

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION**

In re: Center for Ambulatory Surgery, LLC of Westport, CT
d/b/a Center for Ambulatory Surgery, LLC
32 Imperial Avenue, Westport, CT 06880

INTERIM CONSENT ORDER

WHEREAS, Center for Ambulatory Surgery, LLC of Westport, CT, d/b/a Center for Ambulatory Surgery, LLC ("CAS"), has been issued license number 0292 to operate an outpatient surgical facility by the Connecticut Department of Public Health ("Department") pursuant to Chapter 368v of the General Statutes of Connecticut, as amended; and,

WHEREAS, on December 31, 2013, the Department issued a Statement of Charges against CAS, attached as Exhibit A.

WHEREAS, the Department wishes to protect the public during the pendency of this matter.

NOW THEREFORE, the parties hereby stipulate to the following:

1. CAS' license number 0292 to operate an outpatient surgical facility in Connecticut shall be suspended until the Statement of Charges is fully resolved by Memorandum of Decision, Consent Order, dismissal, surrender of license or other final disposition.

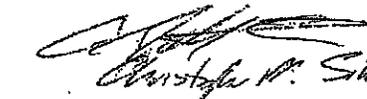
2. This stipulation shall not deprive CAS of its right to a hearing on the merits of this case, nor shall it be construed as an admission of any fact or waiver of any right to which CAS may be entitled, other than as specifically provided for herein.
3. This Interim Consent Order shall become effective on the day it is approved and signed by a representative of CAS and a representative of the Department.
4. CAS understands and agrees that this Interim Consent Order is a public document and shall be reported in accordance with state and federal law and regulations, and consistent with Department policy.
5. CAS has consulted with its attorney prior to signing this Interim Consent Order.
6. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the Medicaid Fraud Control Unit or the Bureau Chief of the Division of Criminal Justice's Statewide Prosecution Bureau.
7. This Interim Consent Order embodies the entire agreement of the parties with respect to this case. All previous communications or agreements regarding the subject matter of this interim consent order, whether oral or written, between the parties are superseded unless expressly incorporated herein or made a part hereof.



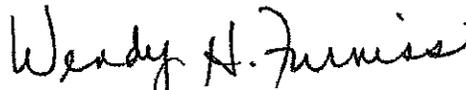
I, Joel Singer, M.D., am licensed to practice medicine and surgery in Connecticut, and I am the sole owner of CAS. I am authorized to sign this Interim Consent Order on behalf of CAS. I have read the above Interim Consent Order, and on behalf of CAS, I agree to the terms set forth therein. I further declare the execution of this Interim Consent Order to be my free act and deed.


Joel Singer, M.D.
Sole Owner, CAS

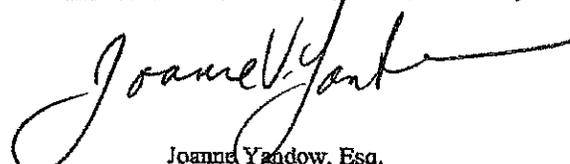
Subscribed and sworn to before me this 9th day of January, 2014.


Christopher M. Shea, Esq. 428116
Notary Public
Commissioner of the Superior Court

The above Interim Consent Order having been presented to the duly appointed agent of the Commissioner of the Department of Public Health on the 16th day of January, 2014, it is hereby accepted.


Wendy H. Furniss, RN, MS
Branch Chief

The above Interim Consent Order having been presented to the duly appointed Hearing Officer of the Department of Public Health on the 16th day of January, 2014, it is hereby accepted and ORDERED.


Joanne Yandow, Esq.
Hearing Officer

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION**

To: Center for Ambulatory Surgery, LLC of Westport, CT
d/b/a Center for Ambulatory Surgery, LLC
32 Imperial Avenue
Westport, CT 06880

Pursuant to the provisions of Connecticut General Statutes §19-13-D56 the Connecticut Department of Public Health, Facility Licensing and Investigations Section (hereinafter "Department") brings the following charges against Center for Ambulatory Surgery, LLC of Westport, CT, d/b/a Center for Ambulatory Surgery, LLC (hereinafter "respondent").

COUNT ONE

1. Respondent is, and has been at all times referenced in this Statement of Charges, the holder of an Ambulatory Surgical Center License No. 0292.
2. Respondent is licensed to operate an Outpatient Surgical Facility located at 32 Imperial Avenue in Westport, Connecticut (hereinafter "Facility").
3. On March 28, 2013, an inspection was concluded at the Facility by investigators from the Facility Licensing and Investigations Section of the Department.
4. Between approximately May 3, 2011 and March 20, 2013, respondent failed to ensure a sanitary and safe environment for all patients in that respondent failed to ensure that instrumentation was sterilized and/or cleaned in accordance with manufacturer's recommendations and/or facility policies and procedures and/or failed to implement the plans of correction approved by the Department of Public Health (hereinafter

"Department") October 17, 2011 in regard to sterilization procedures in one or more of the following ways, including but not limited to:

- a. The biological monitoring, which monitors the effectiveness of the steam sterilization, was not processed in accordance with manufacturer's instructions. The facility had a conflicting policy on the timeframe on when to read the biological test;
 - b. Staff did not follow the manufacturer's recommendation on the amount of enzymatic detergent used to soak the operating room instruments;
 - c. The wire and nylon brushes used to scrub the surgical instruments were flattened and worn with no additional supplies available;
 - d. Staff failed to maintain logs of sterilized equipment by autoclave load.
5. The above referenced conduct violates Section §19-13-D56(c) Ownership and Administration (1) and/or 19-13-D56 (d) Chief Executive Officer (3) and/or §Section 19-13-D56 (e) Professional Staff (1) Clinical Director (C) and/or Section §19-13-D56(i) General (3) and/or (5) of the Public Health Code.

COUNT TWO

6. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.
7. Between approximately May 3, 2011 and March 20, 2013, respondent failed to ensure a clean and/or safe environment in one or more of the following ways, including but not limited to:
- a. The machine used to sterilize the surgical equipment (autoclave) was rusted in its interior which transferred onto the surgical pack wrappings;
 - b. Between February 14, 2013 and March 20, 2013, the facility did not have documentation that the auto had been cleaned weekly since February 14, 2013;

- c. A specimen jar labeled with a patient's name containing nasal cartilage was stored in a freezer containing ice packs and instruments in the freezer compartment which was within a refrigerator containing medications;
8. The above referenced conduct violates Section §19-13-D56(c) Ownership and Administration (1) and/or Section §19-13-D56 (d) Chief Executive Officer (3) and/or Section §19-13-D56(e) Professional Staff (1) Clinical Director (C) and/or Section §19-13-D56(i) General (3) and/or (5) of the Public Health Code.

COUNT THREE

9. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.
10. On one or more occasions in 2012, Respondent failed to maintain minimum nursing staff.
11. During two surgeries on or about December 20, 2012, only one registered nurse was present at the Facility.
12. The above referenced conduct violates Section §19-13-D56 (g) Nursing Staff and/or Section §19-13-D56 (i) General (5) of the Public Health Code.

COUNT FOUR

13. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.
14. During at least 2011, 2012, and up to March 20, 2013, Respondent failed to develop an adequate infection program to control facility-associated infections and/or failed to designate a qualified infection control practitioner to monitor and perform periodic assessments to determine compliance with infection control principles.

15. The above referenced conduct violates Section §19-13-D56 (e) Professional Staff (4)(D)(f) and/or Section§19-13-D56 (i)General(5) of the Public Health Code.

COUNT FIVE

16. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.

17. During at least 2011 and into 2012, Respondent failed to conduct fire alarm testing, failed to conduct fire drills, failed to conduct fire safety education, lacked medical gas inspections/certifications, failed to safely store medical gases, failed to maintain and test the generator in one or more of the following ways, including but not limited to:

- a. Semi-annual alarm testing was not completed according to schedule;
- b. The fire alarm had been out of service from October 29, 2012 until March 28, 2013;
- c. Quarterly fire drills were not conducted during the second and fourth quarters of 2012;
- d. Documentation related to fire safety education was not provided for past and present employees;
- e. The testing of the medical air gas system was last conducted on May 4, 2011 and was not conducted yearly;
- f. Unsecured H-tanks and E-tanks in med gas room and medical gas room door was not latched;
- g. The medical gas alarm was silenced and each bank indicated that the reserve tanks were in use;
- h. Respondent failed to obtain work permits for the plumbing and electrical work done and for repairs to the vacuum system;
- i. Respondent failed to obtain a final inspection by the local building department for work performed on the vacuum system;

- j. Respondent failed to obtain qualifications and certification of the installer for the medical gas system repairs/maintenance;
 - k. Respondent failed to obtain acceptance testing of the upgrades to the medical gas system by the contractor and witnessed by the local officials;
 - l. Respondent failed to obtain third party verification of the total system after the medical gas system work was completed;
 - m. Documentation was not available to indicate that the requirements for the air pressure and ventilation were achieved;
 - n. Respondent failed to ensure that there was fuel in generator; the unit was off from August 31, 2012 until October 18, 2012, until fuel delivery and/or on October 26, 2012 (load test of unit);
 - o. Respondent failed to conduct monthly load testing of generator as required. The weekly exercise of the generator was last documented on March 16, 2012.
18. The above referenced conduct violates Section §19-13-D56 (b) Physical Standards (I) and/or (J) and/or (K) and/or Section §19-13-D56 (i) General (5) of the Public Health Code.

COUNT SIX

19. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.
20. Respondent failed to prepare and adequately maintain medical records on each patient in a manner so as to explain and justify treatment outcome.
21. The above referenced conduct violates Section §19-13-D56 (f) Records and Reports (3) of the Public Health Code.

COUNT SEVEN

22. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.
23. During at least 2011, 2012 and 2013, respondent failed to ensure staff credentialing files was complete.
24. The above referenced conduct violates Section §19-13-D56 (c) Ownership and Administration (4)(E) of the Public Health Code.

COUNT EIGHT

25. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.
26. During at least 2011, 2012, and 2013, Respondent failed to ensure that the required Medical Staff, Governing Body, Quality Assurance meetings/reviews were conducted.
27. The above referenced conduct violates Section §19-13-D56 (c) Ownership and Administration (1) and/or (7) and/or Section §19-13-D56 (d) Chief Executive Officer (3) and/or Section §19-13-D56 (e) Professional Staff (4)(D) of the Public Health Code.

COUNT NINE

28. Paragraphs 1, 2, and 3 of Count One are hereby incorporated by reference as if set forth fully herein.
29. The Licensee executed a Second Amended Consent Order with the Department on August 15, 2013 (Attachment A). The Licensee failed to ensure implementation of the Second Amended Consent Order in the following ways:

- a. The Clinical Consulting Firm (CCF) failed to provide documentation to reflect a minimum of four hours every other week of direct observation of staff performance to monitor the implementation of the issues in paragraph five of the Amended Second Consent Order in accordance with paragraph 7b.
- b. The Clinical Consulting Firm (CCF) failed to provide an update to reflect staffs' credentialing and orientation files to ensure compliance with state and federal laws and/or regulations in accordance with paragraph 7d;
- c. The Clinical Consulting Firm (CCF) failed to provide the timeframes for the analysis and development of recommendations in accordance with paragraph 7e;
- d. The Clinical Consulting Firm (CCF) failed to include the number of onsite hours for the assessment report in accordance with paragraph 9;
- e. The Clinical Consulting Firm (CCF) and Nurse Supervisor failed to meet with the Department and/or participate in a conference call at monthly intervals during the period of the Second Amended Consent Order in accordance with paragraph 11;
- f. The Clinical Consulting Firm (CCF) failed to provide biweekly reports to the Department in accordance with paragraph 22;
- g. The Licensee failed to provide documentation to reflect that all invoices and copies of payment receipts monthly to the CCF. The CCF failed to provide a report to the Department the status of all vendor payments in accordance with paragraph 14;
- h. The Licensee failed to provide documentation to reflect that all clinical staff and the CCF have been paid in full. The CCF failed to provide a report to address bills and payment receipts from the Licensee in accordance with paragraph 15; and
- i. The Clinical Consulting Firm (CCF) failed to provide a report to the Department to address the infection control program, nurse staffing, training and credentialing and/or nurse supervisor appointment and/or written recommendations for improvements in physician, RN, and scrub technician credentialing, operating room, instrument reprocessing, instrument supplies, and governing body and management; and,
- j. The Licensee failed to pay the full civil penalty required by the Second Amended Consent Order.

30. The above referenced conduct violates the Second Amended Consent Order and the statutes and regulations, including, but not limited to, §19-13-D56(c)(1), related to the provision of care at outpatient surgery centers.

Therefore, the Department of Public Health prays that: the Commissioner of Public Health, as authorized in Section 19-494 of the Connecticut General Statutes, revoke or take any other actions as authorized in said section against the Outpatient Surgical Facility License as she deems appropriate and consistent with law.

Dated at Hartford, Connecticut this 31st day of December, 2013.

By: Wendy H. Furniss
Wendy H. Furniss, RN, MAS (WHF)
Branch Chief
Department of Public Health
Facility Licensing and Investigations Section