Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007882	A. BUILDING: _____ B. WING _____	03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUSTIN WOMENS HEALTH CENTER	1902 SOUTH IH 35 AUSTIN, TX 78704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 Administrator and Office Manager the morning of 3-27-18. 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 Administrator, Office Manager and Clinic Coordinator the afternoon of 3-27-18. Preliminary findings of the survey were discussed, and an opportunity given for questions.	A 000		
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;	A 197		

SOD - State Form

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007882	A. BUILDING: _____ B. WING _____	03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUSTIN WOMENS HEALTH CENTER	1902 SOUTH IH 35 AUSTIN, TX 78704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 197	Continued From page 1 This Requirement is not met as evidenced by: Based on observation, the facility failed to maintain a safe and sanitary environment that was properly maintained to protect the health and safety of patients and staff at all times. Findings were: During a tour of the facility on 3-27-18, the following was noted: 'The formica-type edging on the countertop in the instrument sterilization area had peeled back in some areas and was missing in other areas. Missing edging creates a porous surface that cannot be cleaned or properly maintained and provides an area for bacteria to grow. The above was confirmed in an interview with the Clinic Manager and the Facility Administrator the afternoon of 3-27-18.	A 197		