STATE OF C⁻NNECTICUT

DEPARTMENT OF PUBLIC HEALTH

March 3, 2014

Tanya Little, Administrator
Summit Womens Center Inc. - Bridgeport
3787 Main Street
Bridgeport, CT 06606-1822

Dear Ms. Little:

Unannounced visits were made to Summit Womens Center Inc. - Bridgeport on February 21 and 26, 2014 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure inspection and a revisit for the purpose of implementation of a plan of correction for the violation letter dated February 7, 2012.

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 visits.

An office conference has been scheduled for March 18, 2014 at 1:00 PM 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 March 17, 2014 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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,

Loan Nguyen

Loan Nguyen, RN
Supervising Nurse Consultant
Facility Licensing and Investigations Section

LN:lsl

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An Equal Opportunity Employer

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

The following are violations of the Regulations of Connecticut State Agencies Section 19a-116-1 and/or 19-13-D48 Professional Staff (b)(1)(2) and/or 19-13-D51 Pharmaceuticals and/or 19-13-D52 Maintenance.

1. Based on observations and interview, MD #1 failed to administer intravenous medications in a manner to prevent the spread of infections. The finding includes:
   a. Observation on 2/21/14 at 9:35am identified MD #1 and RN #1 performing a count of the narcotics which included fentanyl and versed. The narcotic box also contained a 10cc syringe filled with 7cc of clear fluid labeled as "versed" and "2/19". The syringe label lacked the strength of the medication and the initials of who drew up the medication. Interview with MD #1 identified that the medication was left over from procedures 2 days prior and was probably drawn up by CRNA #1 who worked on 2/19/14 and that there is a medication shortage.

      Patient #5 underwent a surgical abortion on 2/21/14 and received fentanyl and versed intravenously that was injected via a "T" port which was approximately 12 inches from the intravenous catheter site. Constant observation of staff and supplies identified after Patient #5 was moved from the procedure room to the recovery area and Patient #6's was set up for a surgical abortion. The same syringes of fentanyl and versed that were used on Patient #5 were set up for Patient #6. As MD #1 was going to inject versed, this surveyor stopped MD #1, asked to visualize the syringe which was dated 2/19, and asked if she was going to draw up a new syringe since this one was used on Patient #5. MD #1 asked if the surveyor preferred new syringes drawn up and although it was identified that it was a standard to use a new syringe with each patient, MD #1 continued to inject the versed and fentanyl filled syringes used on Patient #5 for Patient #6. At the conclusion of Patient #6's procedure, the syringe with 6cc of fentanyl was returned to the narcotic box. This surveyor requested that the syringe of fentanyl be discarded. Observation of MD #1 and RN #1 discarded the medication and syringe and cosigned the narcotic tracking sheet. According to Centers for Disease Control and Prevention, healthcare providers should never reuse a needle or syringe either from one patient to another or to withdraw medicine from the vial. Both needle and syringe must be discarded once they have been used.

      The Department directed the facility to submit an action plan to address the issue of multiple patient uses from a single syringe. The facility submitted a narcotic policy which identified that all physicians, nurses, and certified registered nurse anesthetists (CRNA's) will read and initial the policy prior to the provision of services. The policy included that all narcotics are to be drawn up for single use only and any unused portions are to be discarded. Discards must be witnessed by a second licensed provider, documented in the narcotic log, and that multiple patient uses from a single syringe are not acceptable.

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Observation on 2/26/14 at approximately 8:30am with RN #1 identified a 3cc syringe filled with 2cc's of clear solution in the narcotics box. The syringe was labeled as versed 1mg/cc 2/22/14 10am and a staff person's initial. RN #1 verified that the initials were from CRNA #1 who worked at the facility on 2/22/14. Interview with CRNA #1 on 2/26/14 at 10:35am identified that although she was informed by MD #1 and had signed the action plan on 2/22/14 regarding the facility's narcotic policy, she could not explain why she saved the 2cc's of versed in the narcotic box. The Department requested a plan to address CRNA #1's re-education and supervision of her performance.

2. Based on observation, review of facility documentation in interviews, the facility failed to ensure that all the emergency equipment is checked to ensure that it is available and functioning. The findings include:
   a. Review of the Emergency Equipment Checklist for January and February 2014 identified that emergency equipment was checked by RN #1 on 1/8/14, 1/22/14, and 2/7/14. The column identifying that the Automatic External Defibrillator (AED) in the recovery room and in the procedure room lacked documentation for the checks. Interview with RN #1 identified that she checks the emergency equipment including the AED in the recovery room every day that she works at the facility and CRNA #1 checks the AED in the procedure room. Interview with CRNA #1 on 2/26/14 identified that she does not check the AED in the procedure room. Interview with the Administrator on 2/16/14 identified that it is the facility's practice to check the emergency equipment monthly.

   Observation of emergency equipment supplies on 2/26/14 in the procedure room with CRNA #1 identified a laryngoscope, oral airways, ambu bag, oxygen, and nasal cannulas. The supplies did not include endotracheal tubes (ETT). Interview with CRNA on 2/26/14 was not able explain why there were no endotracheal tubes. CRNA #1 further identified that she would call 911 if there was an emergency and the patient required transfer to the hospital. Interview with the Administrator on 2/16/14 identified that the Medical Director reviewed what type of equipment was the needed in the facility and could not explain why there were no ETT's.

   Review of the Equipment and Supply Inventory policy directs that medical personnel check equipment at the start of every clinic day. The inspection is logged on to the appropriate sheet. The nurse checks the anesthesia equipment; all other equipment is checked by the Medical Assistants or nursing staff. Subsequent to surveyor inquiry, the Administrator immediately ordered ETTs and would have them at the facility for the next surgical procedure day.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19a-116-1 and/or 19-13-D47 Governing Board, administrator (3)(b) and/or 19-13-D48 Professional staff (b)(2) and/or (4) and/or 19-13-D49 Records (a) and/or 19-13-D50 Nursing personnel and/or 19-13-D51 Pharmaceuticals and/or 19-13-D52 Maintenance and/or 19-13-D54 Abortions (d).

3. Based on observation, review of the clinical record and interview for 17 of 19 patients undergoing a surgical abortion (Patient's # 3 - #19), the facility failed to maintain accurate and complete clinical records. The findings include:
   a. Patient #3 underwent surgical abortion on 02/12/14. Review of the clinical record on 02/21/14 failed to identify physician pre-operative physical examination of heart and lungs. Review of the Anesthesia record failed locate documentation of the time and route the anesthesia (Fentanyl 100 milligrams (mg) and Midazolam 2 mg) was administered and the time the blood pressure was obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although the oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations and level of consciousness.
   b. Patient #4 underwent surgical abortion on 02/12/14. Review of the clinical record on 02/21/14 failed to locate a physician pre-operative physical examination. Review of the Anesthesia record failed locate documentation of the time and route the anesthesia (Fentanyl 150 mg and Midazolam 3 mg) was administered and the times the blood pressure(s) were obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations and level of consciousness.
   c. Patient #5 underwent a surgical abortion on 2/21/14. Observation during the procedure on 2/21/14 at 10:31am identified staff inserted an intravenous (IV) of 150cc Normal Saline (NS). At the end of the procedure, the IV was infiltrated and was discontinued. Review of the record failed to reflect documentation of the IV insertion, amount of IV fluids absorbed, the infiltration site, or when the IV was discontinued. Further observation during the procedure identified the patient received fentanyl 100mcg and versed 2mg intravenously prior to the procedure and then received an additional versed 0.5mg during the procedure. The Operative Procedure Record failed to document the times that the medications were administered. In addition, the patient complained of eyes itching and skin itching after administration of medications although this was not documented in the record. Review of the Operative Procedure Record and post procedure record failed to identify documentation of respirations or level of consciousness. Although pulse oximetry was documented, the record failed to reflect the time the pulse oximetry was obtained. The post procedure record identified a patient pain rating of 4 (scale 0-10) before and after administration of ibuprofen

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800mg, the record failed to document the time of the pain assessment. Pain rating at time of discharge was also lacking.

d. Patient #6 underwent a surgical abortion on 2/21/14. Observation during the procedure identified the patient received fentanyl 100mcg and versed 2.5mg prior to the procedure. The Operative Procedure Record failed to document the time that the medications were administered. The record lacked the time of the IV start, the site and the type and amount of fluids. Review of the Operative Procedure Record and post procedure record failed to identify documentation of respirations or level of consciousness. Observation identified the patient arrived in the recovery area with 75cc of IV fluids. The record lacked the type fluids, the volume absorbed and the time the IV was discontinued. The post procedure record failed to identify a pain rating although Acetaminophen 1000mg was administered to the patient.

e. Patient #7 underwent a surgical abortion on 2/8/14. The physical exam failed to include documentation of a heart and lung assessments. The patient received fentanyl 150mcg and versed 2mg by CRNA #1. The Anesthesia Record/Operative Procedure Records lacked documentation of level of consciousness. The post procedure record lacked documentation of respiratory rate and level of consciousness. Interview with the MD #1 and review of the medical record on 2/21/14 identified that MD #2 had not been documenting the preoperative heart and lung assessments.

f. Patient #8 underwent surgical abortion on 02/08/14. Review of the clinical record on 02/21/14 failed to identify physician pre-operative physical examination of heart and lungs. Review of the Anesthesia record failed locate documentation of the times and route the anesthesia (Fentanyl 150 mcg and Midazolam 2 mg and an additional Midazolam 1 mg) were administered including the additional Midazlam 1 mg dose and the times the blood pressure(s) was obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations and level of consciousness.

g. Patient #9 underwent surgical abortion on 02/01/14. Review of the clinical record on 02/21/14 failed to locate a physician pre-operative physical examination. Review of the Operative procedure documentation indicated to "see anesthesia record;" however, the clinical record failed to contain an anesthesia record documentation. In addition, the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations and level of consciousness.

h. Patient #10 underwent surgical abortion on 07/24/13. Review of the clinical record on 02/26/14 failed to locate a physician pre-operative physical examination of heart and lungs. Review of the Anesthesia record failed locate documentation of the times and route the anesthesia (Fentanyl 150 mcg and Midazolam 2 mgm) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the

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record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations and level of consciousness.

i. Patient #11 underwent surgical abortion on 02/02/13. Review of the clinical record on 02/26/14 identified the patient had a history of a heart murmur during childhood; however, the physician failed to perform and/or document the pre-operative physical examination of heart and lungs. Review of the Anesthesia record failed locate documentation of the times and route the anesthesia (Nubain 5 mgm and Midazolam 2 mgm) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure and pulse were obtained and failed to document respirations, oxygen saturation and level of consciousness.

j. Patient #12 underwent surgical abortion on 07/27/13. Review of the clinical record on 02/26/14 failed to locate a physician pre-operative physical examination of heart and lungs. Review of the Anesthesia record failed locate documentation of the times and route the anesthesia (Fentanyl 150 mcg and Midazolam 3 mgm) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations and level of consciousness.

k. Patient #13 underwent surgical abortion on 07/26/13. Review of the Operative procedure record on 02/26/14 failed locate documentation of the dose and times of the administration of Midazolam and Fentanyl anesthesia and the times the intraoperative blood pressure(s), pulse and oxygen saturation were obtained and the failed to identify documentation of respirations or level of consciousness.

l. Patient #14 underwent surgical abortion on 07/27/13. Review of the clinical record on 02/26/14 identified the patient has asthma without medication treatment; however, the physician failed to perform and/or document the pre-operative physical examination of heart and lungs. Review of the Anesthesia record failed locate documentation of the times and route the anesthesia (Fentanyl 100 mcg and Midazolam 2) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure and pulse were obtained and failed to document respirations, oxygen saturation and level of consciousness.

m. Patient #15 underwent surgical abortion on 02/22/14. Review of the Anesthesia record on

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02/26/14 failed locate documentation of the times and route the anesthesia (Fentanyl 100 mcg and Midazolam 2 mgm) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations, and level of consciousness.

n. Patient #16 underwent surgical abortion on 02/22/14. Review of the clinical record on 02/26/14 identified the patient has a history of asthma and hypertension without medication treatments. Review of the Anesthesia record failed locate documentation of the times and route the anesthesia (Fentanyl 100 mcg and Midazolam 2 mg and an additional Fentanyl 50 mcg) were administered including the additional Fentanyl 50 mcg dose and the times the blood pressure(s) was obtained and the failed to identify documentation of heart rate, respirations or level of consciousness during the period of anesthesia despite documentation the patient was transferred to the recovery room awake and alert. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations, and level of consciousness.

o. Patient #17 underwent surgical abortion on 02/22/14. Review of the Anesthesia record on 02/26/14 failed locate documentation of the times and route the anesthesia (Fentanyl 100 mcg and Midazolam 2 mgm) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of heart rate, respirations or level of consciousness. Although oxygen saturation was documented, the record failed to indicate the time the oxygen saturation was obtained. Review of the Operative procedure documentation failed to indicate the time the blood pressure, pulse and oxygen saturation were obtained and failed to document respirations, and level of consciousness.

p. Patient #18 underwent surgical abortion on 02/26/14. Review of the Anesthesia record on 02/26/14 failed identify documentation of the times and route the anesthesia (Fentanyl 150 mcg and Midazolam 2 mg) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of level of consciousness. The recovery vital signs lacked documentation to reflect that respiratory rates or pulse oximetry were monitored. The operative procedure record lacked the time that vital signs were obtained. Cytotec 600mcg per rectum was administered in the procedure room and the operative procedure record lacked the time of administration.

q. Patient #19 underwent a surgical abortion on 2/26/14. Review of the pre-procedure record identified that the patient received Reglan 10mg intramuscularly and lacked documentation for the time of administration. Review of the Anesthesia record on 02/26/14 failed identify documentation of the times and route the anesthesia (Fentanyl 150 mcg and Midazolam 2 mg) were administered and the times the blood pressure(s) was/were obtained and the failed to identify documentation of level of consciousness. The recovery vital signs lacked documentation to reflect that respiratory rates and the time of that the pulse oximetry were

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monitored.

Interview with MD #1 on 2/21/14 identified that the facility uses the National Abortion Federation (NAF) guidelines. The analgesia and sedation guidelines direct when sedation is provided, monitoring must be adequate to detect respiratory, cardiovascular, and neurological effects of the drugs being administered, and this monitoring must be documented.

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

4. Based on observation and interview during tour, the facility failed to properly label solutions. The finding includes:
   a. Observation of the exam room and on the sink in the procedure room identified a bottle of orange colored solution in a bottle of 250 cc sterile water. The bottle lacked a label to identify the strength contents of the solution and when the solution was mixed/expired. Interview with MA #1 on 2/21/14 identified that the solution was diluted chlorhexidine which was used for prepping patients for procedures.

5. Based on observation and interview, the facility failed to properly reprocess surgical instruments. The findings include:
   a. During a tour of the facility on 2/21/14, it was identified that instruments that were packaged in peel away envelopes failed to contain a steam sterilizer indicator in the envelopes to ensure that there was steam penetration by the autoclave. The Centers for Disease Control and Prevention (CDC) Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 directs biological and chemical indicator testing is also done for ongoing quality assurance testing of representative samples of actual products being sterilized and product testing when major changes are made in packaging, wraps or load configuration.

   A tour of the exam room and the procedure room on 2/21/14 identified numerous surgical instruments packaged for use that were heavily pitted, rust stained, or with discolorations. Although the peel away packs had external steam indicators, most of the peel away packs also lacked a sterilization monitor within the envelope to ensure that there was steam penetration by the autoclave. Interview with MA #1 identified that many of these instruments were from a center that had closed and they were extra instruments for this facility. Further observations identified that the "packs" that were used to set up for surgical procedures contained the sterilization monitor strip wrapped within the pack of instruments (blue wraps were used vs peel away packs).

   Observation of the reprocessing room identified a blue solution in a basin which was used

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to soak used surgical instruments. Interview with MA #1 on 2/21/14 identified that she used 2 pumps of the enzymatic solution to the basin which was filled with a few inches of water. MA #1 was unable to explain how much enzymatic was dispensed in each pump or how much water was used in the basin. Interview with MA #2 on 02/21/14 identified that he used 3 pump/squirts of the enzymatic solution to about a ½ filled basin of water. According to the label on the bottle of enzymatic, one ounce of enzymatic should be diluted in a gallon of water and one pump was equivalent to one ounce.

6. Based on observations and interview the facility failed to properly store equipment and patient supplies. The findings include:
   a. Observation during operative procedures on 2/21/14, MD #1 set up his/her sterile field on the top shelf of a three tiered cart and used these supplies and instruments to perform surgical abortions. The bottom and middle shelves contained sterile packs of supplies and instruments for subsequent procedures.

      Observation during a tour of the facility on 2/21/14 identified a kitchen with a refrigerator and snacks for patient use. The kitchen also contained boxes of gloves and an emergency cart containing a suction machine, ambu bag and automatic external defibrillator (AED). Observation of the closet used for storage contained staff coats and clothing on one side, and supplies on the other side. The supplies included Windex, hand lotion, Clorox bleach, chlorhexidine scrub, hand sanitizer, peroxide, and specimen cups.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board, Administrator (b) and/or (c) and/or 19-13-D48 Professional staff (b)(1) and/or 19a-116-1 (e)(3).

7. Based on review of personnel files and interview, the facility failed to ensure that 10 of 16 personnel files were complete. The findings include:
   a. Review of MA #1's personnel file on 2/26/14 identified a date of hire on 4/18/05. The file lacked documentation to reflect that MA #1 was qualified to perform ultrasonography. Review of the personnel file and interview with the Administrator on 2/26/14 identified that MA #1 is qualified by training and had been signed off by MD #1 but could not locate the documentation.
   b. Review of CRNA #1's personnel file on 2/16/14 identified a date of hire in 2010. The file lacked a current Drug Enforcement Agency certificate, performance evaluations, or delineation of privileges. Review of the personnel file and interview with the Administrator on 2/26/14 could not explain the missing documents and the Administrator identified that the facility practice includes annual performance evaluations and all licensed medical personnel maintain current CPR certification. Review of the Bylaws, Rules and Regulations of the Medical Staff of Summit Women's Center, Revised February 2014, Section VI. Allied Health Professional 6.1 defines Allied Health Professionals as licensed individuals

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other physicians, who participate in patient care and who, by virtue of their professional credentials and current documented competence, are privileged to provide certain patient care services. Allied Health Professionals eligible to provide patient care in the Facility may include, but are not necessarily limited to nurse practitioners, nurse anesthetists, physician assistants and other professionals holding appropriate degrees as determined by the Governing Body and 6.3 Allied Health Professionals shall have written job descriptions of clinical duties and responsibilities, and each Allied Health professional shall function in accordance with and be subject to all of the conditions and requirements of these Bylaws and policies of the Facility in which such Allied Health Professional provides services.

c. Review of RN #1's personnel file on 2/26/14 identified a date of hire on 11/20/13. The file lacked documentation of a current cardiopulmonary resuscitation (CPR) card and orientation checklist. Review of the personnel file and interview with the Administrator on 2/26/14 identified that the orientation documentation was missing. The Cardiopulmonary Resuscitation policy directs that all licensed personnel will maintain current CPR status. A copy of each licensed medical staff person's updated card or certificate will be kept in his/her personnel file.

d. Interview and review of MD #2's personnel file with the Administrator on 02/26/14 failed to locate documentation of current area hospital privileges, current cardiopulmonary resuscitation (CPR) certification card, and current Drug Enforcement Agency certificate. The agency policy manual for Physician Qualifications, revised February 2014, indicates the physicians working as independent contractors for any Facility must have current area hospital privileges.

e. Interview and review of RN #2's personnel file with the Administrator on 02/26/14 identified date of hire of 09/13/13 according to payroll initiation failed to locate documentation of position acceptance statement, a current professional registered nurse license, current cardiopulmonary resuscitation (CPR) certification card, a job description, documentation of orientation and training, and a three month performance evaluation according to the Facility new employee training period notification of a 90-day training and orientation period and that that the new employee will be evaluated on or near the third month of employment and satisfactory progress will be rated.

f. Interview and review of RN #3's personnel file with the Administrator on 02/26/14 identified date of hire of as a licensed practical nurse was in 1999 and unclear when the employee was hired as registered nurse; however, unable to locate documentation of position acceptance statement, a job description, documentation of orientation and training, nor any annual performance evaluations. In addition, the available cardiopulmonary resuscitation (CPR) certification expired in 03/2005.

g. Interview and review of MA #2's personnel file with the Administrator on 02/26/14 identified date of hire as 11/20/12 but failed to locate annual performance evaluation.

g. Interview and review of MA #3's personnel file with the Administrator on 02/26/14 identified date of hire as 07/10/10 but failed to locate annual performance evaluations.

i. Interview and review of the Advanced Practice registered nurse (APRN) 's personnel file with the Administrator on 02/26/14 identified date of hire as 08/11/12 but failed to locate a

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current cardiopulmonary resuscitation (CPR) certification card, documentation of orientation and training nor any performance evaluations.

j. Interview and review of RN #4's personnel file with the Administrator on 02/26/14 identified date of hire as 07/10/12 and a new employee training period notification of a 90-day training/orientation period and an on or near three month evaluation and satisfactory progress dated 07/10/12; however, unable to locate documentation a job description, documentation of orientation and training, an on or near three month nor annual performance evaluations and a current cardiopulmonary resuscitation (CPR) certification card.

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 (e).

8. Based on review of facility documentation, surveyor observation and interview with facility staff, the facility failed to ensure availability of the meeting minutes. The findings include:
   a. Review of the Governing Body meeting minutes lacked documentation for the meetings in 2012, 2013, and 2014. Interview with the Administrator on 2/26/14 identified that the meeting minutes from 2012 and 2013 have not been sent to the facility by the attorney. The Quality Assurance Program directs semi-annual meetings of the Governing Body.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D46 Buildings and equipment (b).

9. Based on observation during tour, the facility failed to ensure that unacceptable equipment was not used in the facility. The findings include:
   a. Observation during tour of the facility on 2/21/14 identified a portable space heater in use in the procedure room.

POC Accepted 3/20/14 DD

Violation	Plan of Correction	Date in effect	Responsible for monitoring
#1 Facility Failed to Administer IV medications in a manner to prevent the spread of infection	• Policy entitled " OR Narcotic Policy/Safety" was revised on February 27, 2014, and the staff was educated on the policy revision. The appropriate staff members signed the policy indicating their review and understanding of the policy. • 2 cc single dose vials of Fentanyl and Midazolam, as available, have been ordered. Currently, 2 cc vials of Fentanyl are not available. 5cc vials are in use and will be administered according to the above-referenced policy.	• OR Narcotic Policy/Safety policy revised 2/27/14 • 2cc vials of Midazolam ordered 3/5/14 and will continue to be ordered as long as they are available. Use of 10 cc vials of Midazolam was discontinued 3/19/14. 2cc vials of Midazolam are in use.	• Medical Director and Administrator will monitor policy compliance. Once monthly monitoring for the first 6 months (beginning April 1, 2014), then once bi-monthly for the following 6 months, and quarterly thereafter for one year. • Administrator responsible for ordering of medications.
#2 Facility failed to ensure that all emergency equipment is checked to ensure it is available and functioning.	A. RN #1 has been instructed pursuant to Summit Policy "Equipment and Supply Inventory" to ensure that ALL equipment is working in both the recovery and procedure room prior to the start of procedures each day. New logs for tracking compliance have been put in place. Endotracheal tubes have been ordered and are in place with the other emergency supplies and included on the list of emergency supplies to be completed and checked by RN #1 monthly.	• Instruction to check all equipment began immediately. New logs for tracking in use as of 3/19/14. See attachment. • Revised emergency medication and equipment list put into place 3/19/14. See attachment.	• Administrator responsible for ensuring that equipment checked per policy and appropriately documented on checklists. • Administrator will monitor compliance once monthly for the first 6 months (beginning on April 1, 2014), then once bi-monthly for 6 months and once quarterly thereafter for one year.
#3 Facility Failed to maintain accurate and complete clinical records.	• Via review of State of CT DPH Public Health Code 19-13-D54, physicians have been educated on the requirement of the physical exam pre procedure. All physicians have agreed to this requirement.	• Instruction and agreement to the physical exam requirement complete 3/12/14.	• Administrator will audit charts for completion of the physical exam. Administrator will audit 10% of charts completed the prior month, selected randomly, once per month for 6 months (beginning April 1, 2014), once bi-monthly for the following 6 months and once quarterly thereafter for one year.

Violation	Plan of Correction	Date in Effect	Responsible for Monitoring
#3 Facility failed to maintain accurate and complete clinical records.	• Procedure and anesthesia forms have been updated to include time of all medication administration, time vital signs taken, including level of consciousness and PSaO2, and time of IV initiation and discontinuation. • Forms also updated to include documentation of route of administration of IV medications, amount of fluids absorbed, level of consciousness, respirations, any additional medications given and time administered. • Recovery room record updated to include time of pain scale assessment performed.	• Updated forms completed, staff educated on new forms and will be put into use on 3/21/14. • See updated forms attached.	• Administrator will randomly monitor 10% of charts completed the prior month once monthly for the first 6 months (beginning April 1, 2014), then once bi-monthly for six months and then once quarterly thereafter for one year.
#4 Facility failed to properly label solutions.	• Labeling and storage of all solutions was reviewed with staff and policy entitled "Pre-drawn medications, multi dose vials and solutions" was updated.	• Re-education of staff complete 3/19/14. • Policy attached.	• Administrator to randomly monitor labeling of solutions twice monthly for six months, then once monthly for six months and then once quarterly thereafter for one year.
#5 The facility failed to properly reprocess surgical instruments.	• Per new policy "Instrument Processing and Sterilization," completed Feb 26, 2014, peel away surgical packaging will use steam sterilizer indicators inside package when being sterilized. • Staff was retrained on instrument quality and removing instruments from circulation when they are showing signs of pitting, rusting or discoloration. "Instrument Processing and Sterilization" policy updated to reflect this. • Instruments have been inspected and any showing signs of rust, discoloration or pitting have been removed from circulation. • Staff was retrained on proper use of enzymatic detergent used for washing instruments and written instruction has been affixed to the wall to ensure all staff is aware of proper use of detergent.	• Policy entitled "Instrument Processing and Sterilization" in effect on 2/26/14 • Policy update (3/18/14) and retraining completed on 3/19/14. Policy attached. • Retraining staff on proper use of enzymatic detergent completed 3/5/14. Written instruction has been affixed and staff are aware.	• Administrator will randomly observe instrument processing once monthly for the first 6 months (beginning April 1, 2014), then once bi-monthly for six months and then once quarterly thereafter for one year.

Violation	Plan of Correction	Date in Effect	Responsible for Monitoring
#6 Facility failed to properly store equipment and patient supplies.	• In the procedure room - sterile instrument packs have been removed from the bottom and middle shelves of the three tiered cart that the medical director uses for her work field. Instruments have been temporarily relocated to the closet away from the possibility of contamination until new cabinetry can be installed in the procedure room. • The supplies stored on the shelf in the kitchen area were immediately relocated on 2/21/14 to the recovery area. • Supplies located in cabinet with coats have been temporarily moved to the shelves in the laundry room while we await new cabinetry to be installed.	• Temporary move to closet for instruments in effect 2/27/14. Permanent move to new cabinetry by 4/15/14. • Supplies stored in kitchen relocated to the recovery room on 2/21/14. • Coat closet cleared of supplies on 3/19/14.	• Administrator to ensure that equipment properly stored per this corrective action plan.

#7 Facility failed to ensure that 10 of 16 personnel files were complete.	a- MA #1 file updated with current ultrasonography job description signed by medical director. b- DEA registration has been verified and included in CRNA file, contract outlining CRNA's duties has been included in CRNA file. Performance evaluations are not performed on contractors. As CRNA is a contractor and not an employee, the performance evaluations are not part of the terms of contract. c- RN #1 - CPR certification documentation added to the file. Orientation/training checklist was reviewed, signed and added to the employee file. See orientation checklist attached. d- MD #2 file has been updated with all current information. e, f, h, and j -per diem employees are not scheduled on a regular basis. All paperwork, including position acceptance forms, proof of licensure, current CPR card, job description, documentation of orientation, and performance evaluation, as applicable, will be completed before they will be allowed to work their next scheduled shift. All per diem employees have been notified of this requirement. g - MA #2 evaluation completed for 2014. 2013 was not done due to employees hours being reduced and possibility of position being eliminated. i - APRN job description written (see attached), agreed upon and signed by APRN. CPR documentation secured and added to file. Evaluation to be performed during the next scheduled shift.	a - MA #1 has been performing ultrasonography for several years both in the Hartford (now closed) office of Summit and the Bridgeport office; she has been observed on numerous occasions by Medical Director; most recently 3/14/14. b- Completed 3/19/14. c- proof of current CPR certification added to file on 2/28/14. Orientation checklist 3/19/14. d- Documentation of hospital privileges was added to MD file on 3/18/14. DEA registration verified and proof put into MD file on 3/5/14. e, f, j and h - all notified of paperwork requirements prior to next shift - notification sent 3/19/14. g - completed - 3/19/14 i - job description to be completed, signed and added to file 3/22/14. CPR documentation completed and added to file 3/1/14. Evaluation to be done before end of next scheduled shift 3/22/14.	Administrator Personnel files to be reviewed for completeness on a bi-monthly basis. Beginning 5/1/14. 3/20/14 per T.A. Admin

Americans United for Life

#8 Facility failed to ensure availability of meeting minutes.	All governing body minutes will now remain in the office for easy retrieval. Copies will still be kept with attorney as well. Minutes of 2012, 2013 and 2014 (to date) attached.	Completed 3/14/14.	Administrator
#9 Facility failed to ensure that unacceptable equipment was not used in the facility.	Portable space heater has been removed from the procedure room.	Completed 3/14/14. Hardwired, permanent baseboard heater to be installed - expected completion 4/15/14.	Administrator

Americans United for Life

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION

LICENSING INSPECTION REPORT

Name and Address of Entity Planned Parenthood of Southern New England
263 Main St
Old Saybrook
Old Saybrook, CT 06475

Signature of DHSR Staff [signature] DHSR Nurse Consultant

Licensure Category: Outpatient Clinic

Licensed ~~Capacity~~ #: 6026 Census: _____
Licensed Capacity: _____ Census: _____

Date(s) of onsite inspection: 6/3/14

Date(s) additional information obtained: _____

Personnel contacted: Dawn Culver, adm

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[✓] Licensing Inspection [ ] *Initial* [✓] *Renewal* [ ] *Other:* _____

[ ] Revisit for the purpose of _____

[ ] See Complaint Investigation # _____

[ ] See Reportable Event Investigation # _____

[ ] See Certification File.

[✓] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated 5/1/15.

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies were not identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: [signature] **DATE OF REPORT:** 6/5/14

[✓] Approval for issuance of license granted by: Joan D'Agostino **DATE:** 6-5-14
Supervisor/Title

P:Lic_RPT.Doc

FACILITY: Planned Parenthood So. New England Old Saybrook

DATE(S) of VISIT: 6/3/14 Page 2 of 2

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

a. Facility inspection
b. Observation of patient care
c. Personnel files review
d. Quality assurance program (audits) review
e. Fire drill log/disaster plan review
f. New or revised agency policies and procedures review
g. Clinical record review
h. In-service training/staff meeting documentation
i. CLIA certificate/waiver

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut were/were not identified as a result of this inspection.

SIGNATURE: [signature] 6/5/15

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

May 1, 2015

Sara Culver, Administrator
Planned Parenthood Of Connecticut Inc of Old Saybrook
263 Main Street
Old Saybrook, CT 06475

Dear Ms. Culver:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc of Old Saybrook on June 3, 2014 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by May 15, 2015 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please address the violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Loan Nguyen

Loan Nguyen RN, MSN, BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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DATE(S) OF VISIT: June 3, 2014

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-D48 Professional staff (b) (2) and/or 19-13-D51 and/or 19-13-D51 Pharmaceuticals and/or 19-13-D52 Maintenance

1. Based on review of facility documentation, surveyor observation and interview with agency personnel, the facility staff failed to follow acceptable infection control practices. The findings include:
   a. A tour of the facility on 06/03/14 with the facility Manager identified two opened multi-dose vials of 50 milliliters (ml) Lidocaine Hydrochloride 1% (10mg/ml) stored in the refrigerator. Both vials were not marked with the opening date or the discard date.

      Interview with the facility Manager on 06/03/14 indicated that the multi-dose vials should have been labeled with an opening date and a discard date, and that the numbers "8/14" failed to clarify the opening or discard date of the second vial.

      Interview and review of the facility policy with the Director of Nursing on 06/03/14 and 06/05/14 indicated that an opened and/or accessed (needle-punctured) multi-dose vial required marking with an opening date and a discard date in accordance with the manufacturer's instructions and local regulations, with a discard date within 28 days of the opening date in the absence of specific guidelines.

      The manufacturer's guidelines included recommendations for a safe use time period after a multi-dose vial was accessed.

      The Center for Disease Control (CDC) http://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html retrieved on 06/05/14, directed the dating and discarding within 28 days of opened and accessed (needle-punctured) multi-dose vials, unless the manufacturer specified a different discard date.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

May 1, 2015

Sara Culver, Administrator
Planned Parenthood Of Connecticut Inc of Old Saybrook
263 Main Street
Old Saybrook, CT 06475

Dear Ms. Culver:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc of Old Saybrook on June 3, 2014 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by May 15, 2015 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please address the violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Loan Nguyen RN, MSN, BC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

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DATE(S) OF VISIT: June 3, 2014

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-D48 Professional staff (b) (2) and/or 19-13-D51 and/or 19-13-D51 Pharmaceuticals and/or 19-13-D52 Maintenance

1. Based on review of facility documentation, surveyor observation and interview with agency personnel, the facility staff failed to follow acceptable infection control practices. The findings include:

A tour of the facility on 06/03/14 with the facility Manager identified two opened multi-dose vials of 50 milliliters (ml) Lidocaine Hydrochloride 1% (10mg/ml) stored in the refrigerator. Both vials were not marked with the opening date or the discard date.

Interview with the facility Manager on 06/03/14 indicated that the multi-dose vials should have been labeled with an opening date and a discard date, and that the numbers "8/14" failed to clarify the opening or discard date of the second vial.

Interview and review of the facility policy with the Director of Nursing on 06/03/14 and 06/05/14 indicated that an opened and/or accessed (needle-punctured) multi-dose vial required marking with an opening date and a discard date in accordance with the manufacturer's instructions and local regulations, with a discard date within 28 days of the opening date in the absence of specific guidelines.

The manufacturer's guidelines included recommendations for a safe use time period after a multi-dose vial was accessed.

The Center for Disease Control (CDC) http://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html retrieved on 06/05/14, directed the dating and discarding within 28 days of opened and accessed (needle-punctured) multi-dose vials, unless the manufacturer specified a different discard date.

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p: 860.388.4459
www.ppsne.org

May 15, 2015

To whom it may concern:

On May 1, 2015, Planned Parenthood of Southern New England in Old Saybrook received a letter in regards to the June 3, 2014 licensing inspection of our health center by a representative of the Facility Licensing and Investigations Section of the Department of Health. In the course of the visit, the following violation was identified:

"A tour of the facility on 06/03/2014 with the facility Manager identified two opened multi-dose vials of 50 milliliters (ml) Lidocaine Hydrochloride 1% (10mg/ml) stored in the refrigerator. Both vials were not marked with the opening date or the discard date."

In response to this violation, the following plan of correction was enacted:

1. All lidocaine vials will be labeled with an opening date and a discard date, within 28 days of the opening date. Any vial of lidocaine that has been opened and/or accessed, and is now outside of the 28 day limit will be immediately discarded. This policy is being carried out across all Planned Parenthood of Southern New England CT Health Centers. This information was reviewed with all staff following the June 3rd inspection, to ensure all center staff are aware of and abide by this policy.
2. This new policy went into effect immediately following the DPH inspection on June 3, 2014.
3. Sara Culver, Center Manager will be responsible for monitoring this plan of correction henceforth.

If there are any questions or concerns regarding this correction plan, please do not hesitate to contact this office at (860) 388-4459. We thank you for bringing this to our attention.

Sincerely,

5/15/15

Sara Culver
Center Manager, Old Saybrook
Planned Parenthood of Southern New England

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

June 16, 2015

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

Dear Ms. Yousman:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Hilda Stan on June 12, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a monitoring visit.

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 visits.

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 June 30, 2015 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Donna Ortelle, RN, MSN

Donna Ortelle, RN, PHSM
Public Health Services Mananger
Facility Licensing and Investigations Section

DMO:mb

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
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DATE(S) OF VISIT: June 12, 2015

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

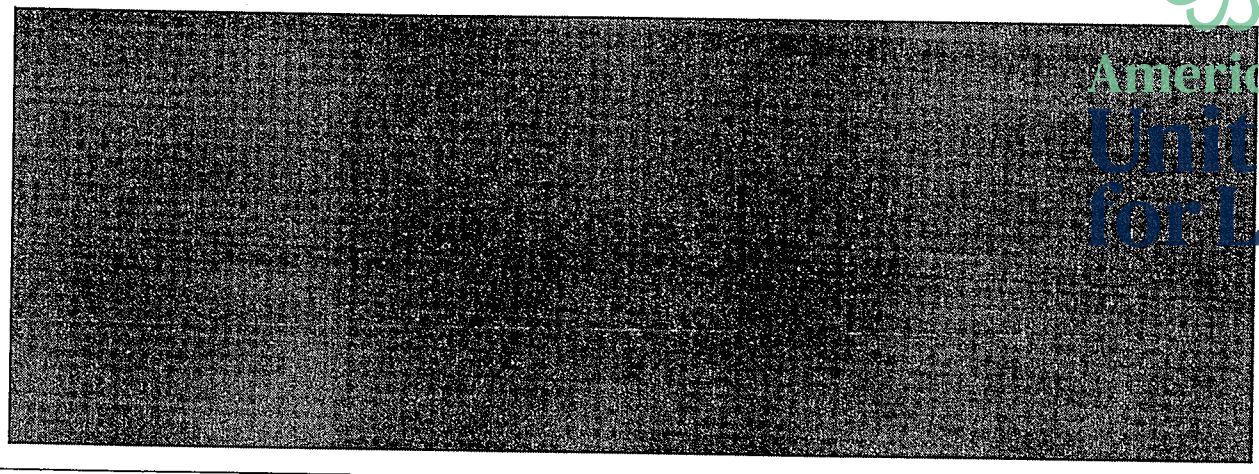
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board. Administration (b) and/or 19-13-D51 Pharmaceutical and/or 19-13-D52 Maintenance.

1. Based on observation and interview, the facility failed to ensure that medications were secured at all times. The finding includes:
   a. Observation of one of the two procedure rooms on 6/12/15 at approximately 10:30am identified that the narcotic cabinet containing fentanyl, versed and other medications including atropine, and lidocaine were in an unlocked cabinet without licensed staff in attendance. The Certified Registered Nurse Anesthetist (CRNA) was observed to complete a procedure in this room and went into another procedure room. Interview with the Clinical Manager on 6/12/15 at 11am identified that the medication cabinets should be locked when licensed staff is not in attendance. And/or

2. Based on observation and interview for one of two pregnancy terminations observed, staff failed to ensure that single patient intravenous (IV) fluids were not used on more than one patient. The finding includes:
   a. Observation of Patient #6's termination of pregnancy procedure on 6/12/15 at approximately 10:40am identified a 500cc bag of normal saline IV fluid with a needle and 3-way stopcock attached. Certified Registered Nurse Anesthetist (CRNA) #1 was observed to withdraw 10cc of fluid from the 500cc bag of normal saline and flushed the patient's IV after administering IV fentanyl, versed and atropine prior to the procedure. Interview with CRNA #1 on 6/12/15 identified that he uses the 500 cc bag for flush solution for all the procedures scheduled in that room for the day and that vials of normal saline are more expensive. Review of the label on the 500ccIV bag identified it was for single patient use.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D49 Records.

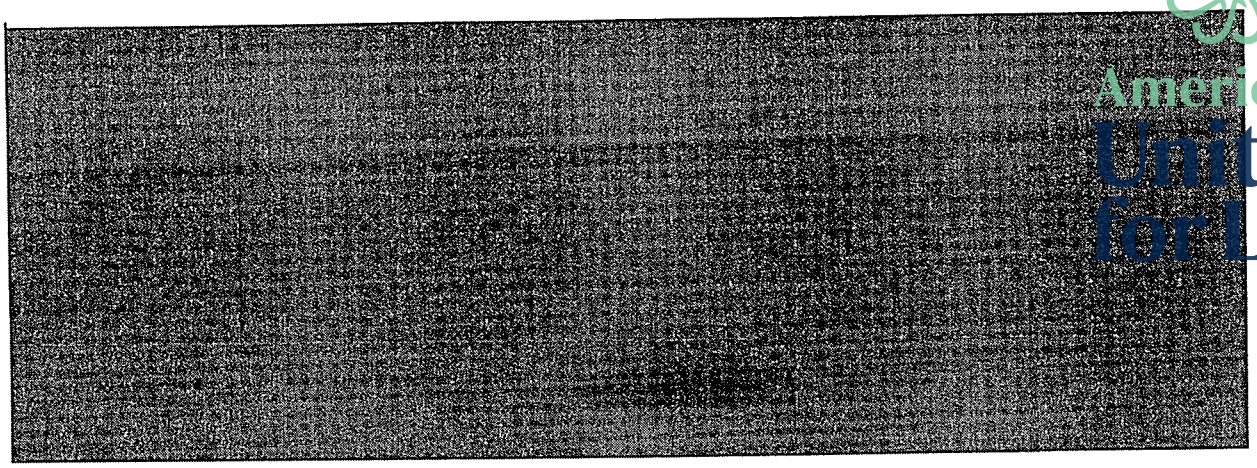
3. Based on review of the medical record and interview, the facility failed to ensure that the printed medical record was completed and accurate when printed. The finding includes:
   a. Review of Patient #1 - 6's printed medical record on 6/12/15 identified that they received medications including, versed, fentanyl, atropine, metronidazole, ibuprofen, Rhophylac, and/or misoprostol. The printed medical record failed to identify the time of administration of the medication and the staff who administered the medication. Review of the electronic medical record with the Clinical Manager on 6/12/15 identified that the time of medication administration and staff who administered the medication was identified in the electronic medical record view but there must be a glitch with the computerized program when the medical record was printed. The Clinical manager further identified that the facility is in the planning phase of getting a new electronic health record program.
   b. Patient #3 underwent an induced termination of pregnancy on 6/12/15. Review of the medical record identified that the patient received intravenous moderation sedation and



DATE(S) OF VISIT: June 12, 2015

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

Monitored Anesthesia Care (MAC) by Certified Registered Nurse Anesthetist (CRNA) #2. The medical record failed to identify the medications received for sedation during the procedure. Review of the Controlled Drug Log dated 6/2/15 identified that Fentanyl 100mcg and Versed 2mg was signed out for Patient #6. Interview with the Clinical Manager on 6/12/15 failed to explain the discrepancy.



7/13/15 POC Accepted - DD

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Planned Parenthood of Southern New England

June 30, 2015

Donna Ortelle, RN, PHSM
Public Health Services Manager
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue MS # 12HSR
Hartford, Connecticut 06134

Dear Ms. Ortelle,

Please find a response and corrective action plan for violations found during the monitoring visit conducted by you on June 12, 2015 at the Planned Parenthood of Sothern New England - Hilda Standish Center located in West Hartford.

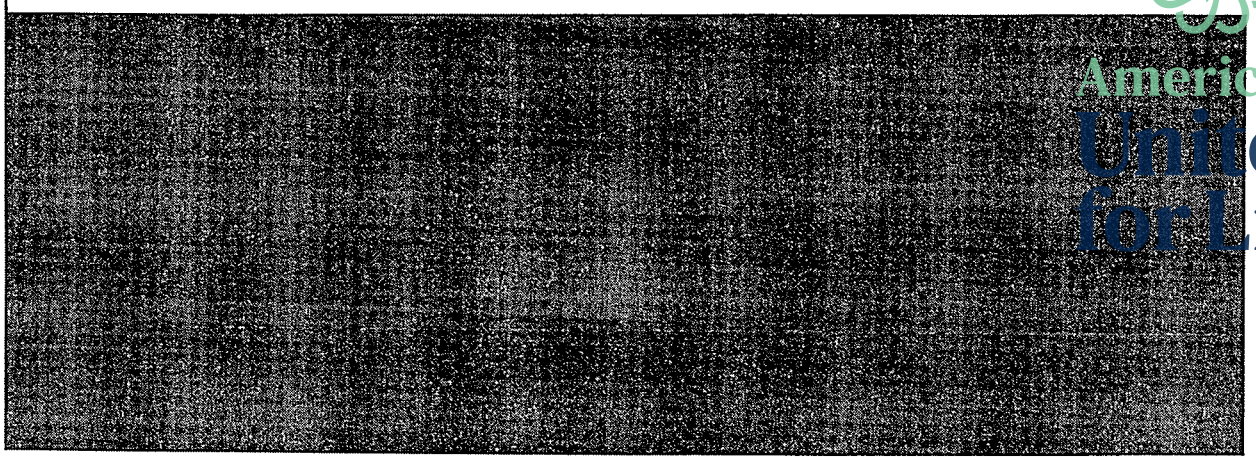
Violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board, Administration (b) and/or 19-13-D51 Pharmaceutical and/or 19-13-D52

1. Based on the observation and interview, the facility failed to ensure that medications were secured at all times. The finding includes:

a. Observation of one of the two exam rooms on 6/12/15 at approximately 10:30 am identified that the narcotic cabinet containing fentanyl, versed and other medications including atropine, and lidocaine were in an unlocked cabinet without licensed staff in attendance.

Response
PPSNE's policy clearly states all medications should be stored in locked medication cabinets when licensed staff is not in attendance. The policy for storing narcotic medications was reviewed with both CRNAs on 6/12/15 and 6/16/15. The CRNA and another licensed staff person are responsible for the day end count and the sign off of the narcotic log. This staff is responsible for ensuring all medication is stored properly and the medication cabinets are locked. Jane Yousman, Center Manager is responsible for checking that this policy is followed.

2. Based on observation and interview for the two pregnancy terminations observed, staff failed to ensure the single patient intravenous (IV) fluids were not used on more than one patient.



Response
Single dose Saline 10cc syringes were ordered and have been in use since 6/26/15. The Abortion Services Coordinator, Getzina Nieves is responsible for ordering and maintaining this stock.

Violations of the Regulations of Connecticut State Agencies Section 19-13-D49 Records

3. Based on the review of the medical record and interview, the facility failed to ensure that printed medical record was completed and accurate when printed.
   a. Review of Patient #1 – The printed record failed to identify the time of administration of the medications and staff who administered the medication.

Response
The electronic health record currently in use does not print this information in the visit summary but the manager did show the reviewers where the information is recorded in the patient record. PPSNE has submitted a ticket on 6/15.15 to the vendor for the EHR system requesting this information be printed on the visit summary for each patient. Additionally, PPSNE is scheduled to migrate to a different EHR system in September of this year.

   b. Patient #3 underwent an induced termination of pregnancy on 6/12/15. The medical record failed to identify the medications received for sedation during the procedure.

Response
An addendum to this chart was created to document the patient did in fact receive sedation on 6/12/15. A chart audit of 20 charts was conducted of this CRNA over a three week period and all sedations patient has the medication documented correctly.

Additionally, a staff meeting was held on 6/25/15 where all these violations and corrective actions were reviewed with all staff.

I hope this response to the violations cited form the June 12, 2015 visit to the Hilda Standish Center. Please do not hesitate to contact me of you have further questions.

Thank you,

Jane Yousman
Center Manager

cc: Mary Bawza
COO

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION

DHSR #13a

LICENSING INSPECTION REPORT

Name and Address of Entity

Planned Parenthood of Southern New England Inc
45 Franklin St.
New London, CT 06320

Signature of DHSR Staff

Licensure Category: Family Planning Clinic

~~Licensed~~ Capacity : 0018 Census : _____

Licensed Capacity : _____ Census : _____

Date(s) of Onsite Inspection : 1/23/15

Date(s) Additional Information Obtained: _____

Personnel Contacted: Lauren Herrera, Center Manager, Sarah Whalen PA

REVIEW/FINDINGS/PROCESS (complete all applicable)

[x] Licensing Inspection: [ ] *Initial* [x] *Renewal* [ ] *Other:* _____

[ ] Revisit for the Purpose of _____

[ ] See Complaint Investigation # _____

[ ] See Reportable Event Investigation # _____

[ ] See Certification file.

[ ] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection.
See violation letter dated _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[x] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection.

[ ] Citation # _____ was verified as corrected. _____ was notified that the licensee was no longer required to post Citation (see narrative).

[ ] Citation # _____ was not corrected (see narrative).

[x] Narrative Report / Additional Information Attached.

[ ] Referral(s) to: _____

REPORT SUBMITTED BY _____ **DATE OF REPORT** 1/23/15

[x] Approval for Issuance of License granted by : Joan D Nguyen 1-29-15
Supervisor Title Date

FACILITY: Planned Parenthood Southern New England, New London office

DATE(S) of VISIT: 1/23/15

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

- ✓a. Facility inspection
- ✓b. Observation of patient care
- ✓c. Personnel files review
- ✓d. Quality assurance program (audits) review
- ✓e. Fire drill log/disaster plan review
- ✓f. New or revised agency policies and procedures review
- ✓g. Clinical record review
- ✓h. In-service training/staff meeting documentation
- ✓i. CLIA certificate/waiver

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut were/(were not) identified as a result of this inspection.

SIGNATURE: [signature] 1/23/15

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

June 16, 2015

Jody Clark, Administrator
Planned Parenthood Of Southern New England
345 Whitney Avenue
New Haven, CT 06511

Dear Ms. Clark:

An unannounced visit was made to Planned Parenthood Of Southern New England on June 12, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a monitoring visit.

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 visits.

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 June 30, 2015 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Donna Ortelle, RN MSN

Donna Ortelle, RN, PHSM
Public Health Supervising Manager
Facility Licensing and Investigations Section

DMO:mb

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
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DATE(S) OF VISIT: June 12, 2015

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-D49 Governing Board Administration (b)(c) and/or 19-13-D50 Nursing Personnel and/or 19-13-D51 Pharmaceutical.

1. Based on observation and interview for one pregnancy terminations observed, staff failed to ensure that single patient intravenous (IV) fluids were not used on more than one patient. The finding includes:
   a. Observation of Patient #6's termination of pregnancy procedure on 6/12/15 at approximately 1:20pm identified a 500cc bag of lactated ringers IV fluid with a needle and 3-way stopcock attached. Certified Registered Nurse Anesthetist (CRNA) #2 was observed to flush the patient IV site with 10cc of fluid after administering IV fentanyl and versed prior to the procedure. Interview with CRNA #2 on 6/12/15 identified that he uses the 500 cc bag for flush solution for all the procedures scheduled in that room for the day. Review of the label on the 500ccIV bag identified it was for single patient use.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D49 Records.

2. Based on review of the medical record and interview, the facility failed to ensure that the printed medical record was completed and accurate when printed. The finding includes:
   a. Review of Patient #1 - 6's printed medical record on 6/12/15 identified that they received medications including, versed, fentanyl, atropine, metronidazole, ibuprofen, depoprovera, and/or microgam. The printed medical record failed to identify the time of administration of the medication and the staff who administered the medication. Review of the electronic medical record with the Clinical Manager on 6/12/15 identified that the time of medication administration and staff who administered the medication was identified in the electronic medical record. The Clinical manager further identified that the facility is in the planning phase of getting a new electronic health record program.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board. Administration (c) and/or 19-13-D50 Nursing Personnel and/or 19-13-D51 Pharmaceutical and/or 19-13-D52 Maintenance.

3. Based on observation, the facility failed to ensure that medication vials were labelled after opening and/or that medications were not expired and/or not stored with food/drink items. The finding includes:
   a. Observation of the medication cart in the procedure room with Certified Registered Nurse Anesthetist (CRNA) #2 on 6/12/15 identified medication vials that were opened and not dated with an expiration date that included Atropine 8mg/20ml and Lidocaine 10mg/ml. Additionally Romazicon was unopened but had expired 4/2015.
   The Center for Disease Control (CDC) http://www/cdc.gov/injectionsafety/providers retrieved on 06/15/15 directed if a multi-dose has been opened or accessed (e.g.,

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

needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. The facility's policy on multi-dose vials directs staff to write the date opened and write "Discard by xx/xx/xx date" unless manufacturer states otherwise.

b. Observation of the refrigerator in the recovery room identified cans of ginger ale and medications including Rhogam and Nuva Ring. Interview with the recovery room nurse on 6/12/15 identified that she puts the medications in the refrigerator in the morning because she cannot leave the recovery room to get the medications when there is a patient in the recovery room. And/or

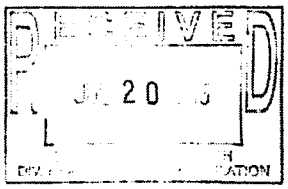
4. Based on observation and interview, the facility failed to ensure that staff followed the manufacturer and facility guidelines when mixing detergent for instrument cleaning. The finding includes:
   a. Interview with Clinical Assistant #1 on 6/12/15 identified that she cleans used instruments with the low suds detergent by pouring enough solution to turn the water in the bucket a color. Review of the label on the gallon jug of low suds detergent directs 1/8 ounce to 2 ounces per 1 gallon of water. Also posted in the cleaning lab is a sign that directs 1 ounce of solution to a gallon of water.

POC Accepted
7/28/15 DO

July 24, 2015

Revised 7/14/15

Donna Ortelle, RN, PHSM
Public Health Services Manager
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue MS # 12HSR
Hartford, Connecticut 06134



Dear Ms. Ortelle,

Please find a response and corrective action plan for violations found during the monitoring visit conducted by you on June 12, 2015 at the Planned Parenthood of Sothern New England's Griswold Buxton Center located in New Haven.

Violation of the Regulations of Connecticut State Agencies Section 19-13-D49 Governing Board Administration (b) (c) and /or 19-13-D50 Nursing Personnel and/or 19-13-D51 Pharmaceutical.

1. Based on observation and interview for one pregnancy termination observed, staff failed to ensure the single patient intravenous (IV) fluids were not used on more than one patient.

Response
Single dose10cc pre-filled, sterile saline syringes have been ordered ensuring only one syringe will be used for each patient. 10cc sterile saline syringes order received on 6/17/15.

Staff education on the use of 10cc prefilled sterile saline syringes done and documented on 6/26/15.

Esther Pellot is responsible for ordering and maintain stock.

Violations of the Regulations of Connecticut State Agencies Section 19-13-D49 Records

2. Based on the review of the medical record and interview, the facility failed to ensure that printed medical record was completed and accurate when printed.

Response
The electronic health record currently in use does not print this information in the visit summary but the manager did show the reviewers where the information is recorded in the patient record. PPSNE has submitted a ticket to the vendor for the EHR system on 6/15/15 requesting this information be printed on the visit summary for each patient. Additionally, PPSNE is scheduled to migrate to a different EHR system in September of this year.

Violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing board, Administration (c) and/or 19-13-D50 Nursing Personnel and/or 19-13-D51 Pharmaceutical and/or 19-13-D52 Maintenance

2. Based on observation the facility failed to ensure that medication vials were labelled after opening and/or that medications were not expired and/or not stored with food/drink items.

    a. The PPSNE Policy for Storage of Multi Dose Vials and Bottles has been reviewed with the CRNA. Jody Clark, Center Manager will do quarterly monitoring and review the medication cart to ensure proper labeling continues to occur. All Staff have been educated on 6/26/15 on the storage policy for Multi Dose Vials and Bottles.

    b. An additional refrigerator has been ordered for the recovery room. In the interim, the staff has been directed to NOT store food and medications in the same refrigerator.

On observation and interview, the facility failed to ensure staff followed the manufacturer and facility guidelines when missing detergent for instrument cleaning.

a. Staff were provided an in-service on 6/26/15 in the manufacturer and facility guidelines for missing detergent for instrument cleaning. Quarterly observation of the detergent guidelines will be monitored by Center Manager (Jody Clark)

I hope this response to the violations cited form the June 12, 2015 visit to the Griswold Buxton Center. Please do not hesitate to contact me of you have further questions.

Best regards,

Jody Clark
Center Manager

CC: Mary Bawza

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

April 8, 2016

Alicia Caban, Center Manager
Planned Parenthood Of Connecticut Inc - Waterbury
969 West Main Street
Waterbury, CT 06702

Dear Ms. Caban:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Waterbury on October 28, 2015 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing 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.

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 April 22, 2016 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Loan D Nguyen

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

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DPH
Connecticut Department of Public Health

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DATE(S) OF VISIT: October 28, 2015

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D48 Professional staff (b) (1) and/or 19-13-D51 Pharmaceuticals (3) and/or 19-13-D52 Maintenance.

1. Based on review of the agency documentation, surveyor observation and interview with agency personnel, the agency failed to maintain compliance with infection control and safety requirements. The findings include:
   a. During a tour of the agency with the Manager on 10/28/15, a multi-dose vial of Lidocaine 50ml for injection was found open, less than half full, stored in the medication refrigerator in the dirty utility room.
   Interview and review of the surveyor observation with the Manager on 10/28/15 failed to identify the documentation on the vial of the date the vial was opened, and/or the date the vial should be discarded.
   The agency policy on storage of multi-dose vials directed the documentation of the discard date as 28 days after opening, unless otherwise directed by the manufacturer;
   During the tour of the agency on 10/28/15, the medication refrigerator was holding a vial of Hepatitis B vaccine, 20 doses of Fluvirin prefilled syringes, a syringe of Rho immune globulin, 10 vials of Gardasil, a vial of Lidocaine and a vial of Epinephrine.
   Interview and inspection of the medication refrigerator with the Manager on 10/28/15 indicated that the medication refrigerator was stored in the dirty utility room under the sink counter where soiled equipment (speculums and probes) were washed, and under the counter holding the sterilizer, and failed to identify a clean and/or appropriate environment to store the medication refrigerator;
   Interview and inspection of the medication refrigerator with the Manager on 10/28/15 identified two purple top blood specimen tubes containing blood used as quality control blood samples for the Rh factor testing device, and failed to identify the maintenance of quality control blood samples in a tightly sealed container in the refrigerator.

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June 28, 2016

Attached is the plan of corrective actions for the violation found during the unannounced inspection of the Waterbury Health Center on October 28, 2015.

1.Violation – Section 19-13-D48 Professional Staff (b) (1) and/or 19-13-D51 Pharmaceuticals (3) and or 19-13-D52 Maintenance.
a. Response – The Manager reviewed the policy and procedure for storage of pharmaceuticals – Administrative Chapter 7: Pharmaceuticals of the Manual of Standards and Guidelines, with staff at a staff meeting on November 3, 2015. The Manager is responsible for ensuring the policy and procedure are as followed.

During the tour it was found the medication refrigerator was stocked with medications and stored in lab refrigerator.

b. Response – The vial of Lidocaine that was found open was discarded on October 28, 2015. Vaccines including and not limited to, prefilled syringes and vials of Gardasil, Lidocaine and Rho immune globulin were moved from the lab refrigerator to a refrigerator in a clean and appropriate environment in the clinician workspace. These medications were moved on October 29, 2015.

During the interview and inspection of the medication refrigerator with the Manager, two purple top blood specimen tubes were found containing blood used as quality control blood samples for Rh factor testing device and failed to identify the maintenance of quality control blood samples in a tightly sealed container.
c. Response - Purple top blood specimen tubes have been labeled as quality controls for Rh factor testing with expiration date and are now stored in a tight sealed container in the refrigerator in the dirty lab. An Advanced Clinical Assistant will monitor refrigerator temperature as well as medication storage. This change was effective October 29, 2015. The Manager is responsible for ensuring this process is followed.

I hope this plan of corrective actions answers the violation found during your visit of October 28, 2015. Please do not hesitate to contact me if you have further questions.

Best regards,
Alicia Caban –
Center Manager - Waterbury

Americans United for Life

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

January 12, 2016

Judy Tabar, Chief Executive Officer
Planned Parenthood Of Connecticut Inc - Norwich
12 Case Street
Norwich, CT 06360

Dear Ms. Tabar:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Norwich on December 22, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure 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.

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 January 26, 2016 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Maureen H Klett RN BSN

Maureen H. Klett, R.N.,C., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

MHK:lsl

Americans United for Life

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P.O. Box 340308 Hartford, CT 06134
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DATE OF VISIT: December 22, 2015

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 Regulation of Connecticut State Agencies Section 19-13-D48 (b)(1).

1. Based on observations and interviews, the facility failed to ensure that credentialed staff had completed the credentialing process and/or that documents were maintained in the clinicians personnel file. The findings include:
   a. Upon surveyor inquiry on 12/22/15, the facility provided documents dated 1/6/16 identifying that credentialed staff was privileged to provide care at the center without specific dates that they are credentialed until. Review of facility policy identified that applications and documentation of privileges are to be maintained in the clinician's personnel file.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D54.

2. Based on review of the clinical record and interviews with facility personnel, the facility failed to ensure that the clinical record was accurate. The findings include:
   a. Patients #1-#5 were admitted to the clinic from 9/17/15-12/17/15 for a surgical procedure. Review of the history and physical and pre-anesthesia assessments failed to indicate that a comprehensive assessment was completed. Review of facility policy identified that a complete assessment of the patient needs were to be completed prior to the procedure being performed. Interview with the Office Manager on 12/22/15 identified that they have a new computer system and some of the patient information was not documented.
   b. Patients #1-#5 were admitted to the clinic from 9/17/15-12/7/15 for a surgical procedure. Review of the consent for a surgical procedure identified that the consent was signed by a medical assistant and not a physician. Review of facility policy identified that the clinician performing a procedure must ascertain that informed consent has been obtained and that all client questions have been answered before providing that procedure. Interview with the Office Manager on 12/22/15 identified that the consent is reviewed with the patient by the medical assistant.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D52.

3. Based on observations and interviews with facility personnel, the facility failed to ensure that infection control practices were maintained. The findings include:
   a. During tour of the post anesthesia care area on 12/22/15, it was observed that two bags of soiled laundry were being stored until it could be picked up by an outside vendor. Interview with the Office Manager on 12/22/15 identified that the laundry bags have been there since the last surgery day, which was 5 days ago.
   b. During tour of the sterile processing area on 12/22/15, it was observed that sterile instruments were being stored in the dirty decontamination area. In addition, multiple

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

boxes, supplies and equipment were being stored in the dirty decontamination area.

c. Review of the sterilization logs dated 11/2015-12/2015 failed to identify the load with patient/pertinent information for each load for tracking purposes.

The following are violations of the Regulations of Connecticut State Agencies Section's 19-13-D46 (a)(b)(c) and/or (d) and/or 19-13-D54 and/or 19a-116-1.

4. On 12/22/15 at 9:30 AM the surveyor, while accompanied by the Center Manager, the Clinical Assistant or the Property Manager observed that :
   a. The battery-powered, emergency light fixture located at the staff restroom within the recovery (PACU) area did not work, as required by "*CT Fire Prevention Code*"; i.e. lamps did nothing when test button was depressed;
   b. The battery-powered, emergency light fixture located at the staff restroom within the waiting area just outside the clinic did not work, as required by "*CT Fire Prevention Code*"; i.e. lamps did nothing when test button was depressed.

5. On 12/22/15 at 11:00 AM the surveyor was not provided with documentation from the Center Manager, the Clinical Assistant or the Property Manager to indicate that:
   a. The facility fire alarm and facility smoke detectors are being tested & inspected semi-annually, as required by "*CT Fire Prevention Code*"; i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;
   b. The smoke detectors that are connected to the facility fire alarm system had had sensitivity testing conducted on them, as required by "*CT Fire Prevention Code*"; i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;
   c. The facility fire extinguishers are being inspected at least monthly, as required by "*CT Fire Prevention Code*";
   d. The battery-powered, emergency lights at the facility are being inspected at least monthly, as required by "*CT Fire Prevention Code*";
   e. The battery-powered, emergency lights at the facility are being tested at least annually, as required by "*CT Fire Prevention Code*";

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POC accepted 2/23/16 MMH

FACILITY: Planned Parenthood of Southern New England – Norwich

DATE OF VISIT: December 22, 2015

February 19, 2016

Maureen Klett, R.N., C., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of CT Department of Health
410 Capitol Avenue –MS #12 HSR
PO Box 340308
Hartford, CT 06134

Dear Ms.Klett

Below please find the listing of violations and plan of correction from the December 22, 2016 visit to the Planned Parenthood of Southern New England Norwich location. Thank you very much for speaking with us to clarify the violations. We also very much appreciate the extension given us to prepare our response.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D48 (b)(1)

1. *Based on the observations and interviews, the facility failed to ensure that credentialed staff had completed the credentialing process and/or that documents were maintained in the clinicians personnel file. The findings include:*
   a. *Upon surveyor inquiry on 12/22/15, the facility provided documents dates 1/6/16 identifying that credentialed staff was privileged to provide care at the center without specific dates that they are credentialed until. Review of facility policy identified that applications and documentation of privileges are to be maintained in the clinician's personnel file.*

Response:
Credentialing files are kept at the administrative office in New Haven with personnel files. Files in centers are shadow files. PPSNE has set up a shared folder and is starting to upload the credentialing documents to the folder for each provider. This process will be added to the credentialing policy. Center managers will have access to the system when surveyor is on site for inspection. This will completed by March 31, 2016. Responsibility for monitoring this will be assumed by Sally Hellerman, APRN, MS, FNP-BC, Director of Medical Services.

The following violation of the Regulations of Connecticut State Agencies Section 19-13-D54

2. *Based on review of the clinical record and interviews with facility personnel, the facility failed to ensure that the clinical record was accurate. The findings include:*

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a. *Patients #1-#5 were admitted to the clinic from 9/7/15-12/17/15 for a surgical procedure. Review of the history and physical and pre-anesthesia assessments failed to indicate that a comprehensive assessment was completed. Review of facility policy identified that a complete assessment of the patient needs were to be completed prior to procedure being performed. Interview with the Office Manager on 12/22/15 identified that they have a new computer system and some of the patient information was not documented.*

Response:
The PPSNE electronic health record has been modified to better ensure that the comprehensive assessment is completed. Additional training has also been provided to the Norwich staff. An audit will be conducted to ensure compliance in June 2016. Additionally the abortion service is audited annually. This plan of correction will be monitored by [redacted], APRN, MS, FNP-BC, Director of Quality Management.

b. *Patient #1-#5 were admitted to the clinic from 9/17/15-12/7/15 for a surgical procedure. Review of the consent for the surgical procedure identified that the consent was signed by a medical assistant and not a physician. Review of facility policy identified that the clinician performing a procedure must ascertain that informed consent has been obtained and that all client questions have been answered before providing that procedure. Interview with the Office Manager on 12/22/15 identified that the consent is reviewed with the patient by the medical assistant.*

Response:
We are modifying our consent process to require that the physician sign the consent form. Signature lines are being added to the consents. Physicians will be notified of this change. Charts for each physician will be audited by the end of March. This change will be in place by March 15. This plan of correction will be monitored by [redacted]h, APRN, MS, FNP-BC, Director of Quality Management.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D52

3. *Based on observations and interviews with facility personnel, the facility failed to ensure that infection control practices were maintained. The findings include:*
   a. *During tour of the post anesthesia care on 12/22/15, it was observed that two bags of soiled laundry were being stored until it could be picked up by an outside vendor. Interview with the Office Manager on 12/22/15 identified that the laundry bags have been there since the last surgery day which was 5 days ago.*

Response:
The Center Manager has arranged for the laundry will be removed by the laundry service on the day of the procedure. If laundry is left onsite, the soiled laundry will be kept in the dirty area of the back lab. This procedure is in effect as of February 1,

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2016. The Infection Control Manual will be update to reflect this by March 30th. Responsibility for monitoring this will be assumed by [redacted]n, APRN, MS, FNP-BC, Director of Medical Services.

b. *During tour of the sterile processing area on 12/22/15, it was observed that sterile instruments were being stored in the dirty decontamination area. In addition, multiple boxes, supplies and equipment were being stored in the dirty decontamination area.*

Response:
Sterile instruments, supplies and equipment are no longer stored in a dirty decontamination area. Staff education has been provided. This will be monitored by [redacted]n, APRN, MS, FNP-BC

c. *Review of the sterilization logs dates 11/2015-12/2015 failed to identify the load with patient/pertinent information for each load for tracking purposes.*

Response:
After telephone conversation of February 4, 2016, PPSNE will be contracting with an infection control nurse consultant to learn how to operationalize this tracking requirement. This will be implemented by April 30, 2016. In the interim, the abortion patient log will be used to track infectious outbreaks. This will be monitored by [redacted]n, APRN, MS, FNP-BC

The following are violations of the Regulations of Connecticut State Agencies Section's 19-13-D46 (a)(b)(c) and/or (d) and/or 19-13-D54 and/or 19a-116-1

4. *On 12/22/15 at 9:30 AM the surveyor, while accompanied by the Center Manager, the Clinical Assistant or the Property Manager observed that:*
   a. *The battery-powered, emergency light fixture located at the staff restroom within the recovery (PACU) area did not work, as required by the "CT Fire Prevention Code", i.e. lamps did nothing when test button was depressed;*

Response:
The repair to the battery powered emergency light fixture was completed February 17, 2016.

   b. *The battery-powered, emergency light fixture located at the staff restroom within the waiting area just outside the clinic did not work, as required by the "CT Fire Prevention Code", i.e. lamps did nothing when test button was depressed.*

Response:
The repair to the battery powered emergency light fixture was completed February 17, 2016.

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5. *On 12/22/15 at 11:00 AM the surveyor was not provided with documentation from the Center Manager, the Clinical Assistant or the Property Manager to indicate that:*
   a. *The facility fire alarm and facility smoke detectors are being tested and inspected semi-annually, as required by "CT Fire Prevention Code", i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;*
   b. *The smoke detectors that are connected to the facility fire alarm system had had sensitivity testing conducted on them, as required by "CT Fire Prevention Code", i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;*
   c. *The facility fire extinguishers are being inspected at least monthly, as required by "CT Fire Prevention Code";*
   d. *The battery-powered, emergency lights at the facility are being inspected at least monthly, as required by "CT Fire Prevention Code",*
   e. *The battery-powered, emergency lights at the facility are being tested at least annually, as requires by "CT Fire Prevention Code";*

Response:
According the Property Manager Annually 100% functional test & inspection of the fire alarm system is performed, including all devices including smoke detector, fire extinguishers, heat detectors, pull stations, load test of all batteries and door holders with a NFPA report. In addition, a visual test is performed semiannually as well as testing of all batteries. The system is also centrally monitored 24/7. The 17 fire extinguishers in the common areas are inspected and tagged monthly by the Property Management Company. The extinguishers, battery powered emergency lights in the suite will be inspected monthly by the Center Manager, [redacted]. The testing will be recorded in the log. This will begin March 1, 2016. The battery powered emergency lights will be tested annually and recorded in a log. The first test will be conducted June 1, 2016. This will also be monitored by [redacted], center Manager.

Please do not hesitate to contact me if you have questions.

Best regards,

Mary Bawza
COO

CC: Sally Hellerman, APRN
Tim Spurrell, MD
Janeen Otiz, center Manager

Americans United for Life

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

September 13, 2016

Beth Murano, Center Manager
Planned Parenthood Of Connecticut Inc- Hartford
1229 Albany Avenue
Hartford, CT 06112

Dear Ms. Murano:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc- Hartford on March 8, 2016 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection.

Attached is a violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by September 27, 2016 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please address the violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.);
2. Date corrective measure will be effected;
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. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Loan D Nguyen

Loan Nguyen M.S.N., R.N., C.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

LDN:lsl

Americans United for Life

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATES OF VISIT: March 8, 2016

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-D48 Professional staff (b)(2) and/or 19-13-D51 Pharmaceuticals and/or 19-13-D52 Maintenance

1. Based on surveyor observation, review of agency documentation and interview with agency personnel, the agency failed to maintain adequate emergency equipment. The findings include:
    a. Interview and review of the surveyor's observation during a tour of the agency with the Manager and the Director of Quality Assurance on 3/8/16 indicated that the Emergency Equipment checklist included Ringer's lactate solution 500cc, that the actual Emergency Equipment box lacked Ringer's lactate solution (on back order) and failed to identify safe management and availability of Emergency Equipment solution for the patient's safety.

Planned Parenthood
Care. No matter what.

345 Whitney Avenue
New Haven, CT 06511
p: 203.865.5168 · f: 203.907.2001
ppsne.org

Planned Parenthood of Southern New England

December 1, 2016

Loan Nguyen, M.S.N., R.N.C
Supervising Nursing Consultant
Facility and Licensing and Investigations Section
State of Connecticut Department of Public Health
410 Capitol Ave PO Box 340308
Hartford, Connecticut 06134

Dear Ms. Nguyen,

Attached is the plan of corrective actions for the violation found during the unannounced inspection of the Hartford Health center located at 1229 Albany Avenue on March 8, 2016.

1. Violation: Section 19-13-D48 Professional Staff (b) (2) and/or 19-13-D51 Pharmaceuticals (3) and or 19-13-D52 Maintenance. Ringer's Lactate solution 500cc was on the Emergency Equipment checklist but was missing from the emergency box (on backorder) and failure to identify safe management and availability of emergency equipment solution for the patient's safety.
2. Measures to prevent recurrence: A policy on how to handle pharmaceutical shortages has been added to the PPSNE Medical Standards and Guidelines. This policy includes notifying the Medical Director and Director of Medical services of all backorders, attempting to find alternatives in order to prevent shortages and when none is available, providing guidance to staff on how to manage the shortage with patients.
3. Date of corrective action: Lactated ringers has since been replaced in the Hartford emergency box. It was immediately replaced with saline solution when the deficiency was noted.
4. Plan to monitor:
   - The Hartford Center Manager will monitor that the emergency box is checked monthly (by the LPN) and verify that all items are present.
   - The Director of Medical services will check in monthly with the purchasing department to monitor if there are any backordered medications in order to prevent shortages.

We hope this plan of corrective actions answers the violation found during your visit of March 8, 2016. Please do not hesitate to contact us if you have further questions.

Best regards,

Stephanie Blanchard
Sally Hellerman

Stephanie Blanchard, Center Manager
Hartford North

Sally Hellerman, MS, FNP-BC
Director of Medical Services

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH SYSTEMS REGULATION

DHSR #13a

Page 1 of ___

LICENSING INSPECTION REPORT

Name and Address of Entity

Planned Parenthood of Southern New England
211 State St
Bridgeport CT 06604

Signature of DHSR Staff

[signature]

Licensure Category : Family Planning Clinic — **Licensed Capacity :** # 001 — **Census :** ___

Licensed Capacity : ___ — **Census :** ___

Date(s) of Onsite Inspection : 3/29/16

Date(s) Additional Information Obtained: ___

Personnel Contacted : Jamie Cole - CM

REVIEW/FINDINGS/PROCESS (complete all applicable)

[✓] Licensing Inspection: [ ] *Initial* [✓] *Renewal* [ ] *Other:* ___

[ ] Revisit for the Purpose of ___

[ ] See Complaint Investigation # ___

[ ] See Reportable Event Investigation # ___

[ ] See Certification file.

[ ] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection.
See violation letter dated ___

[ ] Citation # ___ was issued to this facility as a result of this inspection.

[X] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection.

[ ] Citation # ___ was verified as corrected. ___ was notified that the licensee was no longer required to post Citation (see narrative).

[ ] Citation # ___ was not corrected (see narrative).

[ ] Narrative Report / Additional Information Attached.

[ ] Referral(s) to: ___

REPORT SUBMITTED BY [signature] **DATE OF REPORT** 3/29/16

[✓] Approval for Issuance of License granted by : Joan D Donovan 3-22-16
Supervisor / Title — Date

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity: Planned Parenthood of Southern New England
111 Hazard Ave
Enfield CT 06082
M:

Signature of FLIS Staff: [signature] Robin Barrera MSN Connecticut

Licensure Category: Family Planning Clinic

Licensed Bed Bassinet Capacity: ___

Census: ___

Date(s) of onsite inspection: 5/22/17

Date(s) additional information obtained: ___

Personnel contacted: Jennifer Bradley, Center Manager

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other (e.g.strikes)*: ___

[ ] Visit **OR** Revisit for the purpose of ___

[ ] See Complaint Investigation # ___

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated ___

[ ] Desk Audit ___ [ ] Amended Letter: ___ Original Ltr. ___

[ ] Citation # ___ was issued to this facility as a result of this inspection.

[X] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # ___ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: [signature] MSN **DATE OF REPORT:** 5/23/17

[ ] Approval for issuance of license granted by: Joan A Dapice **DATE:** 5-24-17
Supervisor/Title

r:\flis\hsr\FACESHEETS
Revised 12/2016

Additional Home Health Agency Information

- This Agency is authorized to provide the following services:
  [ ] Nsg.; [ ] PT; [ ] OT; [ ] ST; [ ] SS; [ ] H-HHA; [ ] IV Therapy;
  [ ] Other: _____

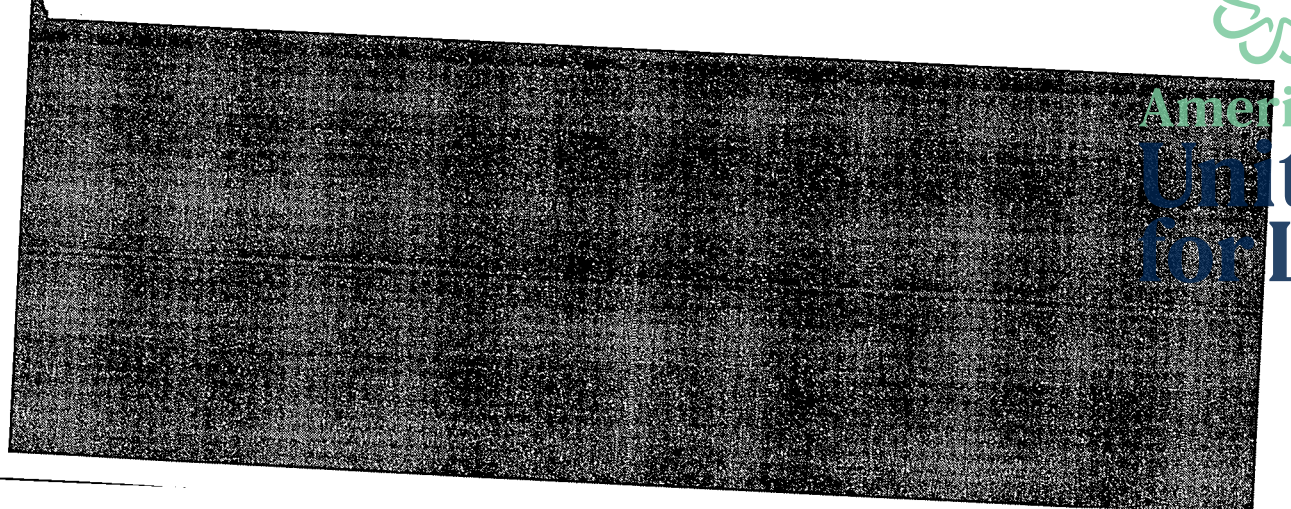
- Patient Services Offices (if applicable) :

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

- Number of Home Visits: 0 Number of Records Recieved: 5



Americans United for Life

FACILITY: Planned Parenthood SE Expansion

DATE(S) of VISIT: 5/22/17 Page 2 of __

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

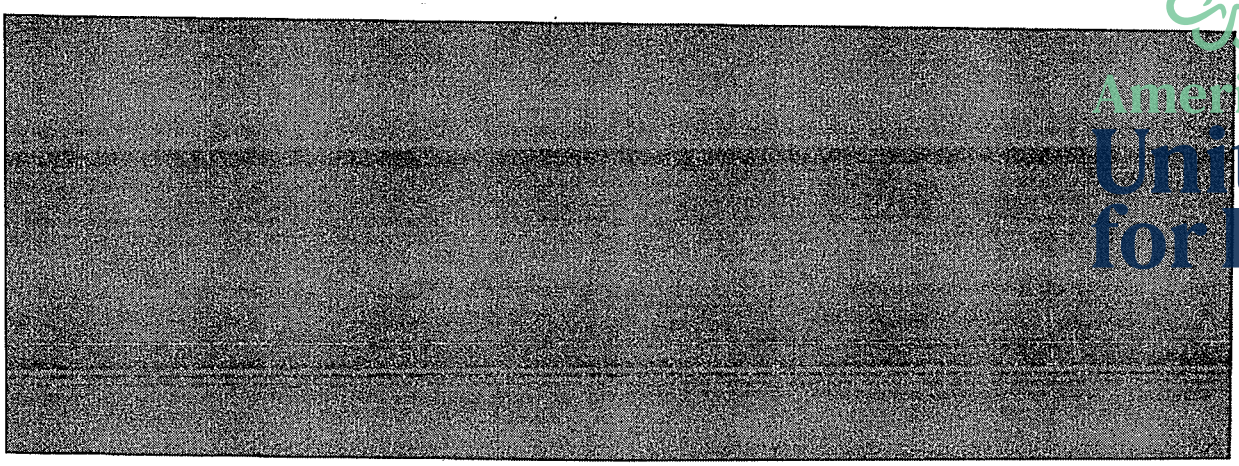
III. The following was conducted:

a. Facility inspection
b. Observation of patient care
c. Personnel files review
d. Quality assurance program (audits) review
e. Fire drill log/disaster plan review
f. New or revised agency policies and procedures review
g. Clinical record review
h. In-service training/staff meeting documentation
i. CLIA certificate/waiver

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut were/were not identified as a result of this inspection.

SIGNATURE: [signature]



Copy

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Planned Parenthood of Bridgeport
4697 Main ST
Bridgeport, CT 06606
M:

Signature of FLIS Staff

Noben Barrera Nurse Consultant

Licensure Category:

Planned Parenthood Family Planning Clinic

Licensed Capacity: _____ Census: _____
Licensed Capacity: _____ Census: _____

Date(s) of onsite inspection: 10/2 /17

Date(s) additional information obtained: _____

Personnel contacted: Esonia Cole Center Manager

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [X] *Initial* [ ] *Renewal* [ ] *Other:* _____

[ ] Desk Audit _____ [ ] Amended Letter: _____ Original Ltr. _____

[ ] Revisit for the purpose of _____

[ ] See Complaint Investigation # _____

[ ] See Reportable Event Investigation # _____

[ ] See Certification File.

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[X] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # _____ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] Referral(s) to _____

REPORT SUBMITTED BY: Noben Barrera **DATE OF REPORT:** 10-2-17

[ ] Approval for issuance of license granted by: Loan D Nguyen **DATE:** 10-4-17
Supervisor/Title

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

February 13, 2018

Jamie Beers, Administrator
Hartford Gyn Center
1 Main Street
Hartford, CT 06106

Dear Ms. Beers:

Unannounced visits were made to Hartford Gyn Center that concluded on October 6, 2017 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through October13, 2017.

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 visits.

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 February 27, 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 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.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATE OF VISIT: October 6, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Respectfully,

Heidi Caron RN

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC/JF:jf

Americans United for Life

DATE OF VISIT: October 6, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D50 and/or 19-13-D52 and/or 19-13-D54 (c)

1. Based on observation during tour with the Administrator on 6/6/17, the following was identified:
   a. During observation of the biological indicators being stored on 6/6/17 it was observed to be in the cabinet directly above the steam sterilizer, thus when the sterilizer's door is cracked open for items to cool and dry, the moist heat travels directly to the cabinet with the stored spores. Manufacturer's directions direct that spores should be stored between the temperatures of 60-80 degrees Fahrenheit and 30-70% humidity.
   b. Review of the facility's spore testing documentation identified that neither the control test nor the spore test were definitively documented as positive or negative or what well of the incubator each vial was placed.
   Additionally, review of the weekly spore testing documentation identified that on 1/2/17, the results of the spore test were not documented and on several days, staff failed to initial who completed the reading.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D48 (b)(4) and/or 19-13-D49 (b) and/or 19-13-D50 (c)

2. Review of the clinical records, review of policies and procedures and interviews with facility personnel for five of five patients reviewed (P #1,#2,#3,#4,#5), the facility failed to ensure that documentation of clinical care was complete and/or accurately reflecting the time the patient received care. The findings include:
   a. Review of the clinical record for five of five patients who underwent a surgical procedure within the timeframe of 8/17/16 through 6/3/17, identified that any assessment completed by a registered nurse, should have the initials "RN" following the name of the person performing the assessment. Likewise, all medical assistants performing documentation of care provided should initial "MA" following their name.
   b. Review of five of five clinical records reviewed, the vital signs documented were listed as blood pressure #1, blood pressure #2., rather than the time during the procedure that the blood pressure was actually taken.
   c. Review of five of five clinical records who had intravenous lines started prior to their procedure, the records failed to reflect what IV solution was hung, the rate it infused and how much the patient absorbed before the IV was discontinued.
   d. Review of five of five clinical records failed to identify that the level of sedation was documented in the anesthesia record.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D48 (b)(4) and/or 19-13-D49 (b).

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

3. Review of the clinical record, review of policies and procedures and interviews with facility personnel for two of five patients (P#1, P#2), the facility failed to ensure that the medication administration portion of the record was accurate and/or complete. The finding includes:
   a. Review of the clinical record for Patient #1, who on 11/16/16 underwent a two-day pregnancy termination, identified that the Medication Administration Record portion of the record failed to include all medications the patient received during the procedure and during recovery. Review of the record identified that the patient received 40mg of Propofol for sedation during the procedure, Medroxyprogesterone acetate 150mg post procedure and a total of 8mg of versed during the witnessed seizure activity in the recovery area that failed to be reflected in the medication administration section of the record.
   b. Review of the clinical record for Patient #2 who underwent a pregnancy termination procedure on 8/17/16, identified a physician's order for Pitocin 10 units. Review of the progress narrative identified that 20 units of Pitocin was administered at 11:34 AM. Review of the medication administration record failed to reflect that any Pitocin had been administered to the patient.

4. Review of the clinical record, review of facility policies and procedures and interviews with facility personnel, for one of five patients (P#2) the facility failed to ensure that anesthesia documentation reflected the need for the patient to return to operating room secondary to bleeding. The findings include:
   a. Review of the clinical record for Patient #2, who underwent a two day pregnancy termination on 8/17/16, identified that the patient was required to return to the operating room from the recovery area secondary to increased bleeding with large clots. The patient was initially brought to the recovery area at 10:35 AM, post procedure where she remained until 11:25 AM when she was brought back to the OR secondary to the bleeding referenced above. The patient was given (per progress note) 200 mg of Propofol between 11:25 AM and 11:37 AM while a fundal message was completed. Patient #2 was observed in the recovery area for one hour. At 1:03 PM, Patient #2 was again taken to the operating room secondary to excessive bleeding over 25 minutes. Review of the progress notes identified that the patient was administered 600 mg of Propofol between 1:06 PM and 1:40 PM. Although vital signs were documented every 5 minutes in the progress narrative, the clinical record failed to reflect documentation of anesthesia/respiratory support given to the patient to maintain an oxygen saturation of 100% throughout this extended surgical procedure. The patient was ultimately sent to the Emergency Department (ED) via ambulance at 2:10 PM.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D47(a)(1)(2)(b).

5. Based on review of facility documentation, review of facility policies and procedures and interviews with facility personnel, the facility failed to ensure that that facility had a transfer agreement with an acute care hospital for emergencies. The findings include:

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

a. Review of facility documentation on 10/6/17 with the Administrator identified that the facility failed to have a transfer agreement with an acute care hospital in case patients needed to be transferred for emergencies. Interview with the Administrator on 10/6/17 identified that he/she was unaware that they needed an agreement with a hospital for transfers.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D47 (a)(1)(b) and/or 19-13-D48 (b)(1).

6. Based on review of credentialing files, review of facility policies and procedures and interviews with facility personnel, the facility failed to ensure that credentialed staff were reappointed and/or that privileges were approved. The findings include:
   a. Review of credentialing files for eight CRNA's and two physicians identified that credentialed staff had not been reappointed for over two years. Further review failed to identify documentation of privileges approved for surgical procedures. Review of facility policy identified that all appointments and reappointments shall be for a period of two years, unless at the discretion of the Governing Body. Further review of facility policy identified that the facility will review a request for privileges during the initial employment and/or contract with credentialed staff.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D47 (b) and/or 19-13-D48 (b)(1)(2) and/or 19-13-D54 (e).

7. Based on clinical record reviews, review of facility policies and procedures and interviews with facility personnel, the facility failed to ensure that appropriate methods of sedation were utilized at the center. The findings include:
   a. Review of the clinical records for P#1, P#6, P#7 who underwent a surgical procedure within the timeframe from 8/16/16-9/27/17. Review of the anesthesia records identified the patients received nitrous oxide during their procedures. Interview with the Administrator on 10/6/17 identified that they have one physician that utilizes the nitrous oxide during his/her procedures.

      The facility submitted an immediate action plan dated 10/13/17 which indicated that they will no longer utilize nitrous oxide for all procedures effective 10/13/17.

      Review of facility policy identified that the center offers two types of pain management options which includes a local anesthesia and/or IV sedation to achieve moderate sedation. Further review of the center policy failed to identify that nitrous oxide was to be utilized for pain management and/or sedation.

OK
3/22/18
HAC

February 27, 2018

Heidi Caron, MSN, RN, BC, CLNC
410 Capitol Ave
PO Box 340308
Hartford, CT. 06134-0308

Dear Heidi Caron,

Thank you for sending me the report of our unannounced visit on October 6, 2017. Please see the following plan of corrections and supporting documentation attached.

1a.

(1) Biological indicators were removed from the cabinet above the sterilizer and are now stored in a location in accordance with manufacturer's directions.
(2) 6/6/17
(3) All staff member using biological indicators were trained on appropriate storage and the Medical Coordinator will perform random spot checks to ensure staff compliance with storage directions.
(4) Administrator

1b.

(1) The log sheet used to document weekly spore testing was updated to indicate incubator well numbers and to include spore test positive or spore test negative as a definitive result.
(2) 6/9/17
(3) The Medical Coordinator held a meeting on 6/9/17 and trained all medical assistant staff regarding the implementation of the new log sheet and the steps for proper spore testing and biological indicator storage. The process for reporting abnormal results immediately to supervisor was reviewed. A copy of the policy was distributed to all staff and new log sheets were put into use immediately. Log sheets are reviewed weekly to ensure spore testing is complete and initialed by the staff person completing the task by the Medical Coordinator or in their absence, the Administrator.
(4) Medical Coordinator

2a.

(1) The letters RN will be included in signatures of registered nurses and MA in signatures of medical assistants when these individuals are documenting in EMR.
(2) 3/20/18
(3) All relevant staff were informed of the requirement for title after signature documentation. Fifteen charts will be reviewed each month (starting 3/20/18) for 3 months to ensure that RN

and MA are consistently being recorded in the EMR. Communication has been initiated with the IT team to ensure that changes to the EHR will be made to ensure compliance with documentation.

(4) Administrator

2b.

(1) All BP recordings documented in the chart will have a corresponding time stamp to show when the BP was taken.

(2) 3/20/18

(3) All relevant staff were informed of the requirement for time with vital sign documentation. Fifteen charts will be reviewed each month (starting 3/20/18) for 3 months to ensure that the vital signs documented are time stamped and signed. Communication has been initiated with the IT team to ensure that changes to the EHR will be made to ensure compliance with documentation.

(4) Administrator

2c.

(1) The type of IV solution being given, its rate of infusion and the volume received at the time of discontinuation will be documented in the patient's IVS record by CRNA.

(2) 3/20/18

(3) All relevant staff and CRNAs were informed of the details required for complete IV fluid documentation. Fifteen charts will be reviewed each month (starting 3/2018) for three months to ensure that CRNAs and RNs are consistently documenting detailed IV fluid use in the patient's EHR. Communication has been initiated with the IT team to ensure that changes to the EHR will be made to ensure compliance with documentation.

(4) Administrator

2d.

(1) Physicians and/or CRNAs will document all analgesia and or anesthesia medications provided. Type of sedation, Local and/or IVS, will continue to be documented in all EHR.

(2) 3/20/18

(3) All relevant staff, CRNAs and physicians were informed of the requirement for analgesia and anesthesia medication documentation. Fifteen charts will be reviewed each month (starting 3/2018) for three months to ensure that documentation is complete. Communication has been initiated with the IT team to ensure that changes to the EHR will be made to ensure compliance with documentatic n.

(4) Administrator

3a.

(1) The medication administration portion of the EHR will reflect an accurate and complete documentation of all medications provided to the patient during their care. In the current EHR system, the medications a patient receives do not currently auto-populate from one document to another. The medications documented by anesthesia- including those administered by CRNA, which can sometimes include Medroxyprogesterone Acetate-, do not appear in the patient's Medication Administration record.

(2) 4/20/18

(3) All relevant staff, CRNAs and physicians were informed of the documentation requirements for the medication administration record. A new EHR document will generate that will combine the medications administered in both the anesthesia visit as well as the abortion visit. This will allow compliance in all areas- patients will leave with a document showing what medications they received on DOS, and a complete MAR will appear in the patient chart. Fifteen charts will be reviewed each month (starting 4/02/18) for 3 months to ensure to ensure compliance and accuracy.

(4) Administrator

3b.

(1) The medication administration portion of the EHR will reflect an accurate and complete documentation of all medications provided to the patient during their care. In the current EHR system, the medications a patient receives do not currently auto-populate from one document to another.

(2) 4/20/18

(3) All relevant staff, CRNAs and physicians were informed of the documentation requirements for the medication administration record. Communication has been initiated with the IT team to ensure that changes to the EHR will be made to ensure compliance with documentation.

(4) Administrator

4a.

(1) In the event of the need to return to the procedure room for additional care including sedation, the CRNA will open an additional IVS document and record the procedure rather than use a progress note. This will ensure that thorough and complete documentation of anesthesia provision occurs.

(2) 3/20/18

(3) In-service with the CRNAs explaining that in the event the patient needs to return to the procedure room, a new IVS document must be opened and started. Over the next three months (starting 4/2/18), all charts of patients that return to the procedure room will be reviewed by the Administrator to ensure compliance.

(4) Administrator

5a.

(1) In the event a patient transfer is required, HGC physicians and staff follow the Hartford Hospital Transfer policy (attached). In accordance with this policy, the attending HGC physician contacts the appropriate on-call Hartford Hospital physician to notify them of the transfer and to provide report. Upon the transferred patients arrival at the hospital, Hartford Hospital assumes care of the patient.

(2) Current and on-going

(3) The Administrator ensures a semi-annual review of the transfer policy with staff and physicians. In addition, the transfer policy is a part of the Policy and Procedure Manual which is reviewed annually by the Adninistrator and Medical Director to ensure staff and provider compliance, make any changes or updates, and to ensure it is a reflection of best practices. All patient transfers are reported to the Quality Assurance Committee which includes a member of the Governing Body, for discussion and review. A review of applicable regulations (inlcuding Section 19-13-D47(a)(1)(2)(b) cited above) does not reveal a requirement for a transfer agreement with an acute care hospital. As such, the Governing Body will advise the Administrator to continue to practice based on stated internal policy and procedures to ensure the continued safety and care of our patients in the event of a hospital transfer.

(4) Administrator

6a.

(1) Reappointment letters have been updated for the two physicians and CRNAs that did not have reappointment letters as of the last Governing Body meeting, which was 2/13/18.

(2) 2/13/18

(3) Reappointment of medical staff will be discussed by the governing body every two years and letters submitted in personnel files. This will be audited quarterly to ensure all MDs and CRNA's letters are current in their files.

(4). Administrator

7a.

(1) Based on discussion with the Medical Director and Governing Body, the use of nitrous oxide was discontinued effective 10/13/17. The policy and procedure manual has been updated to reflect the change and to include all types of pain management options available to patients. HGC provides local anesthesia and/or IV sedation based on the Procedural Pain Management policy attached.

(2) 10/13/17

(3) The Administrator notified all staff of the discontinuation of nitrous oxide and a representative of the Governing Body spoke with the CRNAs and physicians to inform them of the discontinuation of nitrous oxide and to ensure compliance with the Procedural Pain

Management policy. The Governing Body will ensure that pain mangement options offered to patients are reflected in the Policy and Procedure Manual and are provided in a manner consistent with applicable regulations.

(4) Governing Body

Thank you very much for your consideration of our responses to these reported violations. Please contact me with any additional questions.

Sincerely,

Jamie Beers, Administrator

Americans United for Life

Hartford Gyn Center

Procedural Pain Management

The Hartford Gyn Center (HGC) offers abortion patients two pain management options for their procedure: (1) local anesthesia (para cervical block) only; and (2) IV sedation which, based on the clinical judgement of the anesthetist, may include Propofol, Midazolam or Diprivan. IV sedation may also be accompanied by para cervical block. The type and amount of sedation administered is documented in the patient's EHR. All practitioners providing anesthesia at HGC are trained and readily able to rescue patients from any level of sedation.

Americans United for Life

Hartford Gyn Center

Procedural Pain Management

The Hartford Gyn Center (HGC) offers abortion patients two pain management options for their procedure: (1) local anesthesia (para cervical block) only; and (2) IV sedation which, based on the clinical judgement of the anesthetist, may include Propofol, Midazolam or Diprivan. IV sedation may also be accompanied by para cervical block. The type and amount of sedation administered is documented in the patient's EHR. All practitioners providing anesthesia at HGC are trained and readily able to rescue patients from any level of sedation.

Americans United for Life

HARTFORD HOSPITAL (HH) TRANSFERS

General Emergency Room Number:	860-545-0000
General Hospital Number (to page Staff)	860-545-5000
Hospital Delivery Room (for staff schedule)	860-972-2916
WAHS (Drs. Nelson and Beller)	860-972-2780
Admitting Office	860-545-2730

Upon the physician and/or CRNA's decision to transfer a patient to the hospital, the Administrator, or their designee, will be responsible for calling 9-1-1.

Once the patient has been determined to be stable for transport, the HGC MD will call the HH General Number to page the GYN resident on call or WAHS depending on who is covering that day, or the delivery room to obtain the staff schedule to find out who is on-call.

The charge nurse, or their designee, will call the HH General Emergency Room number to alert them to the transfer.

The patient's chart, upon its completion, will be printed and a copy given to EMS to be given to the hospital. The patient's belongings will go with her or her escort, if applicable and appropriate.

The Administrator and MD will speak with the patient's escort, inform them of the transfer, and advise where to go to accompany the patient. If necessary, the Administrator or the designee may accompany the patient to the ED if the escort or emergency contact cannot be reached.

Americans United for Life

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity	*Signature of FLIS Staff*	
Planned Parenthood of Southern new England	Robin Barreau	Renee Connecticut
1229 Albany ave		
Hartford CT 06112		
M:		

Licensure Category:

Planned Parenthood

Licensed Bed Bassinet Capacity: 6 exam rooms

Census:

Date(s) of onsite inspection: 10/23/17

Date(s) additional information obtained:

Personnel contacted: Mary Bawza

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [X] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes):*

[ ] Visit **OR** Revisit for the purpose of

[ ] See Complaint Investigation #

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated

[ ] Desk Audit [ ] Amended Letter: Original Ltr.

[ ] Citation # was issued to this facility as a result of this inspection.

[✓] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to

REPORT SUBMITTED BY: Robin Barreau **DATE OF REPORT:** 10-23-17

Approval for issuance of license granted by: Loan D Nguyen **DATE:** 11-7-17
Supervisor/Title

FACILITY: Planned Parenthood Hartford

DATE(S) of VISIT: 10/23/17

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

a. Facility inspection
b. Observation of patient care N/A
c. Personnel files review
d. Quality assurance program (audits) review
e. Fire drill log/disaster plan review will do on 4/4/y basis
f. New or revised agency policies and procedures review (updated 4/17)
g. Clinical record review N/A
h. In-service training/staff meeting documentation
i. CLIA certificate/waiver

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut ~~were~~/were not identified as a result of this inspection.

SIGNATURE: Nelson Barrera

FACILITY: Planned Parenthood Manchester

DATE(S) of VISIT: 12/28/2017 Page 2 of 2

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D46)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

a. Facility inspection
b. Observation of patient care
c. Personnel files review
d. Quality assurance program (audits) review
e. Fire drill log/disaster plan review
f. New or revised agency policies and procedures review
g. Clinical record review
h. In-service training/staff meeting documentation
i. CLIA certificate/waiver

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut ~~were~~/were not identified as a result of this inspection.

SIGNATURE: Robert Suzuki
12/28/17

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

February 21, 2018

Ms. Sally Helleman, Administrator
Planned Parenthood Of Southern New England
345 Whitney Avenue
New Haven, CT 06511

Dear Ms. Hellerman:

An unannounced visit was made to Planned Parenthood Of Southern New England on January 26, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through January 26, 2018.

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.

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 March 7, 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 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.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

Phone: (860) 509-7400 • Fax: (860) 509-7543
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

PHAB

DATE(S) OF VISIT: January 26, 2018

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

Respectfully,

Heidi Caron RN

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

DATE(S) OF VISIT: January 26, 2018

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D49 (b) Records.

1. Based on review of the clinical record and interviews with facility personnel, the facility failed to ensure that 1 0f 4 clinical records were accurate. The findings include:
   a. Review of Patient #1's clinical record on 1/26/18 at 11:30 AM with the Manager and Director of Medical Services indicated that on 1/3/18 the patient had a surgical procedure completed. The record indicated that the patient's anesthesia completion time was documented as 10:02 AM and the patient was transferred to the recovery area. Review of the recovery documentation indicated that the patient arrived at 9:55 AM. Review with the Director of Medical Services indicated that the discrepancy regarding the documented transfer to recovery would be reviewed with anesthesia. Review of facility policy identified that whether on paper or in the electronic medical record, the time entered into the chart must be accurate.
   b. Review of Patient #1's clinical record with the Director of Medical Services on 1/26/18 at 11:30 AM indicated that on the nursing admission information prior to the procedure indicated that the patient had no known drug allergies (NKDA). However, review of the anesthesia assessment indicated that the patient was allergic to Keflex. Review of facility policy identified that a target medical history would include special attention to patient allergies.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D52 Maintenance.

2. Based on observations and interviews with facility personnel, the facility failed to ensure that infection control practices were maintained. The findings include:
   a. Review of the sterilization logs for the period of 11/1/2017-1/26/2018 failed to identify results of the steam indicator placed in each load on 11/15/17, 11/18/17, 12/7/17, 1/18/18, 1/19/18, and 1/24/18. Interview with the Manager on 1/26/18 at 12:00 PM 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 and pack number.
   b. Review of the autoclave monthly cleaning log for the period of 1/1/17 through 12/31/17 for the large autoclave failed to reflect that cleaning had been completed for the months of May 2017, June 2017 and July 2017. Review of the logs for the small autoclave for the dame period failed to reflect monthly cleaning had been completed for June 2017 and July 2017. Interview with the Manager on 1/26/18 at 12:15 PM indicated that the facility policy is to perform monthly cleaning however, there was a change in management during that time and she in not sure why the cleaning had not been completed. Review of facility policy identified that autoclaves are to be cleaned, drained and have the water replaced at least once a month.
   c. Tour of the recovery area on 1/26/18 at 10:20 AM indicated that patient chairs were cloth

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

covered, rendering them unable to be fully sanitized after patient use. Review of facility policy identified that disinfectant of chairs would be achieved on a vinyl surface.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D50 Nursing Personnel.

3. Based on tour, observation, interview and policy review the facility failed to ensure that medications were labeled with the date, time, medication, amount and person drawing up the medication. The finding includes the following:
   a. Tour of the procedure room on 1/26/18 at 10:00 AM identified five (5) syringes in the top drawer of the anesthesia cart that were labeled as Versed. The label failed to reflect the date and time the medication was drawn up, the initials of the staff member and the amount of medication in the syringe. Interview with the RN on 1/26/18 at 10:10 AM indicated that the syringe contained Fentanyl and Versed and had been drawn up that morning. Interview with the Director of Medical Services on 1/26/18 at 10:30 AM indicated that facility policy is that staff should have labeled the syringe with date and time the medication was drawn up, the initials of the staff member and the amount of medication in the syringe. Review of facility policy identified that medication solution labels will include the following; medication name, strength, quantity, diluent, volume and expiration time.

The following are violations of the Regulations of Connecticut State Agencies Section 19a-116-1(f) Emergency preparedness (B).

4. Based on facility document review and interview the facility failed to ensure that fire drills were completed per policy. The findings include the following:
   a. Review of the fire drill documentation with the Nurse Manager on 1/26/18 at 12:30 PM indicated that a fire drill was conducted October 10, 2017. The facility was unable to provide fire drills prior to that date. Interview with the Nurse Manager indicated that fire drills are to be completed quarterly, but when she started the job in August she was unable to locate any previous documentation that fire drills had been completed. Review of facility policy identified that fire drills are to be completed quarterly.

Planned Parenthood
Care. No matter what.

345 Whitney Avenue
New Haven, CT 06511
p: 203.865.5158 · f: 203.907.2002
ppsne.org

Planned Parenthood of Southern New England

4/3/18 OK HAC

Planned Parenthood of Southern New England
New Haven Health Center

Plan of Correction

March 1, 2018

1. **Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D49(b) Records:**

   a. An investigation into clinical record time documentation regarding surgical procedures revealed that the time in our computer system differed from the time displayed on the analog clock mounted in the procedure room. We have removed this clock because it does not seem to be working properly. I have ordered a digital clock to replace the analog so that there will not be a differing in interpretation. We will also check the time on the clock for accuracy before the start of each surgical clinic which will be 3 times per week. The sedation provider who is scheduled in the procedure room during any surgical clinic will be responsible for ensuring that the time displayed on the clock is accurate and matches the time displayed in our electronic health records system, Athena Health. This corrective action will go into effect on March 2, 2018. In order to ensure that the new clock system is accurate, charts will be audited after clinic session ends on March 7th by the Center Manager to ensure that the times documented in the EHR and on the sedation record correlate appropriately. Additionally, the Director of Quality Management will include this in her annual surgical abortion audit.

   ✓

   Addendum:

   The original plan was to audit charts on March 7th but clinic was cancelled that day due to a snowstorm. Charts were audited on March 14th instead. All charts showed that the patient arrived in the recovery room after the abortion was completed. Five charts will be audited once a month for the remainder of 2018.
   The person responsible for this corrective action plan is Lisa Marvinsmith, Director of Quality Management. She will ensure that the audits are completed and corrective actions taken as indicated

   b. Staff received an in-service on February 2, 2018 on the importance of accurate and thorough documentation for all patient visits with an emphasis on surgical procedures and known allergies. We discussed the importance of updating medical records should the patient disclose something different to the CRNA than what was previously charted in the EHR. Charts will be audited after clinic on March 7th by the Center Manager to ensure that

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the sedation record correlates with the EHR. Additionally, the Director of Quality Management will include this in her annual surgical abortion audit.

Addendum:
Five charts were audited on March 14th to ensure that the charting of the sedation provider correlated with the charting of the other health center staff. Five charts will be audited once a month for the remainder of 2018.
The person responsible for this corrective action plan is Lisa Marvinsmith, Director of Quality Management. She will ensure that the audits are completed and corrective actions taken as indicated.

2. **2) Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D52 Maintenance:**

   a. The sterilization log that we had been using during the timeframe of this violation was found to be poorly structured and unclear to the staff which led to lack of documentation compliance. A new log form was implemented 2/16/2108 to reflect an accurate and readable documentation of indicator results. The sterilization process was also reviewed with staff at the February 2nd staff meeting. The Clinic Assistants will be responsible for completion of the sterilization log and the Health Center Manager will monitor compliance. In addition, the Director of Quality Management will monitor compliance across the agency annually.

   b. Due to a change in management, the autoclave cleaning had not been documented consistently. Autoclave cleaning documentation has been consistently cleaned and maintained since August 2017 and will continue to be cleaned monthly by Clinic Assistants and monitored by the Health Center Manager. The policy was reviewed with the clinic staff at the February 2, 2018 at a staff meeting.

   Addendum: *The Director of Quality Management, Lisa Marvinsmith is responsible for this corrective action.*

   c. We are looking into purchasing new chairs for our recovery room. Currently, we do clean each chair with purple PDI wipes after patient use and we put down a disposable paper chuck for each patient to sit on to maintain cleanliness. We also have the chairs deep-cleaned several times per year and additionally as needed. The Health Center Manager will pursue the purchase of new chairs and will monitor the status of the chairs.

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Addendum: The Regional Director, Shira Revzen is responsible for this corrective action.

3. **Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D50 Nursing Personnel:**

   a. The policy for labeling syringes was reviewed on January 26, 2018 with all staff that perform sedation. The anesthetists will now adhere to the policy of labeling medications with the medication name, strength, quantity, diluent, volume, expiration time and the initials of the person who drew it up. The labeling of syringes has been added to the sedation provider privileging checklist. The Health Center Manager will ensure each sedation provider remains compliant through periodic spot checks.

4. **Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19a-116-1(f) Emergency preparedness (B):**

   a. Due to a change in management, fire drills had not been consistently documented. However, quarterly fire drills have been consistently done since October 2017 and will continue to be facilitated and documented by the Health Center Manager. Fire drills are done quarterly and the policy was reviewed with the clinic staff on February 27, 2018. The Regional Director will monitor the fire drill log for compliance.

   Addendum: The Regional Director will audit the fire drill log every quarter.

Sincerely,

Lauren Perriera
Health Center Manager

Sally Hellerman MS, APRN
Sally Hellerman, MS, FNP-BC
Director of Medical Services

Americans United for Life

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity
Planned Parenthood of Southern New England - Danbury
44 Main ST
Danbury, CT 06810
M:

FLIS Staff
Aileen Barreiro Nurse Consultant

Licensure Category:
Planned Parenthood

Licensed Bed
Bassinet Capacity:

Census:

Date(s) of onsite inspection: 5/23/18

Date(s) additional information obtained:

Personnel contacted: Jennifer Tomasini Center Director

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[ ] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other (e.g.strikes):*

[ ] Visit **OR** Revisit for the purpose of

[ ] See Complaint Investigation #

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated

[ ] Desk Audit [ ] Amended Letter: Original Ltr.

[ ] Citation # was issued to this facility as a result of this inspection.

[X] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to

REPORT SUBMITTED BY: Aileen Barreiro DATE OF REPORT: 5-23-18

[X] Approval for issuance of license granted by: Loan D Nguyen DATE: 6-18-18
Supervisor/Title

FACILITY: RP of So. NE Danbury

DATE(S) of VISIT: 5/23/18

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

a. Facility inspection
b. Observation of patient care
c. Personnel files review
d. Quality assurance program (audits) review
e. Fire drill log/disaster plan review
f. New or revised agency policies and procedures review
g. Clinical record review
h. In-service training/staff meeting documentation
i. CLIA certificate/waiver

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut were/~~were~~ not identified as a result of this inspection.

SIGNATURE: Noreen Sareen

FACILITY: Old Saybrook Planned Parenthood

DATE(S) of VISIT: 6/4/18

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES
LICENSING INSPECTION NARRATIVE REPORT
(P.H.C. Section 19-13-D45)

I. An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.

II. An entrance conference was held.

III. The following was conducted:

a. Facility inspection
b. Observation of patient care
c. Personnel files review
d. Quality assurance program (audits) review
e. Fire drill log/disaster plan review
f. New or revised agency policies and procedures review
g. Clinical record review
h. In-service training/staff meeting documentation
i. CLIA certificate/waiver

IV. An exit conference was provided.

V. Violations of the Public Health Code of the State of Connecticut were/~~were~~ not identified as a result of this inspection.

SIGNATURE: Robin Barrett

OK
HLE
1/22/19

11/02/2018

Donna Ortelle, R.N., M.S.N.
Public Health Services Manager
Facility Licensing and Investigations Section
DPH
410 Capitol Avenue, P.O. Box 340308
Hartford, CT 06134-0308

Dear Ms. Ortelle,

This letter is in reference to the violations letter dated 10/22/18 for the visit to Planned Parenthood of Southern New England's Hilda Standish Center on June 29, 2018. Please see the information listed below which will address each violation individually.

1. a. b. Autoclave log documentation and follow up:

Measures to prevent recurrence:

- On 7/13/18 the West Hartford staff who run the autoclave were retrained on how to complete the autoclave log. Also discussed the rationale for each entry and importance of filling in each entry on the log. Reviewed the autoclave policy including procedures to follow when a load fails. Staff members stated that they always put an indicator in each load and always check the indicator when removing the load but sometimes forget to document completely on the log. The staff member who documented the load failure and the staff members who didn't document pass or fail both stated that they have no recollection of a load ever failing. They stated that they would check the policy, notify the center manager and call Sally Hellerman, Dir of Medical Services immediately if a load failed.
- Donna Nucci, RN, Infection Control Consultant recommended several sterilization continuing education modules for staff. We are in the process of implementing a course from Steris University.

Date corrective measure was effective:
Initial corrective measures were implemented on June 28, 2018 after receiving feedback from Pamela Beebe, RN on the date of the inspection. Additional training was done on 7/13/18 at the staff meeting.

Plan to monitor quality assessment and performance improvement:
To ensure compliance, the West Hartford site is faxing their autoclave logs every Friday afternoon for the next 3 months to Sally Hellerman, Director of Medical Services. The logs are being assessed for completeness. If any load fails, the West Hartford center's plan of remediation will be included with the faxed autoclave log. Logs faxed since this was implemented have been complete with no failures.

Once a quarter, every PPSNE health center will be asked to fax their autoclave logs that include two randomly selected dates chosen by the Director of Medical Services from the past quarter. Logs will be reviewed for completeness and for any Failed loads.

Review of autoclave logs is also on the PPSNE Annual Health Center Compliance Audit Checklist which is done at least annually at each health center.

Compliance will be ensured by:
The health center manager, Sally Hellerman, MS, FNP-BC, Director of Medical Services and Susan Hitt, MS, Regional Director for West Hartford's health center.

1.c. Recovery room chairs

Measures to prevent recurrence:
The PPSNE staff are now aware that recovery room chairs must be covered with vinyl covering which can be sanitized. All future renovations and furniture replacements will include infection control review as part of the planning process. Disinfection of the chairs was reviewed at the staff meeting on 7/13/2018.

Date corrective measure was effective:
New vinyl covered chairs were received on 7/2/18. See attached photo. The old chairs are no longer at the site.

Compliance was ensured by Jane Yousman, Center Manager and Frank O'Connor, Facilities Manager. Sally Hellerman, Director of Medical Services and Linda Cote, VP for Finance will ensure that this does not recur at any PPSNE health centers.

1.d. Pillow case and hand washing

Measures to prevent recurrence:

- The one cloth pillow case was removed from patient care and put in the trash as soon as staff were aware of the issue.
- The volunteer who was observed not washing her hands after removing gloves was retrained on 6/29/18 regarding use of disposable items, handwashing and how to clean rooms.
- The training process for volunteers who clean rooms during surgical abortion clinic is under review with PPSNE's Volunteer Coordinator to ensure that the training includes OSHA and infection control education. All centers were asked to retrain volunteers who work in patient care areas with the September 10th follow up communication.
- Disposable paper pillow cases were already in use at the center and will continue to be used. Proper use of the paper pillow cases was reviewed at the staff meeting on 7/13/18. Pillows will only be used for surgical procedures going forward.
- All other PPSNE health center managers were asked to survey their centers for cloth pillow cases and to discard any if found.
- Hand washing was a highlighted topic at this summer's Risk Management trainings for all PPSNE health centers. The West Hartford staff reviewed this training at their risk management staff meeting on 6/28/18.
- In addition, proper techniques for cleaning patient care areas was discussed at the 7/13/18 West Hartford staff meeting.

Date corrective measure was effective:
The cloth pillow case was removed from the health center on 6/29/18. The volunteer was retrained on 7/13/18.

Plan to monitor quality assessment and performance improvement:
Sites will be checked for the use of proper pillow cases as part of PPSNE's Annual Health Center Compliance Audit Checklist which is done at least annually at each health center.

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Compliance will be ensured by
Molly Martino, Lead RN and Sally Hellerman, Director of Medical Services will ensure training of volunteers and staff and will monitor appropriate use of pillow cases and hand hygiene.

2. Evacuation Plans

Measures to prevent recurrence:
All center managers were reminded of the importance of keeping evacuation plans posted all the time including when renovations are being done at the center. The PPSNE Facilities Manager, Frank O'Connor has also been notified.

Date corrective measure was effective:
Evacuation plans were re-posted on 7/11/18. On 8/21/18 they were updated and reposted showing 2 evacuation routes.

Plan to monitor quality assessment and performance improvement:
Evacuation routes are on the Annual Health Center Compliance Audit Checklist.

Compliance is ensured by:
Center managers and Regional Directors are responsible for ensuring that evacuation routes are posted at all times.

3. Fire drill and fire emergency

Measures to prevent recurrence:
Center managers were informed of the need to have fire drills twice a year at their center where the fire alarm is actually activated. This has been added to the center manager's Quarterly Compliance Checklist.

Date corrective measure was effective:
PPSNE staff participated in a 1030 New Britain Avenue building-wide fire drill on 7/10/18 where the alarm was activated.

On June 14th a full security/safety drill was performed under the guidance of Samuel Brown, PPSNE Director of Security. On 8/16/18, medical emergency drills were done under the guidance of Molly Martino,RN, Lead RN.

Plan to monitor quality assessment and performance improvement:
This was added to the Annual Health Center Compliance Audit Checklist

Compliance is ensured by:
Each center manager is responsible for ensuring that fire drills are done quarterly. Each center manager is responsible for ensuring that the alarm is actually activated as part of a drill ~~twice~~ quarterly a year.
Overall PPSNE compliance is monitored by the Regional Director.

5. Sprinkler system inspection, testing and maintenance

Measures to prevent recurrence:
The Property Manager at 1030 New Britain Avenue is now aware of the requirement to inspect, test and maintain the sprinklers and gauges. This requirement has been added to the Annual Health Center Compliance Audit Checklist

Date corrective measure was effective:
The sprinkler company was in the health center on 8/22/18 as an initial follow up and returned on 8/30/18. They removed 5 sprinkler heads for testing. All sprinkler heads passed inspection. See attached. A representative from Connect Systems spoke to David Kromas and states that he now understands what is expected by DPH.

Plan to monitor quality assessment and performance improvement:
The sprinkler system and gauges have been added to the Annual Health Center Compliance Audit Checklist

Compliance will be ensured by:
The Center Manager and the Regional Director.

5. Fire alarm maintenance

Measures to prevent recurrence:
The Property Manager at 1030 New Britain Avenue is now aware of the requirement to maintain the fire alarm system and that he must provide documentation of maintenance to the health center manager. The center manager is now aware that she must keep documentation of fire alarm maintenance. The requirement to ensure documentation of maintenance of the fire alarm system has been added to the Annual Health Center Compliance Audit Checklist.

Date corrective measure was effective:
On 7/10/18, Connected Systems serviced the fire alarm system. A copy of the report was provided to Jane Yousman, Center Manager. See attached: Connected Systems.

Plan to monitor quality assessment and performance improvement:
This will be monitored annually when each health center has their annual health center compliance audit.

Compliance is ensured by:
The Health Center Manager and Regional Director

Sincerely,

Sally A Hellerman MS, FNP-BC

Sally Hellerman, MS, FNP-BC
Director of Medical Services

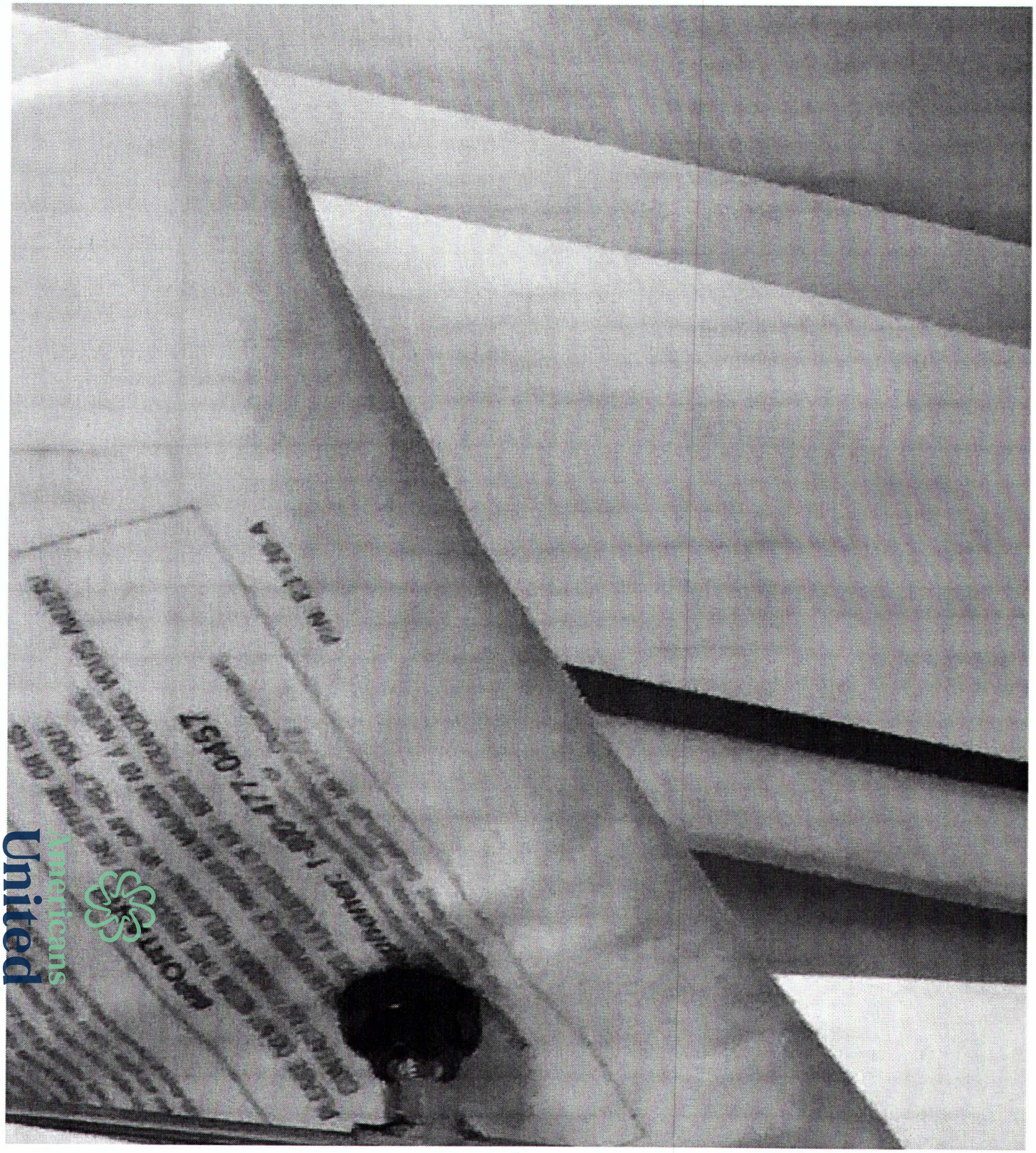
Jane Yousman,
Center Manager, West Hartford

Jane Yousman 8/4

Americans United for Life

Caron, Heidi

From: Sally Hellerman <sally.hellerman@gmail.com>
Sent: Friday, November 2, 2018 3:01 PM
To: Hellerman, Sally



FIRE SPRINKLER TEST RESULTS

Report for:
Tri-City Fire Protection LLC
Dave Fusco
67 Meadowood Rd
Tolland CT 06084
PO# Planned Parenthood/CC

Job Name:
Planned Parenthood
1030 New Britain Ave
West Hartford CT 06110 United States

For Service Call: 860-872-3473

Job Number: 104600
Number of Sprinklers 6
Date Received: 09/04/2018
Report Date: 09/07/2018
Page: Page 1 of 6

Sprinkler Information

Location: Planned Parenthood Bathroom

Year Marking:	1956	Dry Sprinkler:	No
Manufacturer:	Reliable	Additional Attribute:	Not Specified
Identifier (Series, Model or SIN):	C	Coverage Type:	Standard Spray
Orientation:	Upright	Response Type:	Standard Response
Decorative Attribute:	Not Specified	Water Seal Config:	Copper Gasket
Nominal K-Factor (US):	Not Specified	Releasing Mechanism:	Fusible Link
		Temp Rating (°F/°C):	160 / 71

Test Results

Fulfills NFPA 25 2017 Ed. 5.3.1.1

Sprinkler Number: 1

Test	Method	Test Value	Specification	Test Result
Appearance	NFPA 25 2017 Ed. 5.2.1.1	Determined During Floor Level Inspection		
Response Time, Sec.	LBTR-3404	48.3	25.5 - 132.8	Pass

Comments:

Pictures of these sprinklers, including an image of the waterway post testing, were made available via a link (active for 90 days) in the results email and are also available upon request. Dyne does not identify any appearance or waterway issues.

For a further explanation about results, see LBTR-4402 (Sprinkler Testing Explanation).

Kayla Kuhlman, Quality Manager

DYNE FIRE PROTECTION LABS

FIRE SPRINKLER TEST RESULTS

Report for:
Tri-City Fire Protection LLC
Dave Fusco
67 Meadowood Rd
Tolland CT 06084
PO# Planned Parenthood/CC

Job Name:
Planned Parenthood
1030 New Britain Ave
West Hartford CT 06110 United States

For Service Call: 860-872-3473

Job Number: 104600
Number of Sprinklers 6
Date Received: 09/04/2018
Report Date: 09/07/2018

Sprinkler Information

Location: Planned Parenthood Clean Room

Year Marking:	1956	Dry Sprinkler:	No
Manufacturer:	Reliable	Additional Attribute:	Not Specified
Identifier (Series, Model or SIN):	C	Coverage Type:	Standard Spray
Orientation:	Upright	Response Type:	Standard Response
Decorative Attribute:	Not Specified	Water Seal Config:	Copper Gasket
Nominal K-Factor (US):	Not Specified	Releasing Mechanism:	Fusible Link
		Temp Rating (°F/°C):	160 / 71

Test Results

Fulfills NFPA 25 2017 Ed. 5.3.1.1

Sprinkler Number: 2

Test	Method	Test Value	Specification	Test Result
Appearance	NFPA 25 2017 Ed. 5.2.1.1	Determined During Floor Level Inspection		
Response Time, Sec.	LBTR-3404	65.5	25.5 - 132.8	Pass

Comments:

Pictures of these sprinklers, including an image of the waterway post testing, were made available via a link (active for 90 days) in the results email and are also available upon request. Dyne does not identify any appearance or waterway issues.

For a further explanation about results, see LBTR-4402 (Sprinkler Testing Explanation).

Kayla Kuhlman, Quality Manager

Dyne FIRE PROTECTION LABS

FIRE SPRINKLER TEST RESULTS

Report for:	Job Name:		
Tri-City Fire Protection LLC	Planned Parenthood	Job Number:	104600
Dave Fusco	1030 New Britain Ave	Number of Sprinklers	6
67 Meadowood Rd	West Hartford CT 06110 United States	Date Received:	09/04/2018
Tolland CT 06084		Report Date:	09/07/2018
PO# Planned Parenthood/CC	For Service Call: 860-872-3473	Page:	Page 3 of 6

Sprinkler Information

Location: Planned Parenthood Recover

Year Marking:	1956	Dry Sprinkler:	No
Manufacturer:	Reliable	Additional Attribute:	Not Specified
Identifier (Series, Model or SIN):	C	Coverage Type:	Standard Spray
Orientation:	Pendent	Response Type:	Standard Response
Decorative Attribute:	Not Specified	Water Seal Config:	Copper Gasket
Nominal K-Factor (US):	Not Specified	Releasing Mechanism:	Fusible Link
		Temp Rating (°F/°C):	160 / 71

Test Results

Fulfills NFPA 25 2017 Ed. 5.3.1.1

Sprinkler Number: 3

Test	Method	Test Value	Specification	Test Result
Appearance	NFPA 25 2017 Ed. 5.2.1.1	Determined During Floor Level Inspection		
Response Time, Sec.	LBTR-3404	45.7	25.5 - 132.8	Pass

Comments:

Pictures of these sprinklers, including an image of the waterway post testing, were made available via a link (active for 90 days) in the results email and are also available upon request. Dyne does not identify any appearance or waterway issues.

For a further explanation about results, see LBTR-4402 (Sprinkler Testing Explanation).

Kayla Kuhlman, Quality Manager

DyneFIRE PROTECTION LABS

FIRE SPRINKLER TEST RESULTS

Report for:
Tri-City Fire Protection LLC
Dave Fusco
67 Meadowood Rd
Tolland CT 06084
PO# Planned Parenthood/CC

Job Name:
Planned Parenthood
1030 New Britain Ave
West Hartford CT 06110 United States

For Service Call: 860-872-3473

Job Number: 104600
Number of Sprinklers 6
Date Received: 09/04/2018
Report Date: 09/07/2018
Page: Page 4 of 6

Sprinkler Information

Location: Planned Parenthood Room 3

Year Marking:	1956	Dry Sprinkler:	No
Manufacturer:	Reliable	Additional Attribute:	Not Specified
Identifier (Series, Model or SIN):	C	Coverage Type:	Standard Spray
Orientation:	Upright	Response Type:	Standard Response
Decorative Attribute:	Not Specified	Water Seal Config:	Copper Gasket
Nominal K-Factor (US):	Not Specified	Releasing Mechanism:	Fusible Link
		Temp Rating (°F/°C):	160 / 71

Test Results

Fulfills NFPA 25 2017 Ed. 5.3.1.1

Sprinkler Number: 4

Test	Method	Test Value	Specification	Test Result
Appearance	NFPA 25 2017 Ed. 5.2.1.1	Determined During Floor Level Inspection		
Response Time, Sec.	LBTR-3404	47.7	25.5 - 132.8	Pass

Comments:

Pictures of these sprinklers, including an image of the waterway post testing, were made available via a link (active for 90 days) in the results email and are also available upon request. Dyne does not identify any appearance or waterway issues.

For a further explanation about results, see LBTR-4402 (Sprinkler Testing Explanation).

Kayla Kuhlman, Quality Manager

DYNE FIRE PROTECTION LABS

FIRE SPRINKLER TEST RESULTS

Report for:	Job Name:		
Tri-City Fire Protection LLC	Planned Parenthood	Job Number:	104600
Dave Fusco	1030 New Britain Ave	Number of Sprinklers	6
67 Meadowood Rd	West Hartford CT 06110 United States	Date Received:	09/04/2018
Tolland CT 06084		Report Date:	09/07/2018
PO# Planned Parenthood/CC	For Service Call: 860-872-3473	Page:	Page 5 of 6

Sprinkler Information

Location: Planned Parenthood Room 1

Year Marking:	1956	Dry Sprinkler:	No
Manufacturer:	Reliable	Additional Attribute:	Not Specified
Identifier (Series, Model or SIN):	C	Coverage Type:	Standard Spray
Orientation:	Upright	Response Type:	Standard Response
Decorative Attribute:	Not Specified	Water Seal Config:	Copper Gasket
Nominal K-Factor (US):	Not Specified	Releasing Mechanism:	Fusible Link
		Temp Rating (°F/°C):	160 / 71

Test Results

Fulfills NFPA 25 2017 Ed. 5.3.1.1

Sprinkler Number: 5

Test	Method	Test Value	Specification	Test Result
Appearance	NFPA 25 2017 Ed. 5.2.1.1	Determined During Floor Level Inspection		
Response Time, Sec.	LBTR-3404	48.9	25.5 - 132.8	Pass

Comments:

Pictures of these sprinklers, including an image of the waterway post testing, were made available via a link (active for 90 days) in the results email and are also available upon request. Dyne does not identify any appearance or waterway issues.

For a further explanation about results, see LBTR-4402 (Sprinkler Testing Explanation).

Kayla Kuhlman, Quality Manager

DYNE FIRE PROTECTION LABS

FIRE SPRINKLER TEST RESULTS

Report for:
Tri-City Fire Protection LLC
Dave Fusco
67 Meadowood Rd
Tolland CT 06084
PO# Planned Parenthood/CC

Job Name:
Planned Parenthood
1030 New Britain Ave
West Hartford CT 06110 United States

For Service Call: 860-872-3473

Job Number:	104600
Number of Sprinklers	6
Date Received:	09/04/2018
Report Date:	09/07/2018
Page:	Page 6 of 6

Sprinkler Information

Location: Planned Parenthood Break Room

Year Marking:	1956	Dry Sprinkler:	No
Manufacturer:	Viking	Additional Attribute:	Not Specified
Identifier (Series, Model or SIN):	C	Coverage Type:	Standard Spray
Orientation:	Pendent	Response Type:	Standard Response
Decorative Attribute:	Not Specified	Water Seal Config:	Copper Gasket
Nominal K-Factor (US):	Not Specified	Releasing Mechanism:	Fusible Link
		Temp Rating (°F/°C):	160 / 71

Test Results

Fulfills NFPA 25 2017 Ed. 5.3.1.1

Sprinkler Number: 6

Test	Method	Test Value	Specification	Test Result
Appearance	NFPA 25 2017 Ed. 5.2.1.1	Determined During Floor Level Inspection		
Response Time, Sec.	LBTR-3404	51.3	25.5 - 132.8	Pass

Comments:

Pictures of these sprinklers, including an image of the waterway post testing, were made available via a link (active for 90 days) in the results email and are also available upon request. Dyne does not identify any appearance or waterway issues.

For a further explanation about results, see LBTR-4402 (Sprinkler Testing Explanation).

Kayla Kuhlman, Quality Manager

DYNE FIRE PROTECTION LABS

TRI-CITY FIRE PROTECTION, LLC

67 MEADOWOOD RD. TOLLAND, CT. 06084
OFFICE : 860-872-3473 F1-40324

Office : 860-872-3473 FAX:860-926-4346 CELL:860-836-8194

FIRE SPRINKLER 5 YEAR INTERNAL INSPECTION REPORT

SERVICE LOCATION
NAME: PLANNED PARENTHOOD
ADDRESS: 1030 NEW BRITIAN AVE
CITY, STATE, ZIP: W. HTFD CT
SERVICE DATE: 8-30-18
INSPECTOR: DAVID FUSCO
WORK ORDER #: FI-40324
ACCESS NOTES:

OWNER/AGENT CONTACT INFO
NAME: HERSHFIELD PROPERTIES
ADDRESS: 1030 NEW BRITIAN AVE
CITY, STATE, ZIP: W. HTFD CT
CONTACT: CHRIS STAR
PHONE:
FAX:
EMAIL:

ALARM VALVE INTERNAL INSPECTION: ALL NEW GAUGES

	YES	NO	N/A
1. VERIFIED THAT ALL COMPONENTS INCLUDING STRAINERS, FILTERS, AND RESTRICTION ORIFICES OPERATE, MOVE FREELY AND ARE IN GOOD CONDITION PER NFPA 25 13.4.1.2.	X		
2. INTERNAL COMPONENTS CLEANED/REPAIRED AS NECESSARY IN ACCORDANCE WITH THE MANUFACTURERS INSTRUCTIONS PER NFPA 25 13.4.1.3.1	X		

CHECK VALVE INTERNAL INSPECTION:

	YES	NO	N/A
1. VERIFIED ALL COMPONENTS OPERATE PROPERLY, MOVE FREELY AND ARE IN GOOD CONDITION PER NFPA 25 13.4.2.1	X		
2. INTERNAL COMPONENTS CLEANED/REPAIRED AS NECESSARY IN ACCORADANCE WITH THE MANUFACTURERS INSTRUCTIONS PER NFPA 25 13.4.2.2	X		

INTERNAL INSPECTION OF PIPING PER NFPA 25 2011 EDITION 14.2.1:

	YES	NO	N/A
1. OPENED A FLUSHING CONNECTION AT THE END OF MAIN AND REMOVED SPRINKLER TOWARD END OF ONE BRANCH LINE FOR PURPOSE OF INSPECTING FOR THE PRESENCE OF FOREIGN ORGANIC AND INORGANIC MATERIAL	X		
	HOME		

SYSTEM VALVES:	PASS: X FAIL:___ N/A:___	CROSS MAIN:	PASS: X FAIL:___ N/A:___
RISER:	PASS: X FAIL:___ N/A:___	BRANCH LINE:	PASS: X FAIL:___ N/A:___

OBSTRUCTION INVESTIGATION AND PREVENTION PER NFPA 25 2011 14.3.1:

	YES	NO	N/A
1. THE DISCHARGE OF OBSTRUCTIVE MATERIAL DURING ROUTINE WATER TESTS		X	
2. FOREIGN MATERIALS IN FIRE PUMPS, IN DRY PIPE VALVES, OR IN CHECK VALVES			X
3. FOREIGN MATERIAL IN WATER DURING DRAIN TESTS OR PLUGGING OF INSPECTORS TEST CONNECTIONS		X	
4. PLUGGED SPRINKLERS		X	
5. PLUGGED PIPING IN SPRINKLER SYSTEM DISMANTLED DURING BUILDING ALTERATIONS			X

6" VIKING MOD-E

STATIC = 95
RESIDUAL = 90

OBSTRUCTION INVESTIGATION AND PREVENTION PER NFPA 25 2011 14.3.1: COUNTINUED	YES	NO	N/A
6. FAILURE TO FLUSH YARD PIPING OR SURROUNDING PUBLIC MAINS FOLLOWING NEW INSTALLATIONS OR REPAIRS			X
7. ABNORMALLY FREQUESNT FALSE TRIPPING OF A DRY PIPE VALVE(S)			X
8. A SYSTEM THAT IS RETURNED TO SERVICE AFTER AN EXTENDED SHUTDOWN (MORE THEN 1 YR)			X
9. PINHOLE LEAKS			X
10. A 50% INCRESE IN THE TIME IT TAKES WATER TO TRAVEL TO THE INSPECTORS TEST CONNECTION FROM THE TIME THE VALVE TRIPS DURING A FULL FLOW TEST OF A DRY PIPE SPRINKLER SYSTEM WHERE COMPARED TO THE ORGINAL ACCEPTABLE TEST			X

COMMENTS & DEFICIENCIES

REMOVE 6 SPRINKLER HEADS FOR 50+ YEAR OLD TESTING. RESULTS PENDING. SENT TO INDEPENDANT TESTING LAB FOR SPRINKLER HEAD TESTING. ALL INTERNAL PIPE WAS IN GOOD STANDARD. NO SLUDGE OR SCALE IN MAINS, ALARM VA OR BRANCH LINES. NO SLUDGE IN 1" PIPE @ PENDANT HEADS

IT IS THE RESPONSIBILITY OF THE PROPERTY OWNER OR DESIGNATED REPRESENTATIVE THAT REQUESTED THIS INSPECTION TO REVIEW REPORTS AND CORRECT DEFICIENCIES NOTED

WATER FLOW SWITCH ACTIVATES FIRE ALARM PANEL

SIGNATURE & ACKNOWLEDGEMENT:

THIS TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS.

INSPECTOR: [signature] **OWNER:** _____

DATE: 8-30-18

Americans United for Life

SPRINKLER INSPECTION REPORT

Report To: PLANNED PARENTHOOD **LOCATION** _____

STREET 1030 NEW BRITAIN AVE **INSPECTOR** DAVE FUSCO

CITY, STATE, ZIP WEST HARTFORD CT **DATE** 8/30/2018

		Yes	N/A	No
1	**GENERAL**			
	a. Is the building occupied?	X		
	b. Is occupancy same as previous inspection?	X		
	c. Are all systems in service?	X		
	d. Are all fire protection systems same as last inspection?	X		
	e. Is hazard completely sprinkled?	X		
	f. Are all new additions and building changes properly protected?	X		
	g. Is all stock or storage properly below sprinkler piping?	X		
	h. Was property free of fires since last inspection? (Explain any fire on page 2)	X		
	i. In areas protected by wet system, does the building appear to be heated in all areas?	X		
2	**CONTROL VALVES**			
	a. Are all sprinkler system main control valves open?	X		
	b. Are all other valves in proper position?	X		
	c. Are all control valves in good condition and sealed or supervised?	X		
3	**WATER SUPPLY**			
	a. Was a water flow test made and results satisfactory?	X		
4	**TANK, PUMPS, FIRE DEPARTMENT CONNECTIONS**			
	a. Are pumps, reservoirs, gravity & pressure tanks in good condition and maintained?	X		
	b. Are fire department connections in satisfactory condition?	X		
5	**WET SYSTEMS**			
	a. Are cold weather valves open or closed as necessary?	X		
	b. Have anti-freeze systems been tested and left in satifactory condition?	X		
	c. Are alarm valves, water flow indicators and retards in satisfactory condition?	X		
6	**DRY SYSTEMS**			
	a. Is dry valve in service and in good condition?		X	
	b. Is air pressure and priming water level normal?		X	
	c. Is air compressor in good condition?		X	
	d. Were low points drained during fall and winter inspection?		X	
	e. Are Quick Opening Devices in service?		X	
	f. Has piping been checked for stoppage within the past 10 years?		X	
	g. Has piping been checked for proper pitch within the past 5 years?		X	
	h. Have dry valves been trip tested satisfactory as required?		X	
	f. Are Dry Valves adequately protected from freezing?		X	
	j. Valve house and heater condition satisfactory?		X	
7	**SPECIAL SYSTEMS**			
	a. Were valves tested as required?	X		
	b. Were all heat responsive systems tested and results satisfactory?	X		
	c. Were supervisory features tested and results satisfactory?	X		
8	**ALARMS**			
	a. Water motor and gong test satisfactory?	X		
	b. Electric alarm test satisfactory?	X		
	c. Supervisory alarm test satisfactory?	X		
9	**SPRINKLERS - PIPING**			
	a. Are all sprinklers in good condition, not obstructed, and free of corrosion?	X		
	b. Are all sprinklers less than 50 years old?		X	
	c. Are extra sprinklers readily available?	X		

	Yes	N/A	No
d. Is condition of piping, drain valves, check valves, hangers, pressure gauges, open sprinklers & strainers satisfactory?	X		
e. Are all sprinklers of proper temperature?	X		
f. Are Fire Hoses in satisfactory condition?	X		
g. Is hand held hose on sprinkler system satisfactory?	X		
10 **DATE DRY SYSTEM WAS LAST CHECKED FOR STOPPAGE:**			
11 **DATE DRY SYSTEM WAS LAST CHECKED For PROPER PITCH:**			
12 **DATE DRY PIPE VALVE WAS LAST TRIP TESTED:**			
13 **DATE LAST INTERNAL ALARM VALVE WAS TESTED:**			
14 **DATE LAST 5 YEAR TEST WAS COMPLETED:**		8/30/2018	

15 **WET SYSTEMS** **No?** **Make and Model?** 6" VIKING MODEL E

16 **DRY SYSTEMS:** **No?** **Make and Model?**

17 **SPECIAL SYSTEMS:** **No?** **Make and Model?**

18 **ALARM MONITORING COMPANY:**

19 **ALARM COMPANY PHONE:**

20 **ALARM ACCOUNT NUMBER OR PASS CODES:**

Control Valves	No?	Type?	Open?	Secured?	Closed?	Signs?	Condition
City Connection Control Valve	Y	OS&Y	Y	Y	N	Y	STEM GREASED AND GOOD CONDITION
Tank Control Valves							
Pump Control Valves							
Sectional Control Valves							
System Control Valves	Y	0S&Y	Y	Y	N	Y	STEM GREASED AND GOOD CONDITION

21 **Water Flow Test**

a. Water Pressure? City _____ PSI Tank _____ PSI Fire Pump _____

b. Water Flow Test? _____ (If none made, why?) _____

Test Pipe Located	Test Pipe Size	Pressure Before	Flow Pressure	Pressure After
BACK WALL	2"	95	90	95

22 **Explanation of Any "NO" Answer:** SPRINKLER HEADS ARE BEING SENT FOR TESTING

23 **RECENT CHANGES IN BUILDING OCCUPANCY OR FIRE PROTECTION EQUIPMENT:**

24 **ADJUSTMENTS OR CORRECTIONS MADE:**
5 YEAR INTERNAL INSPECTION COMPLETED W/ NEW GAUGES INSTALLED

25 **DESIRABLE IMPROVEMENTS:**

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

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

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

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

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.

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

August 23, 2018

Cassandra Lehr, Administrator
Hartford GYN Center
1 Main Street
Hartford, CT 06105

Dear Ms. Lehr:

Unannounced visits were made to Hartford GYN Center on July 6, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

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 visits.

An office conference has been scheduled for September 11, 2018 at 3:00 PM 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. Please be prepared to discuss those violations Identified with an asterisk.

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 September 5, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.
4. 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.

Connecticut Department of Public Health

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DATE(S) OF VISIT: July 6, 2018

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

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

Respectfully,

Donna Ortelle, RN, PHSM

Donna Ortelle, RN, PHSM
Public Health Services Manager
Facility Licensing and Investigations Section

DMO:mb

Americans United for Life

DATE(S) OF VISIT: July 6, 2018

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board, administrator (c).

1. Based on clinical record review, interview and policy review the facility failed to ensure that for three of three records reviewed that a physical was completed by a Licensed Independent Practitioner (LIP). The findings include the following:
   a. Patient #1 presented to the clinic on 4/14/18 for an elective termination. Review of the clinical record indicated that the physical exam was completed on 4/14/18 at 9:36 AM that indicated that lungs were auscultated and were clear in all fields, apical pulse auscultated heart tones audible, regular, within normal limits. The record indicated that the physical was completed by the ultrasound technician (US Tech) tech.
   b. Patient #2 presented on 5/12/18 for an elective termination. Review of the clinical record indicated that the physical exam was completed on 5/12/18 at 7:32 AM that indicated that lungs were auscultated and were clear in all fields, apical pulse auscultated heart tones audible, regular, within normal limits. The record indicated that the physical was completed by a registered nurse (R.N.).
   c. Patient #3 presented on 6/2/18 for an elective termination. Review of the clinical record indicated that the physical exam was completed on 6/2/18 at 7:57 AM that indicated that lungs were auscultated and were clear in all fields, apical pulse auscultated heart tones audible, regular, within normal limits. The record indicated that the physical was completed by the US tech.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D50 Nursing Personnel.

2. Based on clinical record review, interview and policy review the facility failed to ensure that for one patient that the patient was assessed prior to discharge. The findings include the following:
   a. Patient #1 presented to the clinic on 4/14/18 for an elective termination. A second trimester dilation and evacuation (D&E) was completed. The patient was brought to the procedure room at 1:27 PM, the procedure was started at 1:36 PM, and a time out was completed. The procedure was completed at 2:46 PM.
   The PACU record indicated that the patient arrived to PACU at 2:55 PM and vital signs were obtained at 2:55 PM, 3:10 PM and 3:25 PM. The record indicated that at 3:10 PM and that the patient was in severe pain and received Vicodin two tablets at 3:10 PM, and Benadryl 50 mg IV over two minutes. The patient's level of pain was identified as mild at 3:25 PM. The Discharge note dated 4/14/18 at 4:35 PM indicated that the patient was able to ambulate to the bathroom, presented as alert and oriented with stable and pain 5/10. The record reflected the administration of Ibuprofen at 4:36 PM and failed to identify that a pre and/or post assessment of the patient's level of pain was completed. In addition the record failed to reflect further vital signs after 3:25 PM and/or prior to discharge. Review of the facility policy indicated that a registered nurses (RN) assessment will be completed on admission, every fifteen minutes post procedure and at discharge.

DATE(S) OF VISIT: July 6, 2018

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

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D52 Maintenance.

3. Based on tour and observation the facility failed to ensure that a safe/ sanitary environment. The findings include the following:
   a. Tour of the facility on 7/13/18 at 9:30 AM identified that the procedure tables in Procedure rooms #1 and 2 had tears and rips in the bottom portion of the table making it unable to be thoroughly cleaned and sanitized.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D50 Nursing Personnel.

4. Based on clinical record review, interview and policy review the facility failed to ensure that documentation in the clinical record of intravenous fluid administration was complete and/or accurate. The findings include the following:
   a. Patient #1 presented to the clinic on 4/14/18 for an elective termination. The pre-procedure record indicated that an IV was inserted to the "left AC of saline" by the certified registered nurse anesthetist (CRNA). Review of the MD note indicated that it was a very difficult case, patients uterus pulled very high up due to a history of previous Cesarean section. The Patient also had a long cervix, only had an 11 extra-long suction cannula to use, fundal pressure was necessary throughout the case to bring the uterus close enough for extraction. A cervical laceration at 5 o'clock was on the cervix was repaired. Hemoglobin at the end of case was 9.5 (was 10.4 preop) and 1 liter of fluid with 20 units of Pitocin in it was administered. Review of the MAR indicated that 10 units of Pitocin were administered by the CRNA via IV at 2:37 PM. The medication administration record (MAR) failed to reflect the IV fluids/Pitocin administration.
   b. The post anesthesia care unit (PACU) record indicated that the patient arrived to PACU at 2:55 PM and that the IV was intact. The notes further indicated that the IV was discontinued, the fluid intake section of the PACU record indicated "continued from OR". However, the record failed to reflect the time of removal and/or the type of fluids administered and/or the amount of fluids absorbed by the patient. The Discharge note dated 4/14/18 at 4:35 PM indicated that the patient was able to ambulate to the BR, presented as alert and oriented with stable vital signs and pain 5/10.
   c. Patient #2 presented to the facility on 5/12/18. The record indicated that an IV was inserted at approximately 10:15 AM in the right antecubital. Review of the recovery room documentation indicated that the IV was intact. Although the documentation indicated that the IV was removed prior to discharge, the record failed to reflect the amount of fluid that was administered.
   d. Patient #3 presented to the facility on 6/2/18. The record indicated that an IV was inserted in the left antecubital. Review of the recovery room documentation indicated that the IV was intact. Although the documentation indicated that the IV was removed prior to

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

discharge, the record failed to reflect the amount of fluid that was administered.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D48 Professional staff (b)(4) and/or 19-13-D49 Records (b) and/or 19-13-D50 Nursing Personnel (c).

5. Based on review of the clinical records, review of policies and procedures and interviews with facility personnel for three of three patients reviewed (P #1, #2, and #3), the facility failed to ensure that documentation of clinical care was complete and/or accurate. The findings include:
   a. Although the facility was previously cited for the failure to include staff titles after their signature in the clinical record and the plan of correction dated 1/27/18 indicated that staff titles would be included as of 3/20/18, review of the clinical record for three of three patients failed to reflect the presence of staff titles. For 3 of 3 patients who underwent a surgical procedure within the timeframe of 4/14/18 through 5/12/18 failed to reflect that documentation completed by registered nurse, medical assistants and/or ultra sound technician contained the credentials of the staff person. Review of the clinical records with the Director on 7/13/18 identified the staff member's titles with the staff member's name.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D48 (b)(2) and/or (4).

6. Based on clinical record review and policy review the facility failed to ensure that for 1 patient reviewed (P #1) that the consent form for anesthesia was completed by the LIP providing anesthesia and/or that for 2 of 2 records (P #1 and P #3) reviewed that the patient's level of sedation was documented. The findings include the following:
   a. Review of Patient #1's clinical record indicated that the patient presented to the clinic on 4/14/18 for an elective termination. The pre-procedure record indicated that an IV was inserted by the certified registered nurse anesthetist (CRNA). The record indicated that the consent for intravenous (IV) sedation was signed by the facility counselor and the patient. Review of the IV sedation consent form obtained from the facility indicated that the CRNA should sign the consent form.
   b. Patient #1's clinical record indicated that the patient received 800 mg of intravenous Diprovan during the period of 1:34 PM and 2:21 PM, the clinical record failed to reflect that patient's level of sedation. The facility policy indicated IV sedation is based on the clinical judgement of the anesthetist, however, does not address documentation of the level of sedation.
   c. Patient #3's clinical record indicated that the patient received 450 mg of intravenous Diprovan during the period of 10:02 AM and 10:15 AM, the clinical record failed to reflect that patient's level of sedation.

· Hartford Gyn Center – POC for VL dated 8/23/18

September 10, 2018

OK
HAE
9/26/18

Donna Ortelle, RN, PHSM
410 Capitol Ave
PO Box 340308
Hartford, CT. 06134-0308

Dear Donna Ortelle,

Thank you for sending me the report of our unannounced visit on July 6th, 2018. Please see the following plan of corrections and supporting documentation attached.

1a, 1b, 1c.

1. In accordance with our "History and Physical Examination" policy (updated 8/1/18 & attached), Hartford GYN Center will ensure that a practitioner will examine the patient immediately before their procedure. All practitioners have received and reviewed this policy. To ensure compliance with this policy, a random chart review was started on August 14th 2018 and will continue for 3 months, 10 charts a month will be reviewed. A monthly report of chart review findings will be made to the Governing Board to ensure compliance. ✓
2. August 13th, 2018.
3. Administrator.

2a.

1. Hartford GYN Center will ensure that all patients are assessed and discharged in accordance with our "Routine Post-Procedure Care in the Recovery Room" policy (attached). We will have a meeting with all nurses regarding our current policy and procedure for assessment and documentation of pain management and our policy and procedure for assessment and documentation of vital signs. To ensure compliance with this policy, a random chart review was started on September 16th 2018 and will continue for 3 months, 10 charts a month will be reviewed. ✓
2. September 15th, 2018.
3. Administrator.

3a.

1. Hartford GYN Center will replace the bottom portion of our procedure tables. If we are unable to replace the bottom portion, we will replace the entire table. ✓
2. October 31st 2018
3. Administrator.

4a, 4b, 4c and 4d.

Americans United for Life

1. Hartford GYN Center will ensure that the documentation of the type and amount of IV fluid will be in every chart. Hartford GYN Center will hold a meeting(s) with all CRNAs and nurses regarding the importance of this documentation. To ensure complete documentation, a random chart review will be done on 10 charts a month for three months starting September 15th, 2018. A monthly report of chart review findings will be made to the Governing Board to ensure compliance.
2. September 15th, 2018.
3. Administrator.

5a.

1. Hartford GYN Center will continue to work with our EMR system to populate automatically the letters RN in signatures of registered nurses and MA in signatures of medical assistants when these individuals are documenting in EMR. In the interim, an in-service will be held with all RNs and MAs to reinforce the requirement of documenting RN, if a registered nurse, and MA, if a medical assistant, when documenting in EMR. To ensure complete documentation, a random chart review will be done on 10 charts a month for three months starting September 15th, 2018. A monthly report of chart review findings will be made to the Governing Board to ensure compliance.
2. November 1st, 2018.
3. Administrator.

6a.

1. Hartford GYN Center has updated our IVS consent to include the CRNA's signature and updated all CRNAs of the need for their signature on this form. Please see "Consent to IV Sedation" attached. To ensure appropriate completion of this consent, a random chart review was started on August 14th 2018 and will continue for 3 months, 10 charts a month will be reviewed. A monthly report of chart review findings will be made to the Governing Board to ensure compliance.
2. August 13th, 2018.
3. Administrator.

6b and 6c.

1. Hartford GYN Center will continue to ensure that all CRNAs provide procedural pain management in accordance with the HGC "Procedural Pain Management" Policy and with attention to complete and accurate documentation as noted in the approved Plan of Corrections submitted on February 27, 2018 and approved on March 27, 2018. A review of applicable regulations (including Section 19-13-D48(b)(2) and/or (4) does not contain a requirement for listing level of sedation in the record. As such, the Governing Board will continue to advise the CRNAs to document in accordance with all current policies.
2. Current and on-going.
3. Administrator.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Planned Parenthood New London
45 Franklin ST
New London, CT
M:

FLIS Staff

Robin Sorrens Nurse Consultant
Linda Gagnon HPA

Licensure Category:

Planned Parenthood

Licensed Bed
Bassinet Capacity:

Census:

Date(s) of onsite inspection: 4/30/19

Date(s) additional information obtained:

Personnel contacted: Esperanza Deleon Santana DANIKA Wynn

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other (e.g.strikes):*

[ ] Visit **OR** Revisit for the purpose of

[ ] See Complaint Investigation #

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated

[ ] Desk Audit [ ] Amended Letter: Original Ltr.

[ ] Citation # was issued to this facility as a result of this inspection.

[X] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to

REPORT SUBMITTED BY: Robin Sorrens **DATE OF REPORT:** 4-30-19

[X] Approval for issuance of license granted by: Loan D Nguyen **DATE:** 5-7-19
Supervisor/Title

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

October 9, 2019

Janeen Ortiz, Regional Manager
Planned Parenthood Of Connecticut Inc-Hartford
1229 Albany Avenue
Hartford, CT 06112

Dear Ms. Ortiz:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc-Hartford on May 10, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing survey inspection with additional information received through June 3rd, 2019.

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.

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 is to be submitted to the Department by October 23, 2019

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 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.

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 October 23, 2019 or if a request for a meeting is not made by the stipulated

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DATE(S) OF VISIT: May 10, 2019

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

date, the violations shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-47 Governing Board, Administrator (a)(2) and/or 19-13-D48 Professional Staff (b)(5) and/or 19-13-D52

DATE(S) OF VISIT: May 10, 2019

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

Maintenance.

1. Based on review of credentialing files and a review of facility documentation, the facility failed to ensure their medical staff is appointed annually. The findings include:
   a. Review of medical staff credentialing files on 5/10/19 identified that the medical staff were not credentialed annually. Interview with the Regional Manager on 5/10/19 identified that they were not aware that the medical staff needed to be credentialed annually. Review of facility policy revealed they are appointing and re-appointing their medical staff for a term of 3 years.

2. Based on review of personnel files, review of facility documentation and observations, the facility failed to ensure that their employees tuberculosis screening was current and/or the emergency eye wash station water temperature was not monitored. The findings include:
   a. Review of personnel files identified that the tuberculosis screening for employees was not current. Review of personnel record for PA#1 revealed he/she had their last tuberculosis screening in March of 2016. Review of personnel record for LPN #1 revealed he/she had their last tuberculosis screening in 2015. Review of CA#1's personnel record revealed he/she is a new employee as of April 15th 2019 and had not had tuberculosis screening. Interview with the Regional Manager on 6/3/19 identified that all new employees should have tuberculosis screening on or before their first day of employment. The Regional Manager indicated that this facility did not have a health center manager for a few months and some things "slipped through the cracks". Review of facility policy revealed the employees should have tuberculosis screening every three years and initially at date of hire.
   b. Review of the facilities quality assurance logs identified that the facility failed to monitor the temperature of the water at their emergency eye wash station. The temperature of the water was seen at 125 degrees. Interview with the Regional Manager on 6/3/19 identified that the facility was not checking the water temperature in the eye wash station. Review of the American National Standards Institute and the Occupational Safety and Health Administration recommendations were to keep the temperature between 60 to 100 degrees Farenheit.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

October 9, 2019

Esperanza Dejesus-Santana, Center Manager
Planned Parenthood Of Connecticut Inc-Danielson
87 Westcott Road
Danielson, CT 06239

Dear Ms. Esperanza:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Danielson on July 2, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through July 2, 2019.

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.

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 is to be submitted to the Department by October 23, 2019.

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 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.

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 October 23, 2019 or if a request for a meeting is not made by the stipulated

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

date, the violations shall be deemed admitted.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D51 Pharmaceuticals (1)(2)(3)(4) and /or 19-13-D52 Maintenance.

DATE(S) OF VISIT: July 2, 2019

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

1. Based on facility documentation and inspection of medication storage, the facility failed to ensure that vaccines were not expired. The findings include:
   a. Observation of medication refrigerator storage on 7/2/19 at 10:00am revealed two vials of Tuburculine (purified protein derivitive) PPD which were opened for over 28 days. Further observation of the medication storage cabinet revealed two Liletta intra-uterine devices which had expiration dates of 04/2019. Interview with the Center administrator on 7/2/19 at 11)0am revealed that staff checks for expired meds on a routine basis and the expired medications should not have been left in storage after being identified.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D48, Professional Staff (a)(5) and/or 19-13-D52 Maintenance.

2. Based on review of personnel files, facility documentation and interviews with personnel, the facility failed to ensure the medical providers were appointed annually. The findings include:
   a. Review of credential files for all medical providers identified that medical staff were not appointed annually. Interview with the Center Administrator on 7/2/19 identified that they were not aware that credentialing of medical staff needed to be completed on an annual basis.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

November 6, 2019

Jennifer Tomasini, Center Manager
Planned Parenthood Of Connecticut Inc-Stamford
35 Sixth Street
Stamford, CT 06902

Dear Ms. Tomasini:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc-Stamford on August 15, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through August 28, 2019.

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.

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 is to be submitted to the Department by November 20, 2019.

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 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.

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 November 20, 2019 or if a request for a meeting is not made by the stipulated

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DATE(S) OF VISIT: August 15, 2019

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

date, the violations shall be deemed admitted.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-D52 Maintenance.

DATE(S) OF VISIT: August 15, 2019

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

1. Based on observations and interviews with facility personnel, the facility failed to ensure that equipment was maintained in good state of repair and able to be properly disinfected. The findings include:
   a. Observation of the procedure room on 8/15/19 at 10:30am identified a stool which is used by the provider during procedures, with a large rip in the cover which was exposing the foam underlayment. Interview with the Health Center Manager on 8/15/19 indicated that they would have the stool replaced.

2. Based on observation and interviews with facility personnel, the facility failed to ensure that infectious waste/biohazard materials were sealed to prevent leakage. The findings include:
   a. Observation of the procedure on 8/15/19 at 10:30am identified two full biohazard bins with the covers left open containing the disposed contents from procedures from the day before. Interview with the Health Center Manager identified the garbages and biohazard bins are supposed to be emptied at the end of the day when procedures take place.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D52 Maintenance and/or19-13-D51 Pharmaceutical.

3. Based on observation, the facility failed to remove expired medications from patient medication supply. The findings include:
   a. Observation of the storage closet on 8/15/19 at 11:00am, identified patient medication which had an expiration date of July 2019. Interview with the Health Center Manager on 8/15/19 revealed the expired medications should have been removed during monthly routine checks.

Americans United for Life

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

October 9, 2019

Antoinetta Schaalman, RN, Center Administrator
Planned Parenthood Of Connecticut Inc-Waterbury
969 West Main Street
Waterbury, CT 06702

Dear Ms. Schaalman:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc -Waterbury on May 9, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing 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.

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 is to be submitted to the Department by October 23, 2019

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 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.

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 October 23, 2019 or if a request for a meeting is not made by the stipulated

Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph
Affirmative Action/Equal Opportunity Employer

DATE(S) OF VISIT: May 9, 2019

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

date, the violations shall be deemed admitted.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

The following are violations of the Regulation of Connecticut State Agencies Section 19-13-47 Governing Board, Administrator(a)(2) and/or 19-13-D48 Professional Staff (b)(5) and/or 19-13-D52

DATE(S) OF VISIT: May 9, 2019

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

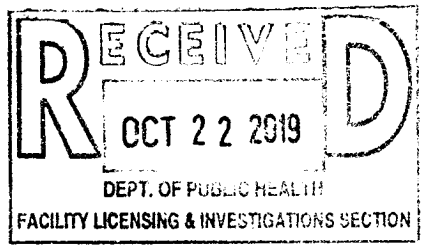
Maintenance.

1. Based on review facility documentation, the facility failed to ensure their medical staff were appointed annually. The findings include:
   a. Review of medical staff credentialing files on 5/9/19 identified that the medical staff were not credentialed annually. Review of facility policy revealed they are appointing and re-appointing their medical staff for a term of 3 years. Interview with the Center Administrator on 5/9/19 identified that they were not aware that the edical staff needed to be credentialed annually.

2. Based on facility documentation and observation, the facility failed to monitor the eye wash station water temperature. The findings include:
   a. Review of the facilities quality assurance logs identified that the facility was not checking the temperature of the water at their emergency eye wash station. The temperature of the water was seen at 120 degrees. Review of the American National Standards Institute and the Occupational Safety and Health Administration recommendations were to keep the temperature between 60 to 100 degrees farenheit. Interview with the Center Administrator on 5/9/19 indicated that the eye wash station temperature was not completed.

10/18/19

OK
10/22/19
HAC



Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

Dear Ms. Caron,

Thank you for your letter dated 10/9/19. I am happy to say that both of our violations have been addressed.

Violation 1 Facility failed to ensure the medical providers are appointed annually.

Plan of Correction:

Planned Parenthood of Southern New England has changed our policy as a result of this violation. Licensed medical providers are now appointed annually after they are reviewed by the credentialing committee. The credentialing manager holds the appointment letters and can provide them upon request.

Violation 2 Facility failed to monitor eyewash station temperature.

Plan of Correction:

Since your visit on 5/9/19, we have had saline eyewash stations installed. We are not able to control the temperature of our water adequately, so we have moved to the wall-mounted saline station. The faucet mounted eyewash stations have been removed.

If there are any questions, please do not hesitate to contact me at 203-574-2051.

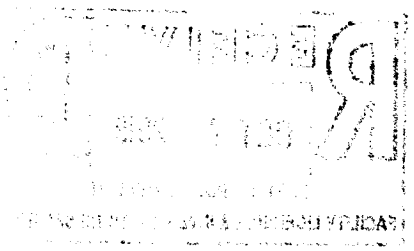
Respectfully

Antoinetta Schaalman, RN, CM

,

Antoinetta Schaalman, RN, Center Manager
Waterbury Planned Parenthood
969 West Main Street
Waterbury, CT 06708

Americans United for Life



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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity

Planned Parenthood New London
45 Franklin ST
New London, CT
M:

FLIS Staff

Robin Sorrens Nurse Consultant
Linda Gagnon HPA

Licensure Category:

Planned Parenthood

Licensed Bed
Bassinet Capacity:

Census:

Date(s) of onsite inspection: 4/30/19

Date(s) additional information obtained:

Personnel contacted: Esperanza Deleon Santana DANIKA Wynn

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [X] *Renewal* [ ] *Other (e.g.strikes):*

[ ] Visit **OR** Revisit for the purpose of

[ ] See Complaint Investigation #

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated

[ ] Desk Audit [ ] Amended Letter: Original Ltr.

[ ] Citation # was issued to this facility as a result of this inspection.

[X] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referral(s) to

REPORT SUBMITTED BY: Robin Sorrens **DATE OF REPORT:** 4-30-19

[X] Approval for issuance of license granted by: Loan D Nguyen **DATE:** 5-7-19
Supervisor/Title

Planned Parenthood
Care. No matter what.

345 Whitney Avenue
New Haven, CT 06511
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ppsne.org

Planned Parenthood of Southern New England

November 4, 2019

Heidi Caron, MSN, RN, BC, CLINC
Supervising Nurse consultant
Facility Licensing and investigations Section
CT Department of Public Health
410 Capitol Avenue, PO Box 340308
Hartford, CT 06134-0308

Dear Ms. Caron:

This letter is in reference to the violations identified on your May 10, 2019 visit to our health center for a licensing survey inspection.

Our plan of correction is as follows:

1. A new Health Center Manager and Assistant Health Center Manager were appointed to the role at the time of the inspection. Since then, there are systems in place to ensure regular monitoring of personnel files including a monthly review of all files and scheduled follow up with each staff prior to expiration of TB testing, required vaccinations and licensure (if applicable).
2. After your inspection, the PA, LPN and CA whose TB testing had expired had subsequent TB testing that was negative on 5/13/19. This documentation was then provided to you for your records.
3. Continuous monitoring of personnel files will be ensured through appointments between the Health Center Manager and Assistant Health Center Manager that recur monthly in our email system, Microsoft Outlook, to ensure that not one, but two individuals are monitoring these files to ensure completion and accuracy.
4. The new Health Center Manager is myself, Amina Carter, MPH, PA-C and the new Assistant Health Center Manager is Cassandra Bonilla, LPN.
5. New single-use eye wash stations were installed to be in better compliance with OSHA recommendations. This water is kept at room temperature.

If you have any additional questions or recommendations, please do not hesitate to reach out directly.

Regards,

Amina Carter, MPH, PA-C, Health Center Manager
Planned Parenthood of Southern New England, Hartford North
1229 Albany Avenue
Hartford, CT 06110
Amina.carter@ppsne.org
(P) 860-728-0203
(F) 860-380-3014

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ppsne.org

Planned Parenthood of Southern New England

10/10/19

Dear Ms. Caron,

Thank you for your letter dated 10/9/19. I am happy to say that both of our violations have been addressed.

Violation 1. Based on facility documentation and inspection of medication storage, the facility failed to ensure that vaccines were not expired (and birth control device).

Plan of Correction:

On July 2, 2019, I personally reviewed the inspection findings with each individual staff member. I discussed our policy and consequences of noncompliance.

On July 9, 2019, at a staff meeting, I reviewed PPSNE's **Medication Inventory Policy** which includes management of medications, vaccines and handling once expired. We have implemented a sticker system where we label all medications and birth control 3 months in advance of expiring. Vaccines are labeled with the opened date and the 28 day expiration date. The staff checks the vaccine expiration date weekly. These procedures alert us well in advance of an expiring medication, birth control method or vaccine. Medications, vaccines and birth control methods are routinely examined and labeled as above when necessary.

Violation 2. Facility failed to ensure the medical providers are appointed annually.

Plan of correction:

Planned Parenthood of Southern New England has changed our policy as a result of this violation. Licensed medical providers are now appointed annually after they are reviewed by the credentialing committee. The credentialing manager holds the appointment letters and can provide them upon request.

If there are any questions, please do not hesitate to contact me at 860-774-0533.

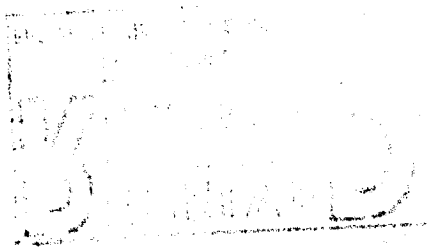
Sincerely,

Esperanza DeJesus-Santana

Esperanza DeJesus-Santana, Center Manager

RECEIVED
OCT 16 2019
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

Americans United for Life



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Planned Parenthood of Southern New England

IPC Cert 2-20-20

11/19/19

Dear Ms. Caron,

Thank you for your letter dated 11/6/19. I am happy to say that all of our violations have been addressed.

Violation 1. Facility failed to ensure that equipment was maintained in good state of repair and able to be properly disinfected.

Plan of Correction: The stool in question has been discarded and replace with a new stool.

Violation 2. Facility failed to ensure that infectious waste/biohazard materials were sealed to prevent leakage (overfull, open biohazard containers).

Plan of Correction:

On 8/16/19, the center manager reviewed proper biohazard use and storage with staff members. The containers in questions were removed, sealed and placed in proper biohazard storage for removal. Policy reviewed and proper biohazard material use and handling is in place.

Violation 3. Based on observation, the facility failed to remove expired medications form patient medication supply:

Plan of Correction:

On 08/16/19, the center manager reviewed the inspection findings with each individual staff member. She discussed our policy and consequences of noncompliance.

We have reviewed PPSNE's **Medication Inventory Policy** which includes management of medications, vaccines and handling once expired. We have implemented a sticker system where we label all medications and birth control 3 months in advance of expiring. These procedures alert us well in advance of an expiring medication, birth control method or vaccine. Medications, vaccines and birth control methods are routinely examined and labeled as above when necessary.

If there are any questions, please do not hesitate to contact me at 203-327-2722.

Sincerely,

Brittany Williams

Regional Director

Brittany Williams

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for Life