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	05C0001822	A. BUILDING _____ B. WING _____	C 05/07/2009

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ALMONT AMBULATORY SURGERY CENTER, INC	9001 WILSHIRE BLVD SUITE 106 BEVERLY HILLS, CA 90211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health and during a Complaint Validation Complaint Intake Number : CA00186703 Representing the Department of Public Health: Rosalinda Ramos, HFEN Sylvia Villaflores, HFE I	Q 000		
Q 003	416.41 GOVERNING BODY AND MANAGEMENT The ambulatory surgical center must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the center's total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the center must assure that these services are provided in a safe and effective manner. This CONDITION is not met as evidenced by: The governing body of the ASC failed to ensure that it was legally responsible for determining, implementing and monitoring polices governing the ASC's total operation and for ensuring that these policies were administered so as to provide quality health care in a safe environment. The governing body failed to adequately monitor interventions for a serious medical condition such as an adverse anesthetic complication (malignant hyperthermia) as the needed supplies and equipment were not readily available at the time	Q 003		

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 003	Continued From page 1 of the survey (Q006). The governing body of the ASC failed to ensure that there was an on-going evaluation of the quality of care provided (Q009). The governing body of the ASC failed to ensure that the facility equipped and maintained a safe and sanitary environment to protect the health and safety of patients (Q010) The governing body of the ASC failed to provide functional and sanitary environment for the provision of surgical services (Q011). The governing body of the ASC failed to equip the operating room with a temperature and humidity monitoring device and functioning scrub sinks (Q012). The governing body of the ASC failed to ensure that the crash cart contained accurate count of listed medications and not expired medications/supplies (Q016). The governing body of the ASC failed to ensure that licensed nursing personnel were trained in cardio-pulmonary resuscitation prior to starting work(Q018). The governing body of the ASC failed to ensure that proctoring was conducted for the physicians prior to the granting of surgical privileges (Q020). The governing body of the ASC failed to conduct proctoring for a nurse anesthetist who was granted privileges (Q022). The governing body of the ASC failed to ensure	Q 003		

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Q 003	Continued From page 2 that patient care responsibilities were delineated for all nursing service personnel (Q024). The governing body of the ASC failed to maintain a system for the proper storage of patient records (Q026). The governing body of the ASC failed to provide drugs and biological in a safe and effective manner, in accordance with accepted professional practice (Q029). The cumulative effect of these systemic practices resulted in the failure of the governing body to deliver statutorily mandated compliance with the provisions of the governing body condition of coverage.	Q 003		
Q 006	416.42(a) ANESTHETIC RISK AND EVALUATION A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Before discharge from the ambulatory surgical center, each patient must be evaluated by a physician for proper anesthesia recovery. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the surgery center failed to adequately monitor interventions for a serious medical condition such as an adverse anesthetic complication (malignant hyperthermia) as the needed supplies and equipment were not readily available at the time of the survey . Findings: On May 5, 2009, at approximately 5:15 p.m., the	Q 006		

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Q 006	Continued From page 3 Administrative Staff Members of the surgery center were requested to meet to inform them of an immediate jeopardy identified during the survey. The facility ' s policy stipulated a separate Malignant Hyperthermia (MH) Cabinet, however, during the tour it was noted that MH medications and supplies were located in different storage areas in the surgery center. There were four (4) boxes of Dantrolene (antidote for malignant hyperthermia {MH}), two (2) of which were expired. The medication refrigerator in the recovery room did not have any available ice for potential use (in the event a patient suffered from MH) nor was the refrigerator large enough space to accommodate bags of ice. The facility failed to have refrigerated saline solution available for immediate use for MH patients as stipulated in their policy. There was a high risk due to the high number of surgical procedures performed in the surgery center that utilized general anesthesia. On May 5, 2009, there were 23 patients who had scheduled surgical procedures that utilized anesthesia during the procedure. The immediate jeopardy was lifted on May 7, 2009, at 9:30 a.m. after the facility provided a detailed comprehensive plan of action to address the concern.	Q 006		
Q 009	416.43 EVALUATION OF QUALITY The ambulatory surgical center, with the active	Q 009		

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Q 009	Continued From page 4 participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided, including medical necessity of procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of center policies and consideration of clinical privileges. This CONDITION is not met as evidenced by: The ASC, with the active participation of the medical staff, failed to conduct an on-going, comprehensive self-assessment of the quality of care provided, including the medical necessity of procedures performed and appropriateness of care. The ASC and its medical staff failed to use the findings, when appropriate, in the revision of center policies and consideration of clinical privileges. There was no documentation or other evidence to indicate that the ASC and its medical staff developed and implemented on-going criteria for the review of the quality and appropriateness of care provided to patients in the ASC. On May 7, 2009, at approximately 10 a.m., an interview with the Administrator revealed that the facility was only conducting studies based on the patient satisfaction survey. There was no documentation or other written evidence to indicate how clinical issues were selected for study nor was there documentation or other evidence to indicate that the medical staff had any input into the selection of those topics.	Q 009		
Q 010	416.44 ENVIRONMENT The ambulatory surgical center must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is not met as evidenced by:	Q 010		

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Q 010	Continued From page 5 Based on observation and interview, the facility failed to equip and maintain a safe and sanitary environment to protect the health and safety of patients. The facility failed to ensure the policies and procedures were implemented with regards to staff wearing gowns when leaving the operating room area. The facility failed to provide temperature and humidity monitoring devices in the operating room. Four scrub sinks were not functioning. Findings: The facility failed to provide a functional and sanitary environment for the provision of surgical services. (Refer to Q11). The facility failed to equip the operating room with temperature and humidity monitoring devices. The facility failed to provide functioning scrub sinks. (Refer to Q12).	Q 010		
Q 011	416.44(a) PHYSICAL ENVIRONMENT The ambulatory surgical center must provide a functional and sanitary environment for the provision of surgical services. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a sanitary environment for the provision of surgical services. Findings: During a tour of the facility on May 5, 2009, from 8:10 a.m.-10:35 a.m., and on May 6, 2009, at 9:15 a.m., the following was observed: 1. In the recovery room, the handwash sink had an aerator device. There were no paper towels for the staff to use in the handwash sink area. There	Q 011		

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Q 011	Continued From page 6 were white deposits on the sink counter around the base of the faucet. There was a plastic container on top of the sink counter with a cover thickly covered with dust. The privacy curtains had brown stains. During an interview on May 5, 2009, at 10:02 a.m., the licensed nurse stated the staff did not use the sink for handwashing. During an interview on May 6, 2009, at 9:15 a.m., the director of nursing stated there should be paper towels in the handwash sink area. During an observation on May 6, 2009, at 10:48 a.m., in the recovery area, there was a pile of clean paper towels on top of the sink counter along the wall. There was no towel dispenser. 2. During an observation on May 6, 2009, at 9:26 a.m., a facility staff member was observed in the front reception area wearing scrubs, cap, mask and foot covers. The same staff member was observed in the recovery room at 9:28 a.m. She proceeded to the operating room area and later exited, proceeding past the recovery room to the outside hallway. The staff member did not have any gown covering the scrubs. 3. During an observation on May 6, 2009, at 9:42 a.m., in the recovery room, there were exposed suction tips (Yaunkers) in recovery bed # 2 and #3 that were hanging over the suction pressure gauge. At the same time, during an interview, the director of nursing stated the suction tip should be bagged and not exposed when not in use. She proceeded to change the suctions tips. However, in recovery	Q 011		

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Q 011	Continued From page 7 #3, the new suction tip was still left exposed. 4. During an observation on May 6, 2009, from 9:45 a.m.-10:27 a.m., the scrub technician was observed washing and disinfecting instruments. He filled the sink compartment with 4 gallons of water and pumped the enzymatic detergent and disinfectant into the water. The instruments (hemostats) from the basic tray were soaked in the compartment with the detergent and disinfectant. The instruments from the laparotomy tray, which included the dissectors and holder, were not completely soaked in the solution. Ten surgical instruments had approximately 3-6 inches of the instrument above the level of the solution and were not totally soaked. The scrub technician wiped the surfaces with a sponge soaked with the detergent and disinfecting solution from the sink compartment. At the same time, during an interview, the scrub technician stated the instruments have to be soaked in the detergent/disinfecting solution for 10 minutes. He stated the sink was too small so all the instruments could not be soaked. 5. During an observation on May 6, 2009, at 10 a.m., the anesthesiologist left the operating room area and proceeded out the door to the hallway. He was not wearing a gown to cover the scrubs he was wearing. At 10:30 a.m., the anesthesiologist was in the hallway. He was not wearing a cover gown. During an observation on May 6, 2009, at 10:27 a.m., there were 3 white gowns hanging on the wall near the two compartment sink. At the same time, during an interview, the scrub	Q 011		

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Q 011	Continued From page 8 technician stated staff were supposed to use a gown to cover the scrubs whenever they left the operating room area to go to another area of the facility. A review of the facility's policy on scrubs revealed the scrubs should be covered with a lab coat or gown when leaving the operating room. A review of the facility's rules and regulations on sterilization revealed a lab coat is to be worn over the scrub dress or suit when leaving the operating room suite and is to be removed upon returning to the operating room. 6. The operating room staff reported that they launder their own scrub uniforms. The American Operating Room Nurses Association's (AORN) "Recommended practices for surgical attire" does not preclude laundering the garments at home, provided they are properly disinfected by including sodium hypochlorite (i.e. chlorine bleach) in the chemical formulation. There was no evidence that surgical attire was being laundered in this manner. 7. On May 5, 2009, at approximately 10 a.m., during the initial tour of the surgery center, it was noted that in OR 2, there was a Sequential Compression Device (SCD) and a black arm wrap on top of the surgical table. During an interview with Employee 5, she stated that the SCD and the arm wrap were being re-used. The label on the SCD was shown to Employee 5 which read" Single Patients Use".	Q 011		
Q 012	416.44(a)(1) ELEMENT of STANDARD	Q 012		

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Q 012	Continued From page 9 PHYSICAL ENVIRONMENT Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. This ELEMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to equip the operating room with temperature and humidity monitoring devices. The facility failed to maintain four functioning scrub sinks. Findings: 1. During a tour of the facility on May 5, 2009, at 11 a.m., in the operating room area, there were 4 operating rooms. There were 6 scrub sinks. Four of the scrub sinks were non-functioning. 2. A review of the facility's temperature and humidity logs revealed no daily documentation. During an interview on May 6, 2009, at 1:45 p.m., the scrub technician stated there were no temperature and humidity monitoring devices in the operating rooms. The facility was not able to provide the survey team with a policy and procedure on temperature and humidity monitoring in the operating rooms.	Q 012		
Q 016	416.44(c) EMERGENCY EQUIPMENT Emergency equipment available to the operating rooms must include at least the following: o Emergency call system.	Q 016		

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Q 016	Continued From page 10 o Oxygen. o Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. o Cardiac defibrillator. o Cardiac monitoring equipment. o Tracheostomy set. o Laryngoscopes and endotracheal tubes. o Suction equipment. o Emergency medical equipment and supplies specified by the medical staff. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the surgical center failed to ensure that the crash cart contained accurate count of listed medications and did not contain expired medications/supplies. Findings: On May 5, 2009, at approximately 9 a.m., during the initial tour of the surgery center, the emergency (crash) cart was observed stored in the hallway by OR 4. The emergency cart contained opened, undated, unsigned, and expired medications/supplies such as Amiodarone, lubricating jelly with an expiration date of November 2004 and Nu-Trake with an expiration date of February 2008. The emergency crash cart list of medications identified Nalbuphine (analgesic) however, it was not found in the cart. There were two medications, Nitrobid and Dopamine, which were not listed, however were found in the cart with other medications. A review of the facility's Policy on	Q 016		

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Q 016	Continued From page 11 Pharmaceuticals stipulated the following: 1. Multiple dose medications must show the date first used, initials of person first using medication and it is understood that the throwaway date was 90 days later. 2. Emergency drugs were to be replaced within one month of the expiration date.	Q 016		
Q 018	416.44(d) EMERGENCY PERSONNEL Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ambulatory surgical center. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the center failed to ensure that licensed nursing personnel were trained in cardio-pulmonary resuscitation (CPR) prior to starting work. Findings: On May 6, 2009, at approximately 9 a.m., during a review of facility staff personnel files, it was noted that Employee 5 was hired on April 9, 2009, with responsibility to work as a Registered Nurse in the recovery unit. The personnel file failed to show written documentation that Employee 5 had a cardio-pulmonary resuscitation certificate prior to providing care to patients in the surgery center. On May 5, 2009, at approximately 11 a.m., Employee 5 was interviewed while preparing OR 2 for the next case. Employee 5 stated that she started working at the surgery center on April 10, 2009 as a circulating nurse.	Q 018		

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Q 018	Continued From page 12 A review of the facility's non-physician mandatory personnel file contents checklist indicated that current CPR or ACLS certification was required (ACLS certification was required for Recovery Nurses). On May 7, 2009, at approximately 8:30 a.m., Employee 1 stated that licensed nurses need to have proof of current CPR/ACLS certification prior to providing care for patients in the surgery center.	Q 018		
Q 019	416.45 MEDICAL STAFF The medical staff of the ASC must be accountable to the governing body. This CONDITION is not met as evidenced by: Based on interview and record review the facility failed to conduct proctoring for 7 medical staff and for 1 nurse anesthetist granted privileges. Findings: The facility failed to verify physician references placed on their applications. There was no proctoring conducted for the physicians that were granted privileges by the governing board. (Refer to Q20). The facility failed to conduct proctoring for one nurse anesthetist who was granted privileges. (Refer to Q 22)	Q 019		
Q 020	416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges in accordance with recommendations from qualified medical personnel.	Q 020		

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Q 020	Continued From page 13 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to show documentation that the references in the physician application files were verified and there was no documentation of proctoring of the medical staff who were granted privileges by the governing body. Findings: 1. A review of 7 physician credential files and 1 allied health professional (CRNA-California Registered Nurse Professional) revealed no documentation that the references placed in the respective physicians' application forms were verified. During an interview on May 7, 2009 at 10:30 a.m., the human resources director stated he called the references on the physician's application, however, he did not document it. 2. A review of the physician/allied health professional personnel files revealed no documentation that the 7 physicians and one allied health professional (CRNA), who were granted privileges at the facility, had any proctoring performed on them per the Medical Staff Bylaws. During an interview on May 5, 2009, at 7:05 p.m., the Chief Executive Officer stated they have not done proctoring with their physicians. A review of the facility's Medical Staff By-Laws section on proctoring revealed all new members and all members granted new clinical services shall be subject to a period of proctoring. All efforts will be made to conduct on-site proctoring.	Q 020		

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Q 020	Continued From page 14 If on-site proctoring cannot be reasonably carried out within the confines of the ambulatory center, evidence of proctoring from a local organization or hospital may be accepted.	Q 020		
Q 022	416.45(c) OTHER PRACTITIONERS If the ambulatory surgical center assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to establish policies and procedures for overseeing and evaluating clinical activities for one California Registered Nurse Anesthetist. Findings: A review of the employee file for one nurse anesthetist revealed no documentation of any oversight/evaluation of clinical activities being conducted. During an interview on May 6, 2009, at 10 a.m., the chief executive officer stated they have not conducted any oversight of the nurse anesthetist.	Q 022		
Q 024	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ambulatory surgical center. This STANDARD is not met as evidenced by:	Q 024		

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Q 024	Continued From page 15 Based on record review and interview, the surgery center failed to ensure that nursing services were provided in accordance with recognized standards of practice as evidenced by completed competencies, delineated job descriptions and completed health requirements prior to providing patient care. Findings: On May 6, 2009, at approximately 9 a.m., nine personnel and health files were reviewed. Four (4) files were that of Registered Nurses (RN) and five (5) files were that of Licensed Vocational Nurses (LVN). a. The personnel files of the nursing staff revealed the exact same competency requirements and job descriptions for RN and LVN in spite of there being a difference in the scope of practice of each profession. For example : Employee 1, a RN was hired on October 13, 2006, as Director of Nurses. She also performed circulating and recovering nurse roles when needed. The personnel file of Employee 1 failed to show written documentation to indicate that competency as a circulating and recovery room nurse was performed. Employees 2, 3 and 4 were hired as RN's and performed the role of recovery room nurse and/or circulating nurse. Employees 5, 6, 7, 8 and 9 were LVN's and were hired as recovery room nurse and/or circulating nurses as well. It is beyond their scope of practice for a LVN to function as a Recovery Room or Circulating Nurse as those positions require patient assessments to be conducted. The nine employee files contained exactly the	Q 024		

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Q 024	Continued From page 16 same competency areas that covered the following : observation of understanding of sterile technique, gowning and gloving, handling of sterile instruments while scrubbed, preparation of sterile supplies, autoclave entries, sterilization methods, sterility testing, observation of proficiency, monitoring and noting of vitals during procedures, interaction with patients and staff, and other essential areas of competency. The competency evaluation on the licensed nurses was performed by the Human Resources Director. On May 7, 2009, at 10:30 a.m., during an interview with Employee 10, he admitted signing competency checklist after asking the physician on how the licensed nurses (both RN and LVN) performed during the procedure. The employee admitted that he was not a licensed health care professional. Employee 10 signed quarterly, as well as yearly evaluations, of Employees 2, 6 and 7. b. The health files of Employees 3, 4 and 5 failed to show documentation of a history and physical examination. Employee 4 did not have written documentation of a tuberculin test , Employees 6 and 7 had a positive skin test and there was no documented evidence to indicate that a chest x-ray was done. On May 7, 2009, at approximately 9 a.m., during an interview with Employee 1, she stated that history and physical examination as well as skin test and chest x-ray (for employees who had a positive skin test) were required for employees prior to starting work. A review of the facility's policy on Purified Protein	Q 024		

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Q 024	Continued From page 17 Derivative Testing (Sin Testing) stipulated that in the event the employee had a positive skin test, a chest x-ray should be obtained.	Q 024		
Q 025	416.47 MEDICAL RECORDS The ambulatory surgical center must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care. This CONDITION is not met as evidenced by: Based on observation and interview, the facility failed to maintain a system for storage of medical records. The facility failed to maintain a system for the proper storage of patient medical records (Refer to Q 26).	Q 025		
Q 026	416.47(a) ORGANIZATION The ambulatory surgical center must develop and maintain a system for the proper collection, storage, and use of patient records. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a system for the proper storage of medical records. Findings: During a tour of the facility on May 5, 2009, from 8:10 a.m.- 10:35 a.m., the following was observed: 1. In pre-op room #1, there were patients' medical records in unlocked cabinet along the wall. The records contained psychological consultation records. 2. In the call center room, there were four facility	Q 026		

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Q 026	Continued From page 18 staff members in their cubicles. On the shelves along the wall, there were patient records which contained confidential patient information and behavioral evaluations. 3. In the recovery room, there was a medical record on top of the blanket warmer. At the same time, during an interview, the director of nursing could not explain why the records were in those areas.	Q 026		
Q 029	416.48 PHARMACEUTICAL SERVICES The ambulatory surgical center must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. This CONDITION is not met as evidenced by: The ASC failed to provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice. Based on observation, interviews and record review, the ambulatory surgery center failed to ensure that opened/undated and/or expired medications and supplies were not stored together with current medications and supplies in various patient areas of the center. The facility failed to show a policy and procedure on glucometer control and monitoring as well as written documentation that quality control monitoring was being done with the glucometer machine prior to it's use during surgery days. Findings: On May 5, 2009, at approximately 9 a.m., during	Q 029		

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Q 029	Continued From page 19 the initial tour of the center, the following was observed: a. In Pre-Op Room 3, there were opened, undated and expired medications such as bottles of 0.9% Sodium Chloride; a bottle of 1 % Lidocaine, a bottle of Hydrogen Peroxide with an expiration date of January 2008, and a bottle of Acetone with an expiration date of January 2009. b. In Pre-Op Room 2, there were opened, undated and expired medications such as a bottle of 1% Lidocaine, a bottle of 0.9% Sodium Chloride; two bottles of Hydrogen Peroxide with expiration dates of November 2007 and June 2008; a bottle of acetone; a bottle of Albumin Chloride with an expiration date of March 2007 and two boxes of sutures with an expiration date January 2009. c. In the Ultra-Sound Room, there were opened, undated and expired medications/supplies such as 3 packets of Disposable ECG Electrode with expiration date of April 10, 2008; two bottles of 0.9% Sodium Chloride, two bottles of 1% Lidocaine HCL; a bottle of Benzoin Compound Tincture USP ; a bottle of 2 % Lidocaine; a vial of Lidocaine HCL and Epinephrine 1:100,000 Inj.; a bottle of Kenalog ; a bottle of Sterile Water and a bottle of Hydrogen Peroxide with an expiration date of June 2008. d. In the Recovery Room, the following was observed: 1. The medication refrigerator had opened, undated and expired medications such as vials of Famotidine & Tuberculin PPD; two vials of Botox Cosmetic Botulinum Toxin Type A (one of which	Q 029		

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Q 029	Continued From page 20 was frozen); and an unlabelled syringe with an unknown white substance dated February 2, 2009. 2. The Metal Cabinet by Space 7 contained opened, undated and expired medications/supplies such as four boxes of Dantrolene, two were expired; a bottle of concentrated Sodium Chloride, a bottle of Lidocaine with an expiration date of November 2007; a carton of Radiiesse (filler for the face) with an expiration date of May 2007 and a box of Polysporin with an expiration date of December 2008. In the corridor, there was a cabinet full of expired dermatology supplies such as creams, moisturizers and other beauty products. The Administrator stated that the facility had informed the physician to remove the expired supplies form the surgery center. e. In Operating Room (OR) 1, there were opened, undated and expired medications/supplies such as 1 box of needles Chitra Type with an expiration date of September 2007, exposed suctioning tubing; an unused refrigerator and a box of Epimed- Tunnel Mini Kit with expiration date of March 2005. f. In OR 2, there were opened, undated and expired medications/supplies such as a box of sutures with an expiration date of June 2008, opened IV solutions of Lactated Ringer; individual syringes labeled with sublimaze, epinephrine, anectine, propanol and neostigmine, and a bottle of Gas Relief with expiration date of August 2008.	Q 029		

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Q 029	Continued From page 21 During an interview with MD 1, he stated that he prepared the syringes in preparation for the next case, however, he admitted to failing to label the syringes with date, time and his initial. He further stated that he "always followed the facility's policy" of labeling syringes with date, time, medication name and his initial. The anesthetic cart had opened and undated medications such as 2% Lidocaine; Labetalol Hydrochloride, Reglan Inj., Neostigmine, Glycopyrrolate Inj and Dopram Inj. g. In OR 3, there was a syringe dated and initialed, however, there was no written indication as to the contents. Also, there was a box of B.O Spinal needle with expiration date of August 2007. h. The policy and procedure/log on the Glucometer machine quality control monitoring was requested, however the records were not provided to the Evaluators during the survey. A review of the facility's Policy on Pharmaceuticals stipulated the following: 1. Multiple dose medications must show the date first used, initials of person first using the medication and it is understood that the "throwaway" date was 90 days after opening of the medication vial. 2. Medication syringes should never be pre-filled, re-capped and stored in the anesthesia cart or other location. 3. Emergency drugs were to be replaced within one month of the expiration date.	Q 029		