instruments are entered and tracked in the Vendor Loaner Instrumentation	Q 242		

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Q 242	Continued From page 11 Log. Findings include: Reference: Facility policy titled: "Vendor Loaner Instrumentation" states: " ... Procedure: ... 2. After receiving instrumentation in Receiving Area, instruments will be entered and tracked in Vendor Loaner Instrumentation Log provided in Receiving Area. ..." 1. On 3/8/2021 at 10:30 AM, during a tour of the Sterilization Room with Staff #8, three (3) trays containing surgical instruments were located on the bottom shelf of a metal cart. a. Staff #8 confirmed that the three (3) trays contained vendor loaner instruments. Upon request, Staff #8 was unable to provide documentation in the Vendor Loaner Instrumentation Log that the instruments were entered and tracked according to facility policy. 2. The above finding was confirmed on 3/8/21 at 3:15 PM by Staff #1, Staff #2, Staff #3. E. Based on one (1) of one (1) observation, staff interview and a review of nationally recognized guidelines, it was determined that the facility failed to ensure that instruments are cleaned and/or disinfected properly after use to prevent the formation of biofilm. Findings include: Reference: "AAMI Comprehensive guide to steam sterilization and sterility assurance in health care facilities," 2017 edition, ST 79 section 6.3.1 states: "Handling of instruments during	Q 242		

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Q 242	Continued From page 12 surgical procedure ... Preparation for decontamination for instruments should begin at point of use. To prevent the formation of biofilm and to reduce the risk of corrosion, cleaning and decontamination should occur as soon as possible after instruments and equipment are used." 1. On 3/8/2021 at 10:09 AM, during a tour of the Decontamination Room, a white bucket containing soiled instruments soaking in a clear liquid was observed in a sink. a. Upon interview, at 10:11 AM, Staff #8 stated that he/she was unsure what the instruments were soaking in, but stated that he/she thought they were soaking in an enzymatic solution. Staff #8 could not identify how long the instruments were soaking. 2. The above finding was confirmed on 3/8/2021 at 10:20 AM by Staff #8. F. Based on one (1) of one (1) observation, staff interview and a review of facility policy and procedure, it was determined that the facility failed to ensure that all hinged instruments are sterilized in an open position. Findings include: Reference: Facility policy titled: "Preparation & Assembly of Surgical Instrumentation" states, "PROCEDURE: Preparation Area ... 3. Preparation of Articles: 3.1 All hinged instruments shall be processed in an open position." 1. On 3/8/2021 at 10:50 AM, during an observation in the Sterilization Room, two (2) peel	Q 242		

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Q 242	Continued From page 13 pouched instruments were observed to be in closed position. 2. These findings were confirmed on 3/8/2021 at 10:55 AM by Staff #8 and Staff #9.	Q 242		
Q 266	DISCHARGE - ORDER CFR(s): 416.52(c)(2) [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: 0Based on medical record review of one (1) of (2) transfers, and staff interview, it was determined that the facility failed to ensure that an accurate discharge order based on the condition of the patient is written. Findings include: 1. Review of Medical Record #20 on 3/8/2021 revealed the following: a. The "Physician Orders Pain Management" preprinted order set states: "Discharge to home" with a physician signature dated [NJ Ex Order 26.4] at 12:30 PM. b. A Nurses Note dated [NJ Ex Order 26.4] states, "1240 Pt [Patient] D/C [Discharge] to ER [Emergency Room] w/ambulance [with] per Dr [doctor] order report given to [NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)] paramedic."	Q 266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001220	A. BUILDING _____ B. WING _____	03/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FELLOWSHIP SURGICAL CENTER LLC	715 FELLOWSHIP ROAD, SUITE A MOUNT LAUREL, NJ 08054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 266	Continued From page 14 2. Upon interview, Staff #3 confirmed that Patient #20 was transferred to the ED (Emergency Department). Staff #3 stated there should have been a written order to transfer Patient #20 to the ED.	Q 266		

DHHS CMS Provider# 31C0001220

Tag	Correction/Prevention/Monitoring	Completion Date	Responsible Party
Q181	• Revision of "Physician Orders Pain Management" and "Physician Admitting Orders": to include check boxes for appropriate [redacted] – to be completed and signed by ordering physicians. • Revision of "Physician Orders Pain Management" and "Physician Admitting Orders": to reflect [redacted] orders for [redacted] orders for [redacted] patients. 1. [redacted]: [redacted] Physician Admitting Orders. 2. [redacted]: [redacted] Physician Orders [redacted] Management. 3. [redacted] for [redacted] [redacted] and all [redacted]: Physician Admitting Orders. 4. [redacted] for [redacted] [redacted] and [redacted] Physician Orders [redacted] Management. • All Clinical Staff will attend in-service on revisions to Physician Orders [redacted] Management and Physician Admitting Orders. • Clinical Staff will conduct monthly Quality Assurance Audits of patient medical records. The goal of the audit will be 90% compliance within three months. If the goal is not reached there will be an additional in-service to review the forms and to determine where there are deficiencies. Monthly audits will continue until the 90% goal is reached and then quarterly medical records audits will resume.	August 25, 2021	Director of Nursing – Revisions to "Physician Orders Pain Management" and "Physician Admitting Orders". Clinical Staff – monthly audit and findings to CQI Committee. Administrator – findings to Board of Managers.

	• Clinical staff will report findings to the CQI Committee. This information will subsequently be reported, by the Administrator, quarterly to the Board of Managers. All revised policies and procedures will be presented to the board for review and approval at the next quarterly meeting.		
Tag	**Correction/Prevention/Monitoring**	**Completion Date**	**Responsible Party**
Q 0241	• To ensure that a sanitary environment is maintained according to AORN's Environmental Cleaning III: 1. Facility policies and procedures for cleaning and disinfection in the OR were reviewed and reinforced by our contracted CIC on April 26, 2021 2. The contracted CIC will train the on-site infection prevention professional to oversee the process for cleaning and disinfection in the OR between cases to ensure compliance with standards. 3. OR Staff and anesthesia providers completed Inservice training provided by contracted CIC on April 26, 2021. 4. Training, competency validation and increased supervision will ensure that appropriate AORN and CDC guidelines are being followed. 5. Monitoring will include verification of adherence to policies and procedures for cleaning and disinfection in the OR, including anesthesia work areas. Results will be reported, by the on-site infection prevention professional, to the CQI Committee, on a quarterly basis, beginning in June 2021. Monitoring of adherence will continue as an ongoing tracking report. These reports will be monitored for	August 25, 2021	Infection Prevention Professional findings reported to CQI Committee. Administrator – findings reported to Board of Managers.

	compliance and results forwarded to the CQI committee and to the Administrator who will report findings to the Board of Managers at their quarterly meetings.		
Tag	**Correction/Prevention/Monitoring**	**Completion Date**	**Responsible Party**
Q 0242	• To ensure Qualification Testing is conducted according to AAMI Guidelines: 1. Revise facility policy to include the procedure for qualification testing in accordance with AAMI ST79. 2. March 10, 2021 all sterilized instrumentation in the facility was reprocessed by the CPT after Qualification Testing was done, on both sterilizers, according to AAMI ST79 Guidelines. 3. Sterile Processing retraining and competency assessment was completed on 5/25/21 by our CIC professional. 4. The Infection Prevention professional will conduct a monthly QA (Quality Assurance) audit – using the facility's Sterile Processing Monitoring Checklist. To include: all autoclave records, printouts, dynamic air removal tests and biological indicators. The goal of the audit will be 90% compliance within three months. If the goal is not reached in three months the checklist will be reviewed to determine where the deficiencies are and in-services performed by CIC to correct deficiencies. Monthly audits will continue until 90% goal is reached. 5. The IP professional will report audit findings to the CQI Committee. The Administrator will report the	August 25, 2021	Infection Prevention Professional – findings reported to CQI Committee. Administrator – findings reported to Board of Managers.

	findings to the Board of Managers at quarterly meetings.		
Tag	**Correction/Prevention/Monitoring**	**Completion Date**	**Responsible Party**
Q 0242	• To ensure that Immediate Use Steam Sterilization (IUSS) is only used in emergent situations and not used as a substitute for insufficient instrumentation: 1. Additional instruments have been purchased to make sure we have sufficient inventory to meet anticipated surgical volume. 2. Monitoring of IUSS will be part of the monthly audit using the Sterile Processing Monitoring Checklist completed by the IP professional. The goal of the audit will be 100% compliance within three months. If the goal is not met the findings will be reviewed to determine what instrumentation needs to be purchased. We will continue to monitor monthly until goal is reached. The IP will forward a list of instrumentation to be purchased to the Administrator. The Board of Managers is responsible to approve purchase of additional instrumentation.	August 25, 2021	Infection Prevention Professional – findings reported to CQI Committee. Administrator – findings reported to Board of Managers.
Tag	**Correction/Prevention/Monitoring**	**Completion Date**	**Responsible Party**
Q 0242	To ensure that all vendor loaner instruments are entered and tracked in the Vendor Loaner Instrumentation Log: 1. Vendor Loaner Instrumentation Policy was reviewed by our CPT, IP Professional and contracted CIC. 2. Monitoring of the FSC Vendor Equipment Log will be part of the monthly audit using the Sterile Processing Monitoring Checklist, completed by the IP Professional. The goal of the audit will be 90% compliance within three months. If the goal is not met the findings will be reviewed to determine where there are deficiencies and	August 25, 2021	Infection Prevention Professional – findings reported to CQI Committee. Administrator – findings reported to Board of Managers.

	what needs to be corrected. We will continue to monitor monthly until 90% compliance is reached. 3. The IP Professional will report findings to the CQI Committee. The Administrator will report findings to the Board of Managers at the next quarterly meeting		
Tag	**Correction/Prevention/Monitoring**	**Completion Date**	**Responsible Party**
Q 0242	To ensure that instruments are cleaned and/or disinfected properly after use to prevent the formation of biofilm: To ensure that all hinged instruments are sterilized in an open position: 1. Revised facility policy to include proper labeling and covering of containers for soaking and for cleaning/decontamination of instruments. 2. Review of Preparation and Assembly of Surgical Instruments – Policy # PMSC11 3. All clinical staff will attend an in-service on revisions to: Decontamination/Preparation of Surgical Instrumentation – Policy # PMSC.04 4. Cleaning, disinfecting and packaging will be part of the monthly audit using the Sterile Processing Monitoring Checklist, completed by the IP Professional. The goal of the audit will be 90% compliance within three months. If the goal is not met the findings will be reviewed to determine where there are deficiencies and what needs to be corrected. We will continue to monitor monthly until 90% compliance is reached. 5. The IP Professional will report findings to the CQI Committee. The Administrator will report findings to the Board of Managers.	August 25, 2021	Infection Prevention Professional – findings reported to CQI Committee. Administrator – findings reported to Board of Managers.
Tag	**Correction/Prevention/Monitoring**	**Completion Date**	**Responsible Party**

Q 266	To ensure that an accurate discharge order based on the condition of the patient is written: 1. A review of the Discharge Procedure Policy – Policy # PMRD.02 was conducted at the post survey Staff Meeting. The DON reinforced with the Clinical Staff that there must be a Discharge Order for all patients going home, to an ER, or transferred to a Rehab facility. 2. Clinical staff will conduct a monthly Quality Assurance audit of the Medical Record – discharge orders. The goal of the audit will be 90% compliance within three months. If the goal is not reached there will be an in-service to review the discharge policy. Monthly audits will continue until the 90% goal is reached. Findings will be shared at the monthly staff meeting, the quarterly CQI meeting. The Administrator will report findings to the Board of Managers at their quarterly meeting.	August 25, 2021	Clinical staff, CQI Committee. Administrator – findings reported to Board of Managers.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
24166 Y1	A. Building B. Wing Y2	10/5/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FELLOWSHIP SURGICAL CENTER LLC	715 FELLOWSHIP ROAD, SUITE A MOUNT LAUREL, NJ 08054

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A2194	Correction	ID Prefix A2376	Correction	ID Prefix A3931	Correction
Reg. # 8:43A-8.5(a)(3)	Completed	Reg. # 8:43A-9.4(a)	Completed	Reg. # 8:43A-13.3(a)(21)	Completed
LSC	07/01/2021	LSC	07/01/2021	LSC	07/01/2021
ID Prefix A4071	Correction	ID Prefix A4190	Correction	ID Prefix A4192	Correction
Reg. # 8:43A-14.2(b)	Completed	Reg. # 8:43A-14.4(a)(1)	Completed	Reg. # 8:43A-14.4(a)(2)	Completed
LSC	10/05/2021	LSC	10/05/2021	LSC	10/05/2021
ID Prefix A4216	Correction	ID Prefix A4793	Correction	ID Prefix	Correction
Reg. # 8:43A-14.4(g)(1)	Completed	Reg. # 8:43A-17.4(a)(14)	Completed	Reg. #	Completed
LSC	10/05/2021	LSC	07/01/2021	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) LK	DATE 3/25/22	[redacted]	DATE 3/25/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	HCSE/NJ	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/9/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001220	A. BUILDING **A1** B. WING _____	**03/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FELLOWSHIP SURGICAL CENTER LLC	**715 FELLOWSHIP ROAD, SUITE A MOUNT LAUREL, NJ 08054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This was a Federal Recertification Survey conducted on March 9, 2021. This facility is in substantial compliance with Emergency Preparedness regulation 416.54, Condition for Coverage for Ambulatory Surgical Centers (ASCs) for this Federal Recertification Survey only.	E 000		
K 000	INITIAL COMMENTS This was a Federal Recertification Survey conducted on March 9, 2021. The facility is in compliance with the National Fire Protection Association's 2012 Life Safety Code for this Federal Recertification Survey only.	K 000	COPY	

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.