Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130019	A. BUILDING: _____ B. WING _____	12/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN WOMENS SURGERY CENTER	8616 GREENVILLE AVENUE SUITE 101 DALLAS, TX 75243

(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
T 000	Ambulatory Surgery Centers 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 unannounced, complaint survey was conducted on site. An entrance conference was held the morning of 12/12/17 with the facility's representatives at Southwestern Women's Surgery Center 8616 Greenville Avenue, Suite 101 Dallas, Texas. The purpose and process of the survey was explained. The survey was conducted to determine compliance with the requirements at 25 TAC 135 - Ambulatory Surgical Center (ASC) Licensing Rules. An exit conference was held the afternoon of 12/18/17 with the facility representatives at which time the findings of the survey were explained. The facility representatives was thanked for their time, cooperation, and given an opportunity to provide evidence of compliance with those requirements of which non-compliance had been found. None was provided. Instructions were provided on writing plans of correction with instructions to return the plans of correction to the Arlington zone office within 10 days. This report was electronically sent to the facility. Complaint #273025 was unsubstantiated with an unrelated deficiency cited.	T 000	R/A RJ 12/26/17	
T 177	135.8(a) QUALITY ASSURANCE IN A LICENSED ASC	T 177		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE ADMINISTRATOR (X6) DATE 12/22/17

STATE FORM 6899 N1TY11 If continuation sheet 1 of 2

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T 177	Continued From page 1 Quality Assurance. (a) Quality assurance includes the selection of professional personnel prior to engagement for service, ongoing review of clinical responsibilities and authority, and peer review and supervision of all professional and technical activities of personnel. This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure peer review and supervision of all professional activities, in that, Peer Review was not completed tri-annually for 2017. Findings included There was no Peer Review completed since the January - April records were reviewed in July. The undated, "Peer Review Program" policy required, "conducted tri-annually...each physician every four months..." During an interview on 12/12/17 at 10:31 AM, Personnel #2 was asked for the Peer Review minutes. Personnel #2 presented the July 2017 Quality Minutes that reflected Peer review of 3 cases for the first 4 months (January, February, March, and April) of 2017. Personnel #2 was asked for subsequent Peer Review. Personnel #2 stated, "They (post April record) have not been reviewed yet."		The Medical Director will complete the already in-progress 2017 Peer Review in the first month of 2018. The second tri-annual period will be complete by January 19, 2018. The third tri-annual period will be complete on the 21st day following the end of the period. The Peer Review program must be completed by the 21st day following the end of the tri-annual period starting 2018. The departure of the former Co-Administrator lead to a lapse in the direction for monitoring this standard. From this point forward, the current Administrator is aware and will monitor, in partnership with the Quality Assurance (QA) Committee, the progress of said Peer Review program. It will be reviewed during our quarterly QA meetings. The Medical Director and Administrator will ensure completion in the time frame specified.	01/19/18 01/21/18