STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

December 8, 2015

Administrator
Metropolitan Family Planning Inst. Inc.
5915 Greenbelt Road
Berwyn Heights, MD 20740

Dear

We have received your facility's response to the list of deficiencies resulting from the Relicensure survey completed at your facility on October 14, 2015.

Please note that an acceptable Plan of Correction (POC) for the identified deficiencies must contain the following information:

1. State what process changes the management team will make to correct each specific deficiency cited.

2. State what process changes the management team will make to correct each specific deficiency identified.

3. Define the projected timeline for each step in the corrective action plan for each deficiency cited.

4. Define the projected completion date for each deficiency cited.

5. Identify who will be responsible for assuring each step in the plan of correction is implemented.

6. State what specific quality indicators the management team will monitor to evaluate the effectiveness of the correction actions.

7. Define what will be the on-going schedule of the quality monitoring activities for each deficiency cited.

NOTE: PLEASE DOCUMENT THE SPECIFIC CORRECTIVE ACTION ACCOMPLISHED FOR EACH PATIENT IDENTIFIED BY TAG NUMBER AND PATIENT IDENTIFIER.

After careful review of your POC, the following component(s) of an acceptable Plan of Correction were not addressed:

____ Scope of Deficiencies not evaluated by the management team;
Tags:

____ Process changes not identified to correct each deficiency by the management team;
Tags:

____ Timeline for each step of corrective action not defined for each deficiency;
Tags:

_X__ Projected completion date not indicated for each deficiency;
Tags: A420, A530, A570, A610, A980, A1080, A1150, A1250, A1510

____ Person responsible for each corrective action is not identified;
Tags:

____ Specify quality indicators for monitoring the corrective action were not identified;
Tags:

____ The schedule for on-going quality monitoring was not stated.
Tags:

____ ADM signature & date missing; include on first page of plan of correction.

Please submit a Plan of Correction within 10 calendar days of receipt of this letter. Please be advised that failure to submit an acceptable POC could result in a recommendation to not license your facility/agency. If there are any questions concerning these instructions, please call this office at (410) 402-8040.

Sincerely,

B Fagan For

Ambulatory Care Programs
Office of Health Care Quality

Enclosure: Form CMS-2567

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000016	A. BUILDING: _____ B. WING _____	10/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN FAMILY PLANNING INST INC	5915 GREENBELT ROAD BERWYN HEIGHTS, MD 20740

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A 000	Initial Comments A re-licensure survey was conducted at Metropolitan Family Planning on October 13 and 14, 2015. An exit interview was conducted on October 14, 2015. The center performs surgical abortion procedures. The facility includes two procedure rooms. The survey activities included an on-site visit, an observational tour of the physical environment, observation of cleaning of patient room, observation of patient ultrasound process, observation of hand hygiene, observation of instrument cleaning/sterilization process, interview of the facility's administrator, registered nurse, and medical assistants, review of the policy and procedure manual, review of the personnel files, review of quality assurance and infection control program, and review of professional credentialing. There were no surgical procedures performed at the facility during this survey. A total of five clinical records were reviewed. The surgical abortion procedures that were performed between February and September 2015 were reviewed. Findings in this report are based on data present in the administrative records at the time of review. The administrator was kept informed of the survey findings as the survey progressed. The agency administrator was given the opportunity to present information relative to the findings during the course of the survey. A key code for patients, medical staff and employees contained herein was provided to the agency administrator.	A 000	JAN - 7 2016	

OHCQ

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

X _____ X Administrator X 1/2/16

STATE FORM 6899 4ONG11 If continuation sheet 1 of 12

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A 420	Continued From page 1	A 420		
A 420	.05 (A)(1)(e)(i) .05 Administration (e) Ensuring that all personnel: (i) Receive orientation and have experience sufficient to demonstrate competency to perform assigned patient care duties, including proper infection control practices; This Regulation is not met as evidenced by: Based on review of training files, review of the policy and procedure manual and interview of the administrator it was determined that five of five staff members did not have orientation that demonstrates competency to perform patient care and training in infection control . Staff: A, B, C, D, E, F The findings include: 1. Review of staff E and F's training files revealed there was no documentation that the staff members had orientation that demonstrated competency to perform patient care and infection control training. Review of staff D's training file revealed that there was no documentation the staff member had orientation that demonstrates competency to perform patient care and infection control training. Interview of staff D on October 13, 2015 at 1:40 PM revealed that the staff member had not had infection control training since hired. Review of staff A and B's training file revealed that there was no documentation the staff members had infection control training. Interview of the administrator (C) on October 14, 2015 at 10 AM revealed the administrator was not aware that there is no orientation and infection control training for the staff members.	A 420	A420 1. Facility manager will audit employee files to determine scope of current training of all employees, to include competency in patient care and training in infection control 2. Facility manager will identify qualified member of the team to perform training to all employees regarding patient care, and proper infection control 3. Effective immediately 4. December 31, 2015 5. The office manager will perform annual audits, and addend policy and procedure manual to include all required training for patient care and infection control, as standards deem necessary 6. Employee will be required to take, and pass a standard quiz to illustrate competency regarding this measure 7. Identified trainer will perform biannual surprise evaluations to insure procedures set forth are being followed and report back to the office facilitator who will update employee training log	

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A 530	.05(C)(1) .05 Administration C. Policies and Procedures. The facility shall have policies and procedures concerning the following: (1) The scope and delivery of services provided by the facility either directly or through contractual arrangements; This Regulation is not met as evidenced by: Based upon review of the policy manual, it was determined that the facility staff did not have policies and procedures in place to provide oversight of the center. The findings include: Review of the policy manuals on October 13 and 14, 2015 revealed that they were incomplete. A facility is expected to ensure that it is in regulatory compliance for all of the facility's areas of operation. Missing policies, as outlined in regulation, include the following: 1. Annual review and revision of policies and procedures; 2. Job descriptions for all personnel; 3. Pre-operative testing and examination; 4. Obtaining routine and emergency laboratory and radiological services to meet the needs of patients; 5. Laboratory turn around time; 6. Review of laboratory reports 7. Documentation of laboratory results.	A 530	A530 1. Facility manager will identify policies and procedures that are missing or require revision to reflect current practices at this facility, and to insure regulatory compliance 2. During this process, facility manager will be sure to include the following policies that are currently missing from the manual: a. Job descriptions for all employees b. Pre-operative testing and examination c. Obtaining lab data to meet the needs of the patient d. Lab turn around time e. Review of lab reports f. Documentation of laboratory results 3. Effective immediately 4. Completion by January 31, 2016 5. Facility manager will be responsible for insuring and obtaining approval for changes to policies put forth above 6. Will audit random charts for above quality indicators 7. Annual quality monitoring	
A 570	.05(C)(2)(c) .05 Administration (c) Procedures to ensure personnel are free from	A 570		

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A 570	Continued From page 3 communicable diseases; This Regulation is not met as evidenced by: Based upon review of policies, review of credentialing and personnel files, and interview, it was determined that the administrator did not comply with regulations to ensure that all medical personnel are free from communicable diseases. Staff: C, D, E, F The findings include: 1. Policy manuals were reviewed on October 13 & 14, 2015 and revealed a policy entitled 'Communicable Disease' that stated "All medical personnel that work within the facility, regardless of patient interaction, must be free from communicable disease. This includes tuberculosis and hepatitis B and C. Procedure: 1. All facility personnel must have annual tuberculosis skin testing a. If test is positive, then staff member must receive a chest x ray and obtain medical clearance. Failure to obtain medical clearance, employee will receive leave without pay. b. If test negative, then no further action must be taken. 2. All facility personnel must have had Hepatitis B vaccination a. If employee did not receive a vaccination, or does not have paperwork to prove vaccination status, then Hepatitis B titers must be obtain (sic) and put on file 3. All facility personnel must have Hepatitis C annual test and provide the facility manager with verification so that it may be placed in employee's file. 4. All facility personnel must obtain an annual	A 570	A570 1. Facility manager will be charged with updating each employee file to insure all vaccinations and testing are up to date 2. Facility manager will request from each employee documentation of vaccination and/or supplemental documentation to be placed in employee file. This policy will also be reflected in the policy and procedure manual. 3. Effective immediately 4. All employees will be required to have a completed file to include vaccination record by Dec 31, 2015. 5. Facility manager is assigned to insure this policy is effectively implemented 6. Will monitor annual vaccination and TB testing. Employees will be required to comply with annual TB testing, and influenza vaccination. 7. Each employee chart will be audited October of each year to insure compliance with above	

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A 570	Continued From page 4 influenza vaccination, and provide verification to the facility manager." 2. Review of personnel file for staff member D revealed, staff member D was hired on [redacted] There is no documented tuberculosis skin test in the file. Review of personnel file for staff member E revealed, staff member E was hired on [redacted] The last documented tuberculosis skin test was March 7, 2013. Review of personnel file for staff member F revealed, staff member F was hired on [redacted]. The last documented tuberculosis skin test was March 1, 2013. Interview of the administrator (C) on October 14, 2015 at 12 PM revealed the administrator was not aware that the annual tuberculosis testing had not been done.	A 570		
A 610	.05(C)(6) .05 Administration (6) Pertinent safety practices, including the control of fire and mechanical hazards; This Regulation is not met as evidenced by: Based on review of policies and interview, it was determined that the administrator did not follow their policy on emergency preparedness. Staff: C The findings include: 1. Review of policies on October 13 & 14, 2015 revealed a policy entitled 'Emergency Preparedness (Disaster) Plan' that stated under the heading 'Facility Manger', in part, that "Ensure	A 610		

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A 610	Continued From page 5 that drills are conducted biannually (or as required by your accreditor or other regulator)." The policy continued under the heading 'Emergency drills' and stated, in part, "Emergency drill shall be conducted to ensure employee familiarity with appropriate procedures to be followed during emergencies. Both fire drills and disaster drills shall be conducted regularly, as required by your accreditor or other regulatory body." 2. Copies of fire and disaster drills were requested during the survey. Interview with the administrator on October 14, 2015 at 12:10 PM revealed that the facility was not conducting fire or disaster drills. Review of the policy entitled 'Orientation to the center' stated, in part, that during orientation to the facility staff would learn about "Emergency procedures 1. Fire 2. Evacuation procedures 3. Environmental disaster (e.g., tornado, ice/snow, hurricane) procedures 4. Disaster plan.".	A 610	A610 1. Facility manager is responsible for reviewing policy and procedures regarding "Emergency preparedness". 2. Facility manager will be charged with creating a new procedure to reflect office procedures, and will insure all state guidelines are met in this policy. The facility manager will also educate all employees on appropriate emergency plans, including exit strategy in case of a fire or natural disaster. 3. Effective immediately 4. Completion December 31, 2015 5. Facility manager will be responsible for educating the employees, and maintaining safety guidelines outlined by state regulation 6. Will log and document employee education, and ensure all members are updated 7. Annual quality monitoring to insure all employees are prepared in case of an emergency to facilitate exit strategies and insure patient care and safety.	
A 980	.07(B)(6) .07 Surgical Abortion Services (6) Emergency services; This Regulation is not met as evidenced by: Based on interview of the administrator, review of personnel files and policy and procedures, it was determined that two of two non-anesthesia personnel did not have current ACLS (advanced cardiac life support) training and certification.	A 980		

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A 980	Continued From page 6 Staff: A, C, D The findings include: 1. Interview of the administrator (C) on October 14, 2015 at 10:45 AM revealed that the physician administers moderate sedation. The medications used are fentanyl 50 mcg (fifty micrograms), versed 2.5 mg (two point five milligrams) and atropine. 4 mg (point four milligrams). The administrator stated that the staff members are not ACLS certified. 2. Review of personnel files of staff A and D revealed the staff members are not ACLS certified. 3. Review of policies on October 14, 2015 revealed a policy entitled 'Moderate Sedation, Non-Anesthesia Personnel' that stated, in part under the heading 'Management of emergencies/complications', that "- For patients who receive moderate sedation by non-anesthesia personnel, an ACLS-certified healthcare provider must be in attendance."	A 980	A980 1. Biennial review of physician credentialing will include audit of ACLS/BLS training for physicians, as well as BLS training for the staff involved in patient care. 2. The management team will insure that each employee per their job description will have current ACLS/BLS certification 3. Effective Immediately 4. Completed by January 31, 2016 5. Facility manager will be responsible for biennial audit of certifications 6. All employees per job description will need to be certified either in BLS or BLS/ACLS 7. Biennial audit of physician and employee file to insure current status for certifications	
A1080	.09(A) .09 Emergency Services A. Basic Life Support. Licensed personnel employed by the facility shall have certification in basic life support. A licensed staff individual trained in basic life support shall be on duty whenever there is a patient in the facility. This Regulation is not met as evidenced by: Based on review of personnel files, review of policy's and procedures and interview of the administrator, it was determined that the administrator did not assure four of four personnel received certification in basic life	A1080		

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A1080	Continued From page 7 support. Staff: A, B, C, E, F The findings include. 1. Review of policy and procedure for emergency services on October 14, 2015 revealed, "All personnel employed by the facility shall have certification in basic life support." 2. Review of four personal files for staff (A, B, E, F) revealed there is no current certification in basic life support. 3. Interview of the administrator (C) on October 14, 2015 at 10:30 AM revealed that the administrator was not aware that training for basic life support was needed.	A1080	A1080 1. Biennial review of physician and employee files to determine BLS certification status 2. Will provide resources for personnel to obtain appropriate certification 3. Effective immediately 4. All office staff must be certified by January 31, 2016 5. Facility manager will be responsible for insuring all personnel have current certification 6. All employees per job description will require certification 7. Biennial audit of physician and employee file to insure current certification status.	
A1150	.09(C)(5) .09 Emergency Services (5) Suction equipment; and This Regulation is not met as evidenced by: Based on a tour of the facility, review of the policy and procedure manual and interview of the administrator it was determined that the administrator did not obtain a suction machine for patient emergencies. Staff: C The findings include: 1. During a tour performed on October 13, 2015 at 9:30 AM it was revealed that there was no suction machine for patient emergencies. 2. Interview of the administrator (C) on October 13, 2015 at 10:30 AM revealed the administrator was not aware that a suction machine was needed for patient emergencies. 3. Review of policies on October 14, 2015	A1150		

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A1150	Continued From page 8 revealed a policy entitled 'Moderate Sedation, Non-Anesthesia Personnel' that stated, in part, "The environment where the induction of sedation occurs will have provisions for emergency power for lighting, resuscitation equipment, monitoring equipment, and telephone. All equipment and supplies must be suitable for the age and size of the patients being treated and located to provide immediate access to the patient. On-site equipment requirements include - blood pressure monitoring system, automatic or manual - oxygen supply with masks and nasal cannulas, including positive pressure oxygen delivery device - nasal and oropharyngeal airways - syringes/needles/IV supplies Equipment immediately available includes - emergency resuscitation drawer - telephone or other device capable of summoning immediate assistance in an emergency." The existing policy does not include the need for suction equipment.	A1150	A1150 1. Facility manager will be responsible for designating an employee to inspect availability, functionality and/or expiration of necessary emergency equipment. Facility manager will also include in the policy and procedure manual "on site equipment requirements" to meet the state regulation. 2. All emergency equipment will be audited by the facility manager biannually to inspect expiration date, and check functionality 3. Effective immediately 4. All audits will be completed by December 31, 2015 5. Facility manager will be responsible for assuring implementation 6. Manager will check log sheets filled by employees who are charged with checking equipment 7. Quality monitoring will occur biannual basis A1150-1 – A suction machine will be available by January 2016 for use in emergencies at this facility. Policy and procedure manual will reflect requirement for suction machine.	
A1250	.10 (B)(5) .10 Hospitalization (5) Appropriate training for staff in the facility 's written protocols and procedures. This Regulation is not met as evidenced by: Based on a review of policies, interview of the administrator and review of personnel files, it was determined that the administrator did not provide emergency training for patient transfers to the	A1250		

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A1250	Continued From page 9 hospital for three of three employees. Staff: C, D, E, F The findings include. 1. Review of personnel files on October 13 and 14, 2015 for staff members D, E and F revealed that there is no documentary evidence that the members received training for emergency patient transfer's to the hospital. 2. Interview of the administrator (C) on October 14, 2015 at 11 AM revealed the administrator was not aware that this type of training needed to be provided. 3. Review of policies revealed that there were none related to the emergency transfer of a patient to a hospital.	A1250	A1250 1. Facility manager will meet with each employee to identify the training needed for appropriate hospital transfer. 2. Facility manager will be responsible for designating a qualified employee to train the staff on appropriate hospital transfer protocol 3. Effective immediately 4. All training to be completed by all employees by January 31, 2016 5. Designated trainer will be responsible for insuring all staff is appropriately trained in hospital transfer 6. Each employee will need to sign a document stating that they have received this training 7. This will be monitored on a biennial review	
A1510	.15 (A) .15 Physical Environment A. The administrator shall ensure that the facility has a safe, functional, and sanitary environment for the provision of surgical services. This Regulation is not met as evidenced by: Based on interview of the administrator and observations, it was determined that the registered nurse did not implement infection control policies and did not ensure that measures to prevent infection were practiced at the facility. These measures did not include performing spore testing on the autoclave. This deficiency was cited on a survey performed on February 22, 2013. Staff: C The findings include. 1. Review of spore testing documentation for the autoclave (machine used for the reprocessing/sterilization of surgical instrument)	A1510		

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A1510	Continued From page 10 revealed that spore testing was not performed in January, February, March, July, August and September of 2015. Spore testing was not performed weekly in April, May and June 2015. The Centers for Disease Control (CDC) recommends weekly use of biological indicators (spore testing) to ensure the efficacy of an autoclave machine in the sterilization process. Interview of the administrator (C) on October 13, 2015 at 10 AM revealed that spore testing is performed monthly and not weekly on the autoclave. The administrator was unaware that spore testing needed to be performed weekly on the autoclave machines. 2. Review of the POC (plan of correction) from the survey completed on February 22, 2013 revealed that the facility was previously cited for this regulation. The POC stated, in part, that: "The POC continued: "3. Spore testing of the autoclave will be done after each use. It is important to note as well that this facility also utilizes sport protecting tape on instrument packages as well as biological testing to ensure continued cleanliness, and spore free environment. these will be monitored quarterly by the office administrator"..	A1510	A1510 1. Facility manager has identified an employee to perform sanitary measures and implement infection control 2. Designated employee will be responsible for appropriately sanitizing all instruments, including the use of chemical indicators, and assuring all expired curettes have been properly discarded 3. Effective immediately 4. New strategies implemented October 31, 2015 5. Facility manager and designated employee are responsible for assuring implementation 6. Will evaluate spore testing, and inspect sterilization packets for appropriate technique 7. Spore testing will be conducted weekly, with associated log sheet to document testing, and results. Policy and procedure manual will also be updated to reflect weekly spore testing and new sterilization technique.	
A9999	Final Comments An exit conference was conducted with the administrator on October 14, 2015. The survey findings were reviewed. The administrator was directed to submit a written plan of correction in response to the 2567 form, following the attached guidelines, within ten	A9999		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN FAMILY PLANNING INST INC	5915 GREENBELT ROAD BERWYN HEIGHTS, MD 20740

(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
A9999	Continued From page 11 calendar days. Failure to submit an acceptable plan of correction may result in delicensure from the Department of Health and Mental Hygiene Surgical Abortion Facilities program.	A9999		

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

November 20, 2015

Administrator
Metropolitan Family Planning Inst. Inc.
5915 Greenbelt Road
Berwyn Heights, Maryland 20740

Dear

Enclosed is a list of State deficiencies resulting from a relicensure survey that was completed at your facility on October 14, 2015.

Please note that an Acceptable Plan of Correction (POC) for the identified deficiencies must include the following information:

1. **State how the management team will evaluate the scope of each deficiency cited.**

2. **State what process changes the management team will make to correct each specific deficiency identified.**

3. **Define the projected time line for each step in the corrective action plan for each deficiency cited.**

4. **Define the projected completion date for each deficiency cited.**

5. **Identify who will be responsible for assuring each step in the plan of correction is implemented.**

6. **State what specific quality indicators that the management team will monitor and evaluate the effectiveness of the corrective actions.**

7. **Define what will be the on-going schedule of the quality monitoring activities for each deficiency cited.**

IT IS IMPERATIVE THAT YOUR POC CONTAIN THE ABOVE COMPONENTS.
Please complete Forms CMS 2567 as follows:

1. **Use the official form provided to you for your response.**
2. **Your Plan of Correction must be entered in the appropriate column on the right.**
3. **An authorized representative of your facility must sign and date the form in the designated space provided.**

PLEASE RETURN COMPLETED CMS 2567:

Barbara Fagan, Program Manager
Ambulatory Care Programs
Office of Health Care Quality
Spring Grove Center
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency(ies) being disputed, and an explanation of why you are disputing those deficiencies, to Dr. Tricia Nay, Director, Office of Health Care Quality, Bland Bryant Building, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Please submit a Plan of Correction within 10 calendar days of receipt of this letter. Please be advised that failure to submit an acceptable POC could result in a recommendation to terminate your facility from the Medicare program.

If you have any questions regarding these instructions, please call the undersigned at (410) 402-8040.

Sincerely,

Barbara Fagan
Program Manager
Ambulatory Care
Office of Health Care Quality

Cc: file

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

March 28, 2016

Administrator
Metropolitan Family Planning Inst. Inc.
5915 Greenbelt Road
Berwyn Heights, Maryland 20740

RE: ACCEPTABLE PLAN OF CORRECTION

Dear

We have reviewed and accepted the Plan of Correction submitted as a result of a initial survey completed at your facility on October 14, 2015.

Please be advised that an unannounced follow-up visit may occur prior to the standard survey to ensure continual compliance.

If there are any questions concerning this notice, please contact this Office at 410-402-8040.

Sincerely,

Barbara Fagan

Barbara Fagan, Program Manager
Ambulatory Care Programs
Office of Health Care Quality