STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

October 22, 2018

Jane Yousman, Administrator
Planned Parenthood Of Connecticut Inc - Hilda Standish Center
1030 New Britain Avenue
West Hartford, CT 06133

This is an amended version of the violation letter originally dated August 16, 2018.

Dear Ms. Yousman:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Hilda Standish Center on June 29, 2018 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing renewal inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

An office conference has been scheduled for September 4, 2018 at 11:00 A.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 30, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes

DATE(S) OF VISIT: June 29, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Donna Ortelle, RN. MSN

Donna Ortelle, R.N., M.S.N.
Public Health Services Manager
Facility Licensing and Investigations Section

DMO:lst

DATE(S) OF VISIT: June 29, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board, Administrator (b) and/or 19-13-D52 Maintenance.

1. Based on observations, policy review and interviews with facility personnel, the facility failed to ensure that infection control practices were maintained. The findings include:
   a. Review of the steam sterilizer documentation with the Director on 6/29/18 at 10:00 AM indicated that for autoclave "A" on 2/27/18 the documentation indicated that the biological had failed. The documentation failed to reflect that the load had been redone. The policy indicated that all sterilization strips must turn the appropriate color and if the spore remains positive the staff should in part, resterilize in an alternate autoclave.
   b. The documentation for 4/3/18 indicated that a load was completed in autoclave A however, the record failed to reflect if the load biological passed or failed. Interview with Director on 6/29/18 at 10:00 AM indicated that the results of the steam indicator should be circled. Review of facility policy identified that documentation of the sterilization logs includes sterilization indicator results, load number, results of biological testing and pack number. Review of the documentation for the autoclave B indicated that on 6/4/18 the number of packs was not documented and the record failed to reflect if the load biological passed or failed.
   c. Tour of the recovery area on 6/29/18 at 9:20 AM indicated that patient chairs were cloth covered, rendering them unable to be fully sanitized after patient use. Interview with the Director on 6/29/18 at 9:30 AM indicated that new chairs are being ordered Review of facility policy identified that disinfectant of chairs would be achieved by spraying disinfectant on the vinyl chair and waiting the recommended time or utilize a two minute wipe before using the chair.
   d. Observation on 6/29/18 at 10:00 AM and 11:50 AM in the procedure room identified a pillow with a cloth pillow case on the table under a paper covering. Observation identified that the paper covering is removed the pillow is picked up the table wiped with a disinfecting wipe and the pillow is returned to the table.
   Staff Person #1 removed her gloves and without performing hand hygiene set the room/table up for the next patient. Interview with the Director on 6/29/18 at 12:00 PM indicated that a disposable pillow cases are supposed to be utilized.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board, Administrator (b) and/or 19a-116-1(f) Emergency Preparedness (1)(A) Evacuation Plans and (b) fire drills.

2. Based on tour of the facility and staff interview, the facility failed to ensure that evacuation plans were posted as required by the public health code:
   a. On 06/29/18 at 10:30 AM, the surveyor observed that no evacuation plans were posted to

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direct patients and staff to at least two evacuation routes

3. Based on documentation review and subsequent staff interview it was identified that facility staff were how fire drills or alarms were activated to alert staff and patients for a fire drill and or fire emergency for the facility:
   a. On 06/29/18 at 10:00 AM, after review of facility documentation and staff interviews, it was identified that fire drills, and fire emergency training were not conducted in accordance with the Public Health Code and the Connecticut State Fire Prevention Code 20.6.2.1.2.2 as referenced by the Connecticut Fire Safety Code i.e. the sounding of the alarm and the transmission of a signal and no documentation of staff emergency preparedness training on the day of survey

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board, Administrator (b) and/or 19-13-D52 Maintenance.

4. Based on documentation review and subsequent staff interview the facility failed to ensure that the water based fire protection system was maintained as required:
   a. On 06/28/18 at 10:00 AM after review of facility documentation and staff interviews, it was identified that the facility failed to maintain the water based fire protection system as required by NFPA 25 “Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems” as referenced by the Connecticut State Fire Prevention Code 13.3.3.4.1.1 i.e. sprinklers were dated 1954 the facility lacked documentation of a 50 year test of sprinklers as required by NFPA 25, Gauges not changed every 5 years “the date on the gauges indicate” they are original to system and were no replaced as required by NFPA 25, no 5th year obstruction test as required by NFPA 25, no quarterly testing as required by NFPA 25 and all sprinkler heads are corroded and shall be replaced in accordance with NFPA 25.

5. Based on documentation review and subsequent staff interview the facility failed to ensure that the fire alarm system was maintained as required:
   a. On 06/28/18 at 12:30 PM, documentation was not available the facility had an established fire alarm testing program and that the system had been installed in accordance with NFPA 72 National Fire Alarm Code as required and as required by the Connecticut State Fire Prevention Code 13.7.3.1.1.2, 13.7.3.2.3.1 and 13.7.3.2.4.