STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	140008	A. BUILDING: _____ B. WING _____	01/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOMEN'S CENTER HOUSTON	8200 WEDNESBURY LANE, SUITE 230 HOUSTON, TX 77074

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A 000	Initial Comments Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An entrance conference was held with the facility office administrator in the morning of 01/15/18. The purpose and process of the licensure resurvey were discussed, and an opportunity given for questions. Continued licensure is recommended, with an approved plan of correction. An exit conference was held with the facility medical director and office administrator on the afternoon of 01/18/18. Preliminary findings of the survey were discussed, and an opportunity given for questions.	A 000		
A 037	TAC 139.8(d)((5)(6)(7) Quality Assurance (d) Minimum responsibilities. The QA committee shall: (5) address medication therapy practices; (6) address the integrity of surgical instruments, medical equipment, and patient supplies; and (7) address services performed in the facility as they relate to appropriateness of diagnosis and treatment. This Requirement is not met as evidenced by:	A 037	The Office Administrator will provide a quality assurance form that will address medication therapy practices which will be evaluated quarterly(3months) by the Medical Director/Committee. The Office Administrator will provide a daily log sheet to assure all medical equipment, surgical instruments, and patient supplies are being performed properly and update policy and guidelines that will be monitored by the Medical Director. REVIEWED FEB 14 2018 BY: Wanda Wilson, RD	04-13-2018

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A 037	Continued From page 1 Based on a review of documentation and interview, the facility failed to ensure that the quality assurance committee addressed medication therapy practices and the integrity of surgical instruments. Finding included: Facility based policy entitled, "Quality Assurance Committee" stated in part, "2. This committee will evaluate the following:...medication therapy practices,the integrity of surgical instruments... 3. This committee will meet quarterly to discuss the above topics and/or any other issues related to quality assurance and patient care..." Review of the quality meeting minutes revealed that medication therapy practices were not addressed quarterly, only one meeting in May 2017 addressed antibiotics. There were no meeting minutes that addressed the integrity of surgical instruments. The above finding were confirmed in an interview with staff member #2 on 01/18/18. The requirement of the quality assurance committee to address medication therapy practices and the integrity of surgical instruments was cited during a previous survey that was completed on 09/13/16.	A 037		
A 126	TAC 139.41(a) Policy Development and Review (a) The licensee shall be responsible for the conduct of the licensed abortion facility and shall assume full legal responsibility for developing,	A 126		

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A 126	Continued From page 2 implementing, enforcing, and monitoring written policies governing the facility's total operation, and for ensuring that these policies comply with the Act and the applicable provisions of this chapter and are administered so as to provide health care in a safe and professionally acceptable environment. These written policies shall include at a minimum the following: This Requirement is not met as evidenced by: Based on a review of documentation and interview, the facility failed to ensure full legal responsibility for developing, implementing, enforcing, and monitoring written policies governing the facility's total operation, as evidence by failing to ensure the facility had policies and procedures specific to this clinic. Findings included: Review of the facility policy and procedure book revealed that facility was continuing to use policies that belonged to a clinic under another medical director (staff member #6) located at a different address. In an interview on 01/18/18, staff member #2 stated that the physician listed on these policies and procedures owned an abortion clinic which was then sold to another group of physicians including staff member #1 (current medical director of the facility). According to staff member #2, staff member #6, who was the medical director of the clinic located at a different address had retired from practice over 10 years ago. Staff member #2 confirmed the policies had not been updated since staff member #6 sold the practice,	A 126		

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A 126	Continued From page 3 which had moved locations, closed and re-opened in the last 5 years, and the new medical director (staff member #1) had taken over. Policies and procedures written for the clinic under another medical director at a different address (staff member #6) who retired over 10 years ago included the following: HIPPA, Patient Appointments, Pre-Operative patient work-up, Operative Procedure, Post-Operative Care, Post-Operative Follow Up, Emergency Involving Use of Oral Suction, Post-Operative Complications, Office Counseling, Laboratory Protocol, Operating Room Format, Sterilization Format, Recovery Room Format, Complaints, Office Ethics and Patient and Personnel Safety, Quality Control/ Quality Assurance, Quality Assurance Committee, Statement of Patient Rights, Patient' Rights at this Facility, TB Skin Tests, Functional IV, Liquids and Food for Patients, Patient Records, Miscellaneous Addition Addressing Under 18 Parental Notification Laws, Free Prescriptions, Miscellaneous Addition addressing the Women's' Right to Know and the 24 hour mandatory wait Period, Students (Ultrasonographer/Medical Assistant), Texas department of Health Induced Abortion Report Form, Abuse and Neglect, and In-service Training and Orientation. A documented tiled "Office Protocol Update 2003" under the medical director (staff member #6) at a different address stated in part, "There were not changes in the office protocol or instruments used during the 2003 year. The office itself was sold this year. On or about October 17, 2003...	A 126	The Office Administrator will provide an updated policy and procedure guidelines for the clinic with the current information such as Physcian name, address, phone number, HIPPA, Patient Appointments, Pre-Operative patient work-up, Operative Procedure, Post-Operative Care, Post-Operative Follow Up, Emergency Involving Use of Oral Suction, Post-Operative Complications, Office Counseling, Laboratory Protocol, Operating Room Format, Sterilization Format, Recovery Room Format, Complaints, Office Ethics and Patient and Personnel Safety, Quality Control/ Quality Assurance, Quality Assurance Committee, Statement of Patient Rights, Patient' Rights at this Facility, TB Skin Tests, Functional IV, Liquids and Food for Patients, Patient Records, Miscellaneous Addition Addressing Under 18 Parental Notification Laws, Free Prescriptions, Miscellaneous Addition addressing the Women's' Right to Know and the 24 hour mandatory wait Period, Students (Ultrasonographer/Medical Assistant), Texas department of Health Induced Abortion Report Form, Abuse and Neglect, and In-service Training and Orientation. All policy and guidelines will be specific to the clinic under practice with the current Medical Director information. Office Administrayor will provide a monthly check list to ensure all information is current and will be reviewed by the Medical Director.	04-13-2018

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A 126	Continued From page 4 (Another physician group) chose to keep all procedures, procedure manuals and protocols the same at this time..." These policies and procedures were still currently being utilized at the facility. The above policies were last updated in 2004 and signed off on in 2006. This abortion facility received a new license in 2015. These policies pre-dated the initial licensure date for this facility in 2015. The facility had documentation that the policies "have been reviewed and approved" dated 01/05/18. These policies were written for a facility located at a different address under the direction of a different medical director. These policies are outdated and were not written for the facility that was surveyed 01/15/18 through 01/18/18 . In an interview on 01/18/18, staff member #2 confirmed the facility needed policies written specific to this clinic under the current medical director (staff member #1).	A 126		
A 197	TAC 139.48(1)(A) Physical & Environmental Requirements The physical and environmental requirements for a licensed abortion facility are as follows. (1) A facility shall: (A) have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients and staff at all times; This Requirement is not met as evidenced by: Based on observation, the facility failed to	A 197		

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A 197	Continued From page 5 maintain a safe and sanitary environment, maintained to protect the health and safety of patients and staff. Findings were: Staff #3 wore short, artificial nails adorned with a decorative, textured finish, creating a surface similar to chipped nail polish with multiple areas for bacteria to become lodged. The polish was also chipped in several areas. According to the CDC Morbidity and Mortality Weekly Report, October 25, 2002 / Vol. 51 / No. RR-16: "Studies have documented that subungual areas of the hand harbor high concentrations of bacteria, most frequently coagulase-negative staphylococci, gram-negative rods (including Pseudomonas spp.), Corynebacteria, and yeasts (14,342,343). Freshly applied nail polish does not increase the number of bacteria recovered from periungual skin, but chipped nail polish may support the growth of larger numbers of organisms on fingernails (344,345). Even after careful handwashing or the use of surgical scrubs, personnel often harbor substantial numbers of potential pathogens in the subungual spaces (346-348) ...HCWs who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing." The above was confirmed in an interview with the Medical Director and office manager on the afternoon of 1-18-18. The above was cited previously in a survey of the facility performed on 9-13-16.	A 197	The Medical Director will observe that all medical staff will comply with no decorative, textured finish, no chipped nail polish, and nails must be smooth with no chipped edges.	04-13-2018

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A 200	TAC 0139.48(1)(D) Physical & Environmental Requirements The physical and environmental requirements for a licensed abortion facility are as follows. (1) A facility shall: (D) have a written protocol for emergency evacuation for fire and other disasters tailored to the facility's geographic location. Each staff member employed by or under contract with the facility shall be able to demonstrate their role or responsibility to implement the facility's emergency evacuation protocol required by this subparagraph; This Requirement is not met as evidenced by: Based on a review of documentation and interview, the facility failed to ensure the implementation of a written protocol for emergency evacuation for fire and other disasters tailored to the facility's geographic location. Each staff member employed by or under contract with the facility shall be able to demonstrate their role or responsibility to implement the facility's emergency evacuation protocol required by this subparagraph. Findings included: Facility based policy and procedure entitled, "Emergency Evacuation and Disaster Plan" stated in part, "All personnel will be familiar and with this plan and an evacuation drill will be held every two (2) months." In an interview on 01/18/18 staff member #2 was asked if the facility had documentation of performing disaster drills every two months. Staff	A 200	The Office Administrator will provide a disaster drills form for emergency evacuation protocol which will be reviewed by Medical Director and performed twice a month.	04-13-18

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A200	Continued From page 7 members stated the drills were done verbally by the medical director twice a year. There was no available documentation that the drills were being performed 2 times a month per facility based policy. The above was cited previously in a survey of the facility performed on 9-13-16.	A200		
A201	TAC 139.48(1)(E)(F) Physical & Environmental Requirements The physical and environmental requirements for a licensed abortion facility are as follows. (1) A facility shall: (E) store hazardous cleaning solutions and compounds in a secure manner and label substances; (F) have the capacity to provide patients with liquids. The facility may provide commercially packaged food to patients in individual servings. If other food is provided by the facility, it shall be subject to the requirements of §§229.161 - 229.171 of this title (relating to Texas Food Establishments); This Requirement is not met as evidenced by: Based on observation and a tour of the facility, the facility failed to store hazardous cleaning solutions and compounds in a secure manner. Findings were: During a tour of the facility on 1-18-18, the following was found inside an unlocked cabinet in the instrument processing area, as well as inside an adjacent closet: Clorox liquid, Clorox spray, Maxcide, speed clean, Comet scrubbing powder,	A201	The Office Administrator will provided a daily checklist to ensure all hazardous cleaning solutions and compounds are stored away in a locked cabinet only the Medical Director will have access to.	04-13-18

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A 201	Continued From page 8 Febreeze spray, Lysol spray and Clorox wipes. The instrument processing area was not locked or secured and was located at the end of the patient hallway. The above was confirmed in an interview with the Medical Director and Office Manager the afternoon of 1-18-18. The above was cited previously in a survey of the facility performed on 9-13-16.	A 201	The Medical Director will provide a lock for the hallway closet that is located in the instrument processing area which only the medical director will have access to.	04-13-18
A 246	TAC 149.49(d)(5)(G)(i)(ii) Infection Control Standards (G) Sterilizers. (i) Steam sterilizers (saturated steam under pressure) shall be utilized for sterilization of heat and moisture stable items. Steam sterilizers shall be used according to manufacturer's written instructions. (ii) Other sterilizers shall be used in accordance with the manufacturer's instructions. This Requirement is not met as evidenced by: Based on a review of documentation and interview, the facility failed to ensure that sterilizers were used in accordance with the manufacturer's instructions, as evidence by not performing maintenance per manufacturer recommendations. Findings included: Review of the manufacturer manual for the Tuttnuaer Operation and stated in part, "8. Service and Maintenance Instructions	A 246	The Office Administrator will provide a daily checklist to ensure that the sterilizers are being used properly with the manufactures instructions and will be reviewed by the Medical Director.	04-13-18

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A 246	Continued From page 9 8.1 Preventative and Scheduled Maintenance The Maintenance operations described in this chapter need to be followed as indicated to keep the device in good working condition... 8.1.2 Weekly 1. ONCE PER WEEK, clean the air jet. To ensure that the temperature inside the chamber rises properly, it is necessary to keep the air jet clean. A dirty air jet will prevent indicator strips from changing color and cause spore tests to fail. See 8.3. 2. Once per week, clean and descale the chamber, copper tubes and the reservoir using Chamber Brite (see 9). 9. CLEANING THE TABLETOP AUTOCLAVES WITH CHAMBER BRITE...will build up and clog the IF the autoclave is not cleaned regularly, dirt and debris will build up and clog the tubing and valves. This dirt can also be transmitted to tubing and valves. This dirt can also be transmitted to the instruments during sterilization. In addition, a layer of dirt on the stainless steel chamber traps moisture against the metal and will lead to the chamber becoming porous and failing. It is recommended that your autoclave be cleaned with CHAMBER BRITE once per week". Review of the autoclave log revealed that the sterilizer was documented as being cleaned with chamber brite weekly. During a tour of the sterilization area on 01/18/18, this surveyor asked staff member #2 (who sterilizes the facility instruments) what was used to clean the	A 246	The Office Administrator will provide a weekly checklist to ensure the autoclave chamber is being properly cleaned on a weekly basis with Chamber Brite will be reviewed by the Medical Director.	04-13-18

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A 246	Continued From page 10 sterilizer. Staff member #2 showed this surveyor a bottle of speed clean. The staff member was asked how often the autoclave was cleaned with speed clean, they responded "once every 3 months". Per interview the autoclave was not being cleaned every 3 months, which does not meet the criteria for weekly cleaning set by manufacturer recommendations. According to the manufacturer recommendations failure to clean the autoclave appropriately could lead to possible failure of the machine. The above findings were confirmed in an interview with staff member # 2 on 01/18/18.	A 246		

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[redacted]	Continued From page 11	[redacted]		
A 362	TAC 139.57(a)(2)(A)(B)(C)(D)(3) Discharge and Follow-up Referrals (a) A licensed abortion facility shall develop and implement written discharge instructions which	A 362		

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A 362	Continued From page 12 shall include: (2) a statement of the facility's plan to respond to the patient in the event the patient experiences any of the complications listed in the discharge instructions to include: (A) a telephone number by which the patient may reach the physician, or other health care personnel employed by the physician or by the facility at which the abortion was performed or induced with access to the woman's relevant medical records, 24 hours a day to request assistance for any complications that arise from the performance or induction of the abortion or ask health-related questions regarding the abortion; (B) the name and telephone number of the nearest hospital to the home of the patient at which an emergency arising from the abortion would be treated; (C) assurance that the responding individual shall be a physician, advanced practice registered nurse, physician assistant, registered nurse, or licensed vocational nurse; and (D) information that the patient may also contact the emergency medical service or present for care at the emergency room of a hospital in addition to contacting the facility; and (3) information concerning the need for a post-abortion examination. This Requirement is not met as evidenced by: Based on a review of clinical records, the facility failed to develop and implement written discharge instructions which shall include the name and telephone number of the nearest hospital to the home of the patient at which an emergency arising from the abortion would be treated.	A 362	The Office Administrator will provide a form with a list of hospitals name, telephone number and address and will circle the hospital nearest to the patients home or location where the patient will reside after leaving the facility.	04-13-18

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A 362	Continued From page 13 Findings were: During a review of clinical records for 23 patients, none of the 23 patients had been furnished the name and telephone number of the hospital nearest their home at which an emergency arising from the abortion would be treated. All 23 records contained a document titled "Hospitals Near Houston", listing 20 hospitals (including hospitals in Houston Tx, Tomball Tx, Galveston Tx, Beaumont Tx, Baytown Tx, Cypress Tx, Richmond Tx, Victoria Tx, San Antonio Tx and the cities of Hammond and Lake Charles in Louisiana). No specific hospital was circled or otherwise indicated (as being closest to their home) for any of the 23 patients. The above was confirmed in an interview with the Medical Director and office manager on the afternoon of 1-18-18. The above was cited previously in a survey of the facility performed on 9-13-16.	A 362		