Planned Parenthood®
of Middle & East Tennessee, Inc.

April 8, 2010

State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Division of Health Care Facilities
227 French Landing, Suite 501
Nashville, TN 37243

Dear Ms. Jones,

We are requesting a name change for our facility. On July 1, 2000 Planned Parenthood of Middle Tennessee changed their name to Planned Parenthood of Middle & East Tennessee. This name change was also registered with the Tennessee Secretary of State on July 1, 2000.

If I can be of further assistance please let me know.

Sincerely,

Jeff Teague
President/CEO

Planned Parenthood®
of Middle & East Tennessee, Inc.

April 8, 2010

RECEIVED
APR 13 2010
Health Care Facilities

State of Tennessee
Department of Health
Bureau of Health Licensure and Regulation
Division of Health Care Facilities
227 French Landing, Suite 501
Nashville, TN 37243

Dear Ms. Jones,

We are requesting a name change for our facility. On July 1, 2000 Planned Parenthood of Middle Tennessee changed their name to Planned Parenthood of Middle & East Tennessee. This name change was also registered with the Tennessee Secretary of State on July 1, 2000.

If I can be of further assistance please let me know.

Sincerely,

Jeff Teague

Jeff Teague
President/CEO

Americans United for Life

Administrative & Education Office: 50 Vantage Way, Suite 102 • Nashville, TN 37228 • 615-345-0952 • Fax 615-345-0958
Nashville Health Center: 615-321-7216 • Knoxville Health Center: 865-694-7155

TENNESSEE DEPARTMENT OF HEALTH
FEE RENEWAL INVOICE

AMBULATORY SURGICAL TREATMENT CENTER

Online Renewal Now Available At www.tennesseeanytime.org/hlrs

PLEASE RETURN THIS FORM ALONG WITH THE ENCLOSED APPLICATION IN THE ENVELOPE PROVIDED

License No: 0000000015 License Status: LICENSED

Expiration Date: 06/30/2010

File ID: 00000015

Transaction No. 000002527

Telephone No. 615-345-0952

JEFFREY TEAGUE
PLANNED PARENTHOOD OF MIDDLE AND EAST TE
50 VANTAGE WAY
SUITE 102
NASHVILLE TN 37228

Facility Location Address:

PLANNED PARENTHOOD OF MIDDLE AND EAST TE
412 D. B. TODD BOULEVARD
NASHVILLE TN 37203

Amount Due: 1,080.00

In making this application, I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements set forth in the Tennessee Code Annotated 68-11-201 sequential and the Rules and Regulations of the State of Tennessee for this type of facility.

SIGNATURE _____ DATE _____

DO NOT WRITE BELOW THIS LINE ---- DO NOT SEPARATE ANY PART OF THIS FORM

DCF300 10083

PH-2092 REV. 4-99

MAKE CHECK OR MONEY ORDER PAYABLE TO THE DEPARTMENT OF HEALTH

RDA-1694

DO NOT SEND CASH

343 05 40010 1,080.00

MAIL TO:

DEPARTMENT OF HEALTH
C/O DEPARTMENT OF REVENUE
P O BOX 198990
NASHVILLE TN 37219-8990

00000015
JEFFREY TEAGUE
PLANNED PARENTHOOD OF MIDDLE AND EAST TE
50 VANTAGE WAY
SUITE 102
NASHVILLE TN 37228

Total Amount Due: $ 1,080.00

34305400100006000000000001505350000025270000108000000000000000000108000008

Americans United for Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	R 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 001}	1200-8-10 Initial A desk review for the Plan of Correction (POC) was conducted for all previous deficiencies cited on 8/27/19. All deficiencies have been corrected and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		

PRINTED: 09/05/2019
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING 01 - MAIN B. WING	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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A 001	1200-8-10 Initial This Rule is not met as evidenced by: Construction Type: II (111) Stories: 1 Constructed: 1950's (no drawings available) Sprinkled: NO Census: 0 Certified beds: 2 procedure rooms A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 8/27/2019. During this life safety survey, this facility was found in substantial compliance with the requirements for participation in Medicare/Medicaid with chapter 1200-08-10, Standards for Ambulatory Surgical Treatment Centers., Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012.	A 001		
A 002	1200-8-10 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on 8/27/2019, no deficiencies were cited under 1200-08-10, Standards for Ambulatory Surgical Treatment Centers.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Denison, Administrator
TITLE: 9/5/19
(X6) DATE

STATE FORM 6899 Q0AJ21 If continuation sheet 1 of 1

45th Day 4/19/19

2019

PRINTED: 03/11/2019
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #2	TNPL53526	A. BUILDING: _____ B. WING _____ 4/3/19 DR	03/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

Accepted

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is not met as evidenced by: An annual Licensure survey was conducted on 3/4/19 - 3/5/19 at Knoxville Center for Reproductive Health. The facility was found to not be in substantial compliance with Chapter 1200-8-10, Standards for Ambulatory Surgery Treatment Centers.	A 001		
A 425	1200-8-10-.04(20)(b) Administration (20) Infection Control. (b) The physical environment of the ambulatory surgical treatment center shall be maintained in a safe, clean and sanitary manner. This Rule is not met as evidenced by: Based on review of review of review of the Association of Professionals in Infection Control and Epidemiology (APIC) guidelines, observation, and interview, the facility failed to ensure prefilled syringes were properly labeled for 8 of 8 syringes in 1 of 1 pre-procedure work areas observed. The findings included: Review of APIC guidelines, "Safe Injection, Infusion, and Medication Vial Practices in Healthcare," dated 2016, revealed "...draw up medication into a syringe as close to administration time as feasible. Inject with 1 hour...after drawing up the medication...label all syringes containing medication if not immediately administered. Include patient identification information, names and amounts of all	A 425	Syringes shall be properly identified with pre-printed medication labels and will include the required information. The nursing supervisor will be responsible for monitoring this practice to ensure all syringes are properly identified and prepared in accordance with the standard to ensure compliance. 3/18/19 All staff responsible for handling and preparing the syringes have been trained and educated in the practice noted above. 3/15/19	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Dennison TITLE: Administrator (X6) DATE: 3/18/19

STATE FORM 6899 VGXG11 If continuation sheet 1 of 2

Americans United for Life

APR 01 2019

45th Day 10/11/19

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #2	TNPL53526	A. BUILDING _____ B. WING _____ 9/23/19	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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A 001	1200-8-10 Initial This Rule is not met as evidenced by: A Licensure survey was conducted on 8/26/19 - 8/27/19 at Knoxville Center for Reproductive Health. The facility was found to not be in substantial compliance with Chapter 1200-8-10, Standards for Ambulatory Surgery Treatment Centers.	A 001	The Nursing Supervisor/Infection Control officer will be responsible for monitoring compliance of all deficiencies cited.	9/30/19
A 425	1200-8-10-.04(20)(b) Administration (20) Infection Control. (b) The physical environment of the ambulatory surgical treatment center shall be maintained in a safe, clean and sanitary manner. This Rule is not met as evidenced by: Based on review of facility policy, review of the Centers for Disease Control and Prevention (CDC) Guidelines, review of the Association of Peri-Operative Registered Nurses (AORN) Guidelines, observation, and interview, the facility failed to maintain sterile technique during 1 of 1 observations made and failed to ensure an opened multi-dose vial of medication was dated, timed, and initialed in 1 (pre-operative prep area) of 9 patient care areas observed. The findings include: Review of the facility policy "Medication Administration Policy" dated [redacted] revealed "...All multi-dose vial medications must be labeled with date opened and RN [Registered Nurse] initials. These medications expire 28 days after initially	A 425	Per facility policy: All multi-dose vial medications shall be opened, dated, timed and initialed by nursing personnel. The Nursing Supervisor/Infection Control officer will be responsible for ensuring this facility policy is followed by completing this procedure herself or monitoring and/or observing the practice is being properly performed by others. Education/In-Service for handling of MDV's occurred 9/19/19. The signature sheet is attached of all practitioner staff. The proper handling is now included in the daily RN checklist. To verify	9/30/19

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Dennison | TITLE: Administrator | (X6) DATE: 9/20/19

STATE FORM 6899 9CTK11 If continuation sheet Page 1 of 5

Kim Dennison Administrator 9/20/19

SEP 20 2019

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	08/27/2019

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A 425	Continued From page 1 opened regardless of manufacturer listed expiration date..." Review of CDC guidelines for "Injection Safety" dated 6/20/19 revealed "...If a multi-dose has been opened or accessed (e.g., [for example] 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..." Review of AORN "Guidelines for Perioperative Practice" dated 2016, revealed "...Items introduced to the sterile field should be opened, dispensed, and transferred by methods that maintain the sterility and integrity of the item and the sterile field. Sterile items that are not opened, dispensed, and transferred by methods that maintain sterility and integrity may contaminate the sterile field..." Observation and interview with Surgical Assistant (SA) #1 on 8/26/19 at 1:00 PM, in treatment room #1, revealed SA #1 was setting up the procedure room for a patient procedure. Continued observation revealed a covered sterile stainless steel tray was sitting on a table. Further observation revealed SA #2 removed the cover from the stainless steel tray, which contained sterile surgical instruments and then retrieved a packaged sterile instrument from the countertop, opened the sterile package, and dropped the sterile instrument into the stainless steel tray with the other surgical instruments. Continued observation revealed the SA then touched the sterile surgical instruments that were located inside the stainless steel tray with the outside of the instrument packaging. Interview with SA #1 confirmed the SA was not aware the instrument packaging had touched the sterile surgical	A 425	Completion, the checklist log will be reviewed weekly by the nursing Supervisor/ Infection Control officer. A copy of the RN checklist is attached. The log is also reviewed by the QA/PI Committee annually. The weekly infection control monitoring sheet is also attached. 9/30/19 Continuing education will be provided by the nursing supervisor/infection control officer to all surgery assistants regarding concepts and practices for establishing and maintaining a sterile field. She will observe their practices and procedures to ensure sterile technique is being maintained and shall monitor these practices by routine evaluation.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING	08/27/2019

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A 425	Continued From page 2 instruments. Interview with the Co-Administrator/Nurse Practitioner #1 on 8/26/19 at 1:15 PM, in the recovery room, confirmed staff were expected to maintain sterile technique when setting up for a surgical procedure. Observation and interview with the Co-Administrator/Nurse Practitioner #1 on 8/26/19 at 1:20 PM, of a pre-operative prep area outside the procedure rooms, revealed 1 opened undated 50 milliliter multi-dose vial of 1% Lidocaine (numbing medicine). Interview with the Co-Administrator/Nurse Practitioner #1 confirmed the Lidocaine was opened and undated. Continued interview confirmed the facility failed to follow facility policy.	A 425	Education regarding sterile technique and sterilization procedures will be provided 9/23/19. The nursing supervisor/ Infection control officer will be responsible for the training. Sterile technique will be observed by the nursing supervisor/ infection control officer for a period of 30 days. A minimum of two cases shall be observed in each procedure room each procedure day. Continued education will be provided on a quarterly basis to promote improved practices and competency. The facility's goal for sustaining compliance is to strive for a culture of safety by providing continued education and training, monitoring practices and procedures and practices and evaluating and revising infection control policies as needed. Infection Control policy guidelines are reviewed by the QA/PI committee annually.	9/30/19 9/23/19 9/30/19
A 436	1200-8-10-.04 (20)(c)6. Administration (20) Infection Control. (c) The chief executive officer or administrator shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develops guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the committee shall include the establishment of: 6. A method of control used in relation to the sterilization of supplies and water, and a written policy addressing reprocessing of sterile supplies;	A 436		

Division of Health Care Facilities

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	TNPL53526	A. BUILDING: _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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A 436	Continued From page 3	A 436		9/30/19

This Rule is not met as evidenced by:
Based on review of a manufacturer's manual, review of a facility sterilization log book, review of the facility's procedure log book, observation, and interview, the facility failed to maintain a complete sterilization log book and failed to document the reading of a biological indicator (used to demonstrate whether conditions during a steam cycle were adequate to achieve a defined level of microorganism inactivation) for 1 of 1 autoclaves (used for steam sterilization).

The findings include:

Review of the Manufacturer's Instruction Manual for "...Biological Indicators for Steam Sterilization...," undated, revealed "...for optimal quality assurance of hospital-sterilized goods, we recommend that an [named] biological indicator be used to monitor every load of steam sterilized supplies. .record results. .log book for steam sterilization..."

Review of the facility's sterilization log book dated 8-19-19 revealed no documentation of the load number, date and time in the incubator, dated and time out of the incubator, and whether the results of the controls (indicates if sterilization was done correctly) had positive or negative results.

Review of the facility's procedure log revealed surgical procedures were performed on [redacted] and [redacted]

Observation and interview with Sterilization Technician #1 on 8/26/19 at 1:30 PM, of the sterilization log book in the Sterilization Room,

The biological testing results that were not recorded the week of 8/19/19 occurred while the sterilization technician was on vacation. The individual responsible for overseeing this procedure during her absence will receive additional training to ensure proper documentation is noted. Our facility policy follows the following CDC guidelines- "A spore test should be used for each sterilizer at least weekly."

Follow-up discussion with the sterilization technician revealed the surveyor reviewed only one of two sterilization log books.

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	08/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 436	Continued From page 4 confirmed surgical procedures were done on [redacted] and [redacted] Further interview confirmed the log book was incomplete and there was no documentation in the sterilization log book to indicate biological testing was performed.	A 436	The technician states she provided the biological indicator log but failed to provide the surveyor with the "Sterilization Maintenance log". This log provides documentation of mechanical and chemical indicators and is completed each procedure day. A copy of the log is attached. The nursing supervisor/ infection control officer will review the logs weekly to confirm procedures are being performed and results are documented as indicated. A copy of the weekly infection control monitoring sheet is attached. 9/30/19	

September 20, 2019

Provider #TNPL53526

Clarifications added to POC #2

The nursing supervisor/infection control officer will be responsible for monitoring compliance of all deficiencies cited.

Education/in-service for handling of MDV's occurred 09/19/19. The signature sheet is attached of all participating staff. The proper handling is now included in the daily RN checklist. To verify completion, the checklist log will be reviewed weekly by the nursing supervisor/infection control officer. A copy of the daily RN checklist log is attached. This log is also reviewed by the QA/PI committee annually. The weekly infection control monitoring sheet is also attached.

Education regarding sterile technique and sterilization procedures will be provided on Monday, September 23rd, 2019. The nursing supervisor/infection control officer will be responsible for the training.

Sterile technique will be observed by the nursing supervisor/infection control officer each procedure day during a 30 day period. A minimum of two cases shall be observed in each procedure room each procedure day. Continued education will be provided on a quarterly basis to promote improved practices and ensure competency.

The facility's goal for sustaining compliance is to strive for a culture of safety by providing continued education and training, monitoring existing procedures and practices and evaluating and revising infection control policies as needed. Infection control and clinical policy guidelines are reviewed by the QA/PI committee annually.

Americans United for Life

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	R 04/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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{A 001}	1200-8-10 Initial A desk review for the Plan of Correction (POC) was conducted for all previous deficiencies cited on 3/5/19. All deficiencies have been corrected and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 002	1200-8-10 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on 3/4/19, no deficiencies were cited under 1200-8-10 Ambulatory Surgical Treatment Centers.	A 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Kim Jemison | Administrator | 3/29/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	03/05/2019

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A 425	Continued From page 1 ingredients, and the name or/initials of the person who prepared...and beyond use date and time..." Observation and interview with Surgery Assistant (SA) #1 on 3/4/19 at 10:25 AM, in the pre-procedure work area, revealed a covered stainless steel container, which contained eight 10 milliliter syringes filled with a clear liquid. Continued observation revealed the syringes were not labeled with the name of the syringe contents or date and time the syringes were prepared. Interview with the SA revealed the eight syringes contained Lidocaine (numbing medicine) and the SA was unsure when the syringes were prepared. Continued interview confirmed the syringes were not labeled with the name of the medication and date or time the medication was prepared. Interview with the Administrator on 3/4/19 at 10:30 AM, in the pre-procedure work area confirmed the syringes were not labeled with the name of the medication and date or time the medication was prepared.	A 425	3/25/19 Each procedure day during the next 30 days the nursing supervisor shall observe the newly established practice to confirm compliance.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING _____ B. WING _____	R 08/01/2018

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{A 001}	1200-8-10 Initial A desk review was conducted on 8/1/18 for all previous deficiencies cited on 6/19/18. All deficiencies have been corrected and no new compliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: 01 - MAIN B. WING	06/18/2018

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KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies During the Life Safety portion of the licensure survey conducted on 6/18/18, no deficiencies were cited under 1200-8-10, Standards for Ambulatory Surgical Treatment Facilities.	A 002		

45th Day 8/3/18

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC # 2	TNPL53528	A. BUILDING _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is not met as evidenced by: An annual Licensure survey was conducted on 6/18/18 - 6/19/18 at Knoxville Center for Reproductive Health. The facility was found to not be in substantial compliance with Chapter 1200-8-10, Standards for Ambulatory Surgery Treatment Centers.	A 001		
A 425	1200-8-10-.04(20)(b) Administration (20) Infection Control. (b) The physical environment of the ambulatory surgical treatment center shall be maintained in a safe, clean and sanitary manner. This Rule is not met as evidenced by: Based on review of the Centers for Disease Control (CDC) Injection Safety guidelines, observation, and interview, the facility failed to maintain a sanitary environment in 2 of 2 procedure rooms and in 1 of 1 sterilization rooms observed. The findings included: Review of the CDC guidelines for "Injection Safety" updated on 8/16/16 revealed "...Multi-dose vials should be dedicated to a single patient whenever possible. If multi-dose vials must be used for more than one patient, they should only be kept and accessed in a dedicated medication preparation area (e.g., nurses station), away from immediate patient treatment areas. This is to prevent inadvertent	A 425	Per the CDC guidelines for 'Injection Safety', 1% Lidocaine/Local anesthetic vials shall be dedicated for single patient use only. On June 20th, 2018 the Surgical staff was educated regarding the CDC guidelines resulting in the change in practice, as noted above. The Medical Director shall be responsible for routinely observing, monitoring and participating in this practice to ensure compliance.	8/1/18

Kim Denison Administrator

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 425	Continued From page 1 contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment that could then lead to infections in subsequent patients. If a multi-dose vial enters an immediate patient treatment area, it should be dedicated for single-patient use only. If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated..." Observation on 6/18/18 at 11:17 AM, in Procedure Room [redacted] revealed: 1. One opened 50 milliliter (ml) multi-dose vial of 1% Lidocaine (numbing medicine) 2. Two unopened 50 ml multi-dose vials of 1% Lidocaine 3. An uncovered stainless steel bowl of betadine solution (surgical scrub) Interview with Surgery Assistant #1, on 6/18/18 at 11:25 AM, in Procedure Room [redacted] confirmed the betadine solution and the Lidocaine were used on multiple patients. Observation on 6/18/18 at 12:15 PM, in Procedure Room [redacted] revealed: 1. One opened 50 ml multi-dose vial of 1% Lidocaine 2. One unopened 50 ml multi-dose vial of 1% Lidocaine 3. An uncovered stainless steel bowl of betadine solution Interview with Surgery Assistant #2, with the Director of Nursing (DON) present, on 6/18/18 at 12:20 PM, in Procedure Room [redacted] confirmed the betadine solution and the Lidocaine were used on multiple patients. Observation and interview with Family Nurse Practitioner (FNP) #1 on 6/18/18 at 2:00 PM, in the sterilization room, revealed 1 opened undated 50 ml multi-dose vial of 1% Lidocaine. Interview	A 425	Betadine Solution shall be poured into a sterile container dedicated for single patient use only. On June 20th, 2018 the Surgical staff was informed of this change. All staff acknowledged understanding. The Medical Director shall be responsible for routinely observing, monitoring and participating in this practice to ensure compliance.	6/25/18 8/1/18

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 425	Continued From page 2 with FNP #1 confirmed the Lidocaine was opened and undated and opened vials of medication were to be dated when opened. Further interview confirmed the multi-dose vials of Lidocaine were placed in the procedure rooms each day, remained in the procedure room throughout all surgical procedures, and were used on multiple patients. Continued interview confirmed the betadine solution was poured into the bowl prior to the first procedure of the day and was used on multiple patients throughout the day. Observation and interview with the Administrator on 6/18/18 at 2:30 PM, of Procedure Room [redacted] revealed eight 11 millimeter (mm) Disposable Rigid Curettes (instrument used to remove material from the uterus) with an expiration date of 5/2018. Interview with the Administrator confirmed the curettes were expired and were available for patient use.	A 425	During the monthly inspection, curettes found with an expiration for the following month shall be banded separately from the others. If not used within the month, they will be discarded. The Nursing Supervisor shall be responsible for monitoring the monthly inspection log to ensure compliance	6/29/18 8/1/18

Division of Health Care Facilities

12/13/17 Acceptable

45th Day 1/13/2018

PRINTED: 12/04/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	TNPL53526	A. BUILDING: _____ B. WING _____	11/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 424	1200-8-10-.04 (20)(a) Administration (20) Infection Control. (a) The ASTC must provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired supplies were not available for patient use in 2 of 2 procedure rooms, in 1 of 1 labs, and in 1 of 1 emergency carts observed. The findings included: Observation and interview with the Administrator on 11/28/17 at 3:30 PM, in Procedure Room [redacted] revealed ten 8 millimeter (mm) Disposable Curved Curettes (surgical instrument used to remove material by a scraping action, especially from the uterus) with an expiration date of 12/2015; one 8 mm Disposable Curved Curette with an expiration date of 6/2016; and one 8 mm Disposable Curved Curette with an expiration date of 9/2017. Interview with the Administrator confirmed the curettes were expired and the facility failed to ensure expired supplies were not available for patient use. Observation and interview with the Administrator on 11/28/17 at 3:45 PM, in Procedure Room [redacted] revealed two bottles of hand sanitizer with an expiration date of 10/2016. Interview with the	A 424	1200-8-10-.04(20)(a) P.O.C. A monthly inspection log has been created to ensure no expired items are available for patient use. Staff members will be responsible for inspecting all items in their designated areas, removing and replacing items as needed and initialing the log once complete.	12/11/17

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Denson

TITLE: Administrator

(X6) DATE: 12/11/17

STATE FORM 6899 8KNJ11 If continuation sheet 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	11/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 424	Continued From page 1 Administrator confirmed the hand sanitizer was expired and the facility failed to ensure expired supplies were not available for use. Observation and interview with the Advance Practice Nurse (APN) on 11/29/17 at 10:20 AM, of the Emergency Cart in the Recovery Room, revealed 6 pairs of sterile latex surgical gloves with an expiration date of 9/2017. Interview with the APN confirmed the gloves were expired and the facility failed to ensure expired supplies were not available for patient use. Observation and interview with the APN on 11/29/17 at 10:50 AM, in the lab, revealed seven 4 mm purple top blood specimen tubes with an expiration date of 10/31/17. Interview with the APN confirmed the blood specimen tubes were expired and the facility failed to ensure expired supplies were not available for patient use.	A 424		
A 680	1200-08-10-.06 (12)(a) Basic Services (12)Medical Records. (a) The ASTC shall comply with the Medical Records Act of 1974, T.C.A. § 68-11-301, et seq. This Rule is not met as evidenced by: Based on review of the State of Tennessee Laws, medical record review, and interview, the facility failed to report an induced termination of pregnancy for 1 patient (#5) of 10 medical	A 680	1200-08-10-.06(12)(a) An inquiry has been made with the Office of Vital Records to determine if the report in question was received or if we inadvertently failed to submit it. It was discussed with the surveyor that making a copy may have been overlooked or misplaced. At the request of the Office of Vital Records, a second report was provided to compare against their records. We are awaiting their findings.	12/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	11/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 680	Continued From page 2 records reviewed. The findings included: Review of the State of Tennessee Laws, Title 68 Chapter 3, Vital Records Part 5 Deaths (68-3-505) Reports of Abortion (termination of pregnancy) dated 2015 and last updated on 1/7/16 revealed "... Each induced termination of pregnancy that occurs in this state shall be reported to the office of vital records within ten (10) days after the procedure by the person in charge of the institution in which the induced termination of pregnancy was performed..." Medical record review revealed Patient #5 was admitted to the facility on [redacted] for an abortion. Further review revealed the patient was discharged home the same day. Continued medical record review revealed a Tennessee Department of Health, Report of Induced Termination of Pregnancy was not in the medical record. Interview with the Administrator on 11/28/17 at 2:40 PM, in the employee lounge, confirmed the facility failed to report the abortion to the State of Tennessee as required by state law.	A 680	1200-08-10-.06(12)(a) P.O.C. Each procedure day the Director of Counseling will make a copy of each 'Report of Induced Termination of Pregnancy'. She will count the number of reports and verify that it equals the number of patients seen that day. The reports will then be given to the Office Mgr. and she will confirm the number of reports received from the Director of Counseling equals the number of patients seen. She is then responsible for mailing them to the Office of Vital Records. If the Director of Counseling is absent, another staff member is designated to complete this task.	12/11/17

PRINTED: 05/10/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	05/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial During a Licensure survey completed on 5/9/17 at Knoxville Center for Reproductive Health, no health deficiencies were cited under Chapter 1200-08-10, Standards for Ambulatory Surgical Treatment Centers.	A 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Rosa Dawson Administrator

STATE FORM 6899 SZT311 If continuation sheet 1 of 1

45th Day 6/23/17

PRINTED: 06/11/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC # 1	TNPL53526	A. BUILDING: 01 - MAIN B. WING	05/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 824	1200-8-10-.08 (24) Building Standards (24) The department requires the following alarms that shall be monitored twenty-four (24) hours per day. (a) Fire alarms; (b) Generators (if applicable); and (c) Medical gas alarms (if applicable). This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain the fire alarm. The finding includes: Observation, record review and interview with the laboratory manager on 5/8/17 at 10:00 AM revealed the main fire alarm control panel was yellow tagged by the fire alarm technician, "system has a trouble for phone lines but the phones are good. System needs replaced." The laboratory manager was present when the deficiency was identified and acknowledged during the exit conference on 5/8/17.	A 824	As noted in the findings during the survey on 5/8/17 the fire alarm technician had determined the control panel needed to be replaced. Pending review and approval by the Dept. of Health the panel will be replaced. Quotation and description of equipment is attached. 6/22/17	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kim Dawson — Administrator — 6/23/17

STATE FORM 6899 8AHJ21 If continuation sheet 1 of 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	11/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial During a Licensure survey conducted on November 14, 2016, at Knoxville Center for Reproductive Health, no deficiencies were cited under 1200-08-10, Standards for Ambulatory Surgical Treatment Centers.	A 001		

1st POC 45th day 6/3/16

PRINTED: 04/29/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1020	1200-8-10-.10 (6)(b) Infectious and Hazardous Waste (b) Pathological waste must be promptly treated, disposed of, or placed into refrigerated storage. This Rule is not met as evidenced by: Based on observation, review of a facility document, and interview, the facility failed to ensure biological waste temperatures were monitored in one of one freezers. **The findings included:** Observation during the facility tour with the facility administrator on 4/18/16 at 11:30 AM, revealed a freezer located in a storage area on the first floor of the facility. Continued observation revealed the freezer contained regulated biological waste. Review of a facility document "...Storage Room...Freezer temperatures..." dated April 2016, revealed no documented freezer temperatures for the month of April. Interview with the facility administrator on 4/18/16 at 2:05 PM, in the break room, confirmed "...a temperature is to be recorded every procedure day and they failed to do so..." Continued interview confirmed procedure days in April were the 1st, 4th, 8th, 9th, and 11th.	A1020	The staff members that are responsible for recording freezer temperatures have been reinstructed to document temperatures each procedure day. A folder clearly marked and identified as the temperature log adheres to the top of the freezer for ease of use. The Medical Director will review and sign the log each month to ensure compliance.	5/5/16

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim Dawson TITLE: Administrator (X6) DATE: 5/5/16

STATE FORM 6899 6X1J11 If continuation sheet 1 of 1

1st POC 45th Day 6/3/16

PRINTED: 04/20/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53528	A. BUILDING: 01 - MAIN B. WING	04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HI	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 805	1200-8-10-.08 (5) Building Standards (5) No new ASTC shall be constructed, nor shall major alterations be made to an existing ASTC without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ASTC is licensed or before any alteration or expansion of a licensed ASTC can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a licensed engineer and in accordance with the rules of the Board of Architectural and Engineering Examiners. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure alterations to the facility were made without prior approval from the Department of Health. The findings include: 1. Observation on 4/19/2016 at 1:15 PM confirmed a fire alarm company was modifying the Fire Alarm Control Panel (FACP). 2. Interview with the Safety Officer and fire alarm service company on 4/19/2016 at 1:50 PM confirmed the facility was having the FACP communicating transmitter interface modified from phone service to cellular service. No other devices were being affected. The facility failed to submit any documentation for this modification. 3. Interview with the Administrator and Safety	A 805	The following individuals have been contacted and are working together to determine if having the FACP communicating transmitter interface modified from phone to cellular service requires prior written approval by the department: Admin. Assistant Plans Review / Fire Safety Section Fire Safety Supervisor Health Care Facilities City of Knoxville, Fire Inspections Fire Safety Supervisor State of TN Fire Marshalls Office Service Manager Simplex Grinnell We have been working to resolve this issue from the date of the survey. Once we have been notified by the proper authorities if corrective action is necessary, we will do so.	6/2/16

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kim Dawson — Administrator — 5/9/16

FORM CMS-2567(02-99) WT3D21 If continuation sheet 1 of 2

PRINTED: 04/20/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53626	A. BUILDING: 01 - MAIN B. WING	04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 805	Continued From page 1 Officer on 4/19/2016 at 2:25 PM revealed they were not aware that submittal, review and approval were required for this change. These findings were verified by the Facility Safety Officer and acknowledged by the Administrator during the exit conference on 4/19/2016.	A 805		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: 01 - MAIN B. WING _____	11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on 11/16/16, no deficiencies were cited under 1200-8-10 Ambulatory Surgical Treatment Centers.	A 002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: 01 - MAIN B. WING	10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 817	1200-8-10-.08 (17) Building Standards (17) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension to the department demonstrating that all applicable codes have been met and the department has granted necessary approval. (a) Before the ASTC is used, Tennessee Department of Environment and Conservation shall approve the water supply system. (b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction. (c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain hot water temperatures between 105 - 155 (115) degrees F. The findings include:	A 817	See page 2 of 2	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator

NOV 0 5 2015

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: 01 - MAIN B. WING	10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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A 817	Continued From page 1 Observation and interview with the Administrator, on 10/20/2015 at 1:22 PM confirmed the hot water temperatures in 2 of 2 procedure rooms and the instrument cleaning room ranged between 130 to 134 degrees F. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 10/20/2015.	A 817	1200-8-10-.08(7) Bldg. Standards; (c) Maintenance was contacted to lower the water heater temperature. Upon completion, the water temperature was tested and measured 110°F. Completion Date: 10/27/15 Annual testing shall be performed to verify the Standard range of 105° - 115° F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING: 01 - MAIN B. WING	10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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45 Day 4/9/12

PRINTED: 02/28/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING _____ B. WING _____	02/21/2012

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KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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A 001	1200-8-10 Initial This Rule is not met as evidenced by: On-site completed to investigate complaint # 29091 and conduct licensure survey. Deficiencies were cited for the complaint.	A 001		
A 407	1200-8-10-.04 (6) Administration (6) The ambulatory surgical treatment center shall ensure a framework for addressing issues related to care at the end of life. This Rule is not met as evidenced by: Based on review of medical records and interview, the facility failed to ensure a framework for addressing issues related to care at the end of life for 10 of 10 medical records reviewed. The findings included: Review of the medical records for ten (#1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) of ten medical records reviewed revealed no documentation the patient was asked if they had executed a living will or Advanced Directives (POST - Physician's Orders for Scope of Treatment) related to end of life issues and desires nor provided information related to formulation of Advanced Directives. Interview in the counselor's office with the Administrator on February 21, 2012, at 2:10 p.m., confirmed the patients were not asked about or provided any information on end of life issues, living wills or Advanced Directives. Continued interview revealed the facility had no framework in place to address these issues.	A 407	Advance Directive Packets have been created based on the Appointment of Healthcare Agent and Advance Care Plan forms provided by the TN Dept. of Health. A brief summary of the purpose of the forms and instructions to complete the forms are included. Patients will be asked if they have executed Advance Directives and if they would like to obtain information about Advance Directives. The forms shall be provided as requested. Patients previously affected shall be offered the opportunity to obtain info. pertaining to Advance Directives upon return for F/U care or other services. Daily chart review and quarterly chart audit shall ensure compliance.	4/6/12
A 424	1200-8-10-.04 (20)(a) Administration (20) Infection Control.	A 424		

Division of Health Care Facilities

Ken Dawson — TITLE Administrator — (X6) DATE 3/7/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 YMSX11 Continuation sheet 1 of 4

Signed + mailed original - 3/7/12

PRINTED: 02/28/2012
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Division of Health Care Facilities

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	TNPL53526	A. BUILDING _____ B. WING _____	02/21/2012

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KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE. KNOXVILLE, TN 37916

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A 424	Continued From page 1 (a) The ASTC must provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure infection control standards were maintained in the laboratory (lab), exam room, and surgical recovery room. The findings included: Observations on February 21, 2012, between 8:50 a.m. and 10:50 a.m., during the facility tour with the Administrator, revealed the following: seventeen vials of various patient's blood stored in the lab refrigerator containing biological materials utilized for lab testing, medications and insertable birth control devices for patients, and medications for staff vaccinations; sterile forceps were stored in a drawer with paperwork and manuals in the exam room; and in the surgical recovery room expired sutures to include one coated Vicryl, expired January 2000, and two Chromic and one Vicryl without an expiration dated listed. Interview in the counselor's office with the Administrator on February 21, 2012, at 10:50 a.m., confirmed the lab refrigerator was not to be used to store patient blood samples, medications, or insertable birth control devices intended for patient use; sterile items were to be stored only	A 424	To ensure infection control standards are being maintained throughout the facility blood and biological materials shall be stored separately from all medications, birth control devices and vaccines only sterile patient care and clean items shall be stored together and expired patient use items shall be discarded. To monitor this practice refrigerated blood and biological contents only shall be verified and documented monthly as being stored separately and signs shall be posted on the refrigerators specifying acceptable contents patient care items with an expiration date shall be included to the monthly supply order form and inventory to be also reviewed monthly staff members shall be informed of acceptable storage practices for clean or sterile patient care items	4/6/12

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING _____ B. WING _____	02/21/2012

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KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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A 424	Continued From page 2 with clean or sterile patient care items; and the sutures had expired and were available for patient use C/O #29091	A 424		4/6/12
A 680	1200-8-10-.06 (5) Basic Services (5) Pharmaceutical Services. The ASTC must provide drugs and biologicals in a safe and effective manner in accordance with accepted standards of practice. Such drugs and biologicals must be stored in a separate room or cabinet which shall be kept locked at all times. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were secured throughout the facility; failed to ensure medications were not stored in areas with items which were not clean in the medication closet; and failed to ensure expired medications were not available for patient use. The findings included: Observations made during the facility tour with the Administrator on February 21, 2012, between 8:50 a.m. and 10:50 a.m., revealed the following: unsecured medications (such as birth control pills, vitamins, over the counter analgesics, and prescription antacids) observed in the unlocked medication storage closet, the lobby, the laboratory, exam rooms, storage areas, and the surgical recovery room. Continued observation revealed the designated medication storage closet contained items such	A 680	All medications shall be stored in a safe, secure and acceptable manner throughout the facility. A storage closet shall house in part a locked medication only storage area which will be constructed to achieve the purpose for which it is intended. Medications will not be stored with unclean items and all medication storage areas shall be kept locked at all times when not in use.	4/6/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING _____ B. WING _____	02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HI	1547 WEST CLINCH AVENUE. KNOXVILLE, TN 37916

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A 680	Continued From page 3 as an electronic piano keyboard, manuals, files, and various types of dusty office equipment. Continued observation revealed the following expired medications: a box of birth control pills located in the exam room dated as expired April 2010, four boxes of 5 tabs each located in the medication storage closet dated as expired July 2010; and a bottle of over the counter analgesic located in the surgery recovery room dated as expired November 2011. Interview in the counselor's office with the Administrator on February 21, 2012, at 10:50 a.m., confirmed the medications in the facility were not secured; the medications were not maintained in an area specifically designated for only medication storage; and various medications throughout the facility had expired and were available for patient use.	A 680	Medication storage area will be inventoried on a monthly basis to dispose of expiring medications and ensure compliance with the above standard of practice.	4/6/12

11.5th Day
4/7/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	A. BUILDING 01 - MAIN B. WING _____	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HE	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

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A 802	1200-8-10-.08 (2) Building Standards (2) The condition of the physical plant and the overall Ambulatory Surgical Treatment Center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure safety equipment was maintained. The findings include: Observation and interview with the lab tech at 11:00 am on February 22, 2012 confirmed the waiting room fire door to the stairwell was missing the center hinge, the label was painted over, and the door failed to close to a positive latch (NFPA 80, 15.2) Observation and interview with the lab tech at 11:40 am on February 22, 2012 confirmed the crawl space 1-1/2 hour rated fire door failed to close to a positive latch and was not self closing. (NFPA 80, 15.2). These findings were acknowledged by the administrator during the exit conference on February 22, 2012.	A 802	To ensure patient Safety and well-being the following safety equipment measures will be corrected and maintained in accordance with the ASTC Building standards. The waiting room fire door located at the base of the stairwell will have the center hinge replaced paint covering the door label will be removed and the door will be adjusted to close to a positive latch. In the door may remain open during business hours, it will be attached to a magnetic door holder and will close in the event the alarm sounds. In addition two smoke detectors linked to the system will be installed as recommended. The crawl space 1-1/2 hr. rated fire door will be altered to perform as Self-Closing and will close to a positive latch.	4/6/12
A 823	1200-8-10-.08(23) BUILDING STANDARDS (23) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.	A 823		

Division of Health Care Facilities

Kim Dennison
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator (X6) DATE 4/7/12

STATE FORM 6899 21Q521 continuation sheet 1 of 2

PRINTED: 02/23/2012
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A 823	Continued From page 1 This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure dirty areas had an operable exhaust per the AIA guidelines.. The findings include: Observation and interview with the lab tech , on February 22, 2012 p.m. at 11:00 a.m. confirmed the soiled utility room and two bathrooms adjacent to the downstairs stairwell were not provided with an operable exhaust; This finding was acknowledged by the Administrator during the exit conference on February 22, 2012.	A 823	A negative air pressure shall be maintained in the soiled utility room and both restrooms located adjacent to the downstairs stairwell. Each area will have an operable exhaust installed as required.	4/6/12

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is met as evidenced by: An onsite licensure survey was completed 6/3/19. The facility demonstrated compliance with the regulations reviewed for health portion of the licensure survey. The facility is in compliance with the Standards for Ambulatory Surgical Treatment Centers.	A 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL63515	A. BUILDING: 02 - STATE BUILDING B. WING	06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 001	1200-8-10 Initial 6/24/19 Accepted per Alternative Proposal This Rule is not met as evidenced by: A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 06/03/2019. During this Life Safety Survey, Planned Parenthood was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgical Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). * All penetrations requiring Fire Stop shall be repaired in accordance with a tested and approved Fire Stop System meeting the requirements of ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. The system used shall be recorded and documentation shall be maintained for the life of the installation. Fire Stop Systems should be on site and available for surveyors on the follow-up visit. Any Engineering Judgements requires state approval.	A 001	Abbreviations used: CCO=Chief of Clinical Operations, HCM=Health Center Manager In addition to the individual responses to the deficiencies contained herein, the CCO and HCM have developed an extensive checklist that is all-inclusive of due dates for both required inspections and drills to monitor that the deficient practice does not recur and ensure proper/timely monitoring. Fire Stop vendor scheduled and work was completed on 6/19/19. HCM and CCO to perform quarterly inspections, as well as after any work is done in any affected areas.	6/20/19 6/19/19
A 801	1200-8-10-.08 (1) Building Standards (1) The Ambulatory Surgical Treatment Center must be constructed, arranged, and maintained to ensure the safety of the patient. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the overall environment.	A 801		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 801	Continued From page 1 The findings included: 1. Document review on 06/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of a 1st quarter sprinkler inspection for 2018 and 2019. NFPA 101, 2. Document review on 06/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual fire alarm inspection for 2019. (The last date was March 2018) 3. Document review on 06/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual backflow preventer inspection for 2018. (The last inspection date was August 2017.) 4. Observations on 06/03/2019 at 3:00 PM, revealed the rated fire/smoke barrier (above the ceiling) in the mechanical room had multiple improperly sealed (sheetrock mud) or unsealed penetrations across the wall. NFPA 101, 8.3.5.1 (2012 Edition) The office manager was present when these deficiencies were identified, and were later acknowledged during the exit conference on 06/03/2019.	A 801	Quarterly sprinkler inspection performed. Deficiencies noted: 4 sidewall sprinkler heads will be replaced by COB 6/24/19. Annual fire inspection performed and passed. Inspection performed in 2018 but documentation could not be located until after exit conference. Properly filed. Fire Stop vendor scheduled and work was completed pn 6/19/19. CCO and HCM to perform quartely inspections, as well as after any work is performed in affected areas.	6/14/19 6/24/19 6/14/19 10/25/18 6/19/19
A 803	1200-8-10-.08(3) BUILDING STANDARDS (3) No ambulatory surgical treatment center shall hereafter be constructed, nor shall major alterations be made to existing ambulatory surgical treatment centers, or change in an ambulatory surgical treatment center type be	A 803		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 803	Continued From page 2 made without the prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ambulatory surgical treatment center is licensed or before any alteration or expansion of a licensed ambulatory surgical treatment center can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer. This Rule is not met as evidenced by: Based on observations, the facility failed obtain written approval for alterations. The finding included: Observations on 06/03/2019 between 2:15 PM - 3:30 PM, revealed the facility had installed access control badge scanners at the stairwells and doors throughout the facility without approval from the Tennessee Department of Health. The office manager was present when this deficiency was identified on 06/03/2019. Attempt was made to contact the office manager on 06/06/2019 without success.	A 803	A punch code access system was replaced with a badge swipe access system. PPTNM did not consider the replacement system as a major alteration and there was no intent of circumventing the proper approval process. PPTNM was standardizing the Nashville ASTC facility with the same badge access system that is currently utilized at the Memphis ASTC facility. The badge swipe system improves staff and patient safety in the event of an emergency by decreasing the time it takes to exit. PPTNM sincerely apologizes and regrets the error. CCO will request guidance from TN Dept. of Health for any future projects.	6/11/19
A1403	1200-8-10-.14 (1)(c) Disaster Preparedness (1) The administration of every facility shall have in effect and available for all supervisory	A1403		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1403	Continued From page 3 personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually: (c) Flood Procedure Plan, if applicable: 1. Staff duties; 2. Evacuation procedures; 3. Safety procedures following the flood. This Rule is not met as evidenced by: Based on document review, the facility failed to perform disaster drills. The finding included: Document review on 06/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual flood drill and training for 2018. The office manager was present when this deficiency was identified, and was later acknowledged during the exit conference on 06/06/2019.	A1403	HCM has documented PPTNM's Flood Procedure Plan and the required drill was performed. CCO and HCM will ensure all drills are performed and properly documented in the future.	6/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1404	Continued From page 4 1200-8-10-.14 (1)(d) Disaster Preparedness (1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually: (d) Earthquake Disaster Procedures Plan: 1. Staff duties; 2. Evacuation procedures; 3. Safety procedures; 4. Emergency services. This Rule is not met as evidenced by: Based on document review, the facility failed to perform disaster drills. The finding included: Document review on 06/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual earthquake	A1404	HCM has documented the Earthquake Disaster Procedures Plan and the required drill was performed. CCO and HCM will ensure all drills are performed and properly documented in the future.	6/14/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL63616	A. BUILDING: 02 - STATE BUILDING B. WING	06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1404	Continued From page 5 drill and training for 2018. The office manager was present when this deficiency was identified, and was later acknowledged during the exit conference on 06/06/2019.	A1404-		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	R 07/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 001}	1200-8-10 Initial This Rule is met as evidenced by: During a follow up survey on 07/15/2019 for all previous deficiencies cited on 06/03/2019, the facility was found in compliance with all regulations under 1200-08-10, Standards for Ambulatory Surgical Treatment Centers.	{A 001}		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: An annual licensure survey was conducted at this facility on 4/9/19. This facility complies with all standards for Chapter 1200-08-10, Standards for Ambulatory Surgical Treatment Center Facilities.	A 002		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is [illegible] as evidenced by: During the annual survey on 04/10/19, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200 -8-10, Standards for Ambulatory Surgical Treatment Centers.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 001}	1200-8-10 Initial This Rule is . met as evidenced by: A Life Safety revisit survey was conducted on 07/11/2019 for all previous deficiencies cited on 06/04/2019. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		

RECEIVED
Division of Health Care Facilities

To Bsm 6/24/19 KJ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
BY:	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 001}	1200-8-10 Initial This Rule is not met as evidenced by: A follow up Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 06/04/2019. During this follow up Life Safety Survey, Planned Parenthood of Greater Memphis was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgicial Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). The facility failed to implement their corrective action plan for A-801.	{A 001}	Accepted 7-1-19 BM	
{A 801}	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the physical plant. The findings included 1. Observation on 6/4/19 at 10:00 AM, revealed an unapproved patch around the duct in the boiler room on the 1 hour fire rated drywall. National Fire Protection Association (NFPA) 101, 21.1.6.3 (2012 Ed.) NFPA 101, 8.3.5 (2012 Ed.)	{A 801}	VENDOR CORRECTED PATCH. CFO will MONITOR ON MONTHLY INSPECTION. 6/17/19	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

CEO 6/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 801}	Continued From page 1 NFPA 101, 8.3.5.1 (2012 Ed.) These findings were verified and acknowledged by the business office manager during the survey on 6/4/19.	{A 801}		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is not met as evidenced by: A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 4/16/2019. During this Life Safety Survey, Planned Parenthood of Greater Memphis was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgicial Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	A 001		
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the physical plant. The findings included: 1. Observation on 4/16/19 at 3:22 PM, revealed the following penetrations in the fire rated assemblies: Elevator room - 1 hour fire rated drywall. a. a 1/2 inch metallic flexible conduit.	A 801	(SEE NEXT PAGE)	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO

STATE FORM 6899 D0S821

Americans United for Life

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 1 Boiler room - 1 hour fire rated drywall b. 1 inch PVC pipe. c. a 3 inch PVC pipe recessed in fire rated drywall not sealed per an approved UL fire stop system. d. a 1/2 inch PVC pipe. e. a 1/4 inch metallic flexible conduit. f. unapproved patches around duct work. Third floor shell area - concrete floor. g. 2 3 inch metal sleeves. National Fire Protection Association (NFPA) 101, 21.1.6.3 (2012 Ed.) NFPA 101, 8.3.5 (2012 Ed.) NFPA 101, 8.3.5.1 (2012 Ed.) 2. Observation on 4/16/19 at 3:25 PM, revealed a receptacle cover missing in Room #6. NFPA 101, 21.5.1.1 (2012 Ed.) NFPA 101, 9.1 (2012 Ed.) NFPA 101, 9.1.2 (2012 Ed.) NFPA 70, 110.3 (B) (2011 Ed.) These findings were verified and acknowledged by the facilty administrator during the survey on 4/16/19.	A 801	1a-g CFO will include on monthly facility inspection checklist, as well as after any maintenance occurs in reference areas. In process of getting quotes for both fire stop and patch repairs. 5/30/19 CFO will monitor monthly or after maintenance occurs. 4/19/19	
A 818	1200-8-10-.08 (18) Building Standards (18) It shall be demonstrated through the submission of plans and specifications that in each ASTC a negative air pressure shall be maintained in the soiled utility area, toilet room,	A 818	(See next page)	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 818	Continued From page 2 janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain negative pressure areas. The findings included: Observation on 4/16/19 at 3:40 PM, revealed the exhaust was not functioning in the soiled utility room. These findings were verified and acknowledged by the facility manager during the survey on 4/16/19.	A 818	No deficiency per device 5/1/19 call. Air pressure requirements are being met. CFO will inspect monthly.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING _____ B. WING _____	04/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF TENNESSEE ANI	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is met as evidenced by: An annual health licensure survey was conducted on 4/22/19. An entrance conference was held on 4/22/19 at 8:00 AM with the Clinical Manager. An exit conference was held on 4/22/19 at 3:30 PM with the Clinical Manager.	A 001		
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: An annual licensure survey was conducted at this facility on 4/22/19. This facility complies with all Standards reviewed for Ambulatory Surgical Treatment Center Facilities.	A 002	This is for your records. You do not have to return this state form. CE	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATE FORM 3C5D11 If continuation sheet 1 of

Mae Copeland

From: Rebecca Terrell [redacted]
Sent: Tuesday, June 26, 2018 2:52 PM
To: Ann R. Reed; Peter H. Warren; Craig L. Parisher
Cc: Eddie J. Stewart; [redacted] Autumn Katz
Subject: RE: Memphis Ctr for Reproductive Health project - Drawing Question

Ms. Reed,

I am in consultation with our attorneys for a final determination regarding the surrender of the ASTC license. I will notify your office as soon as a decision is made, hopefully in the next two weeks.

Thanks,

Rebecca Terrell
Executive Director
CHOICES.
Memphis Center for Reproductive Health

1726 Poplar Ave., Memphis, TN 38104
Direct: [redacted] Fax 901-274-3551
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"You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete."

R. Buckminster Fuller

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From: Ann R. Reed [mailto:Ann.R.Reed@tn.gov]
Sent: Tuesday, June 26, 2018 2:48 PM
To: Peter H. Warren; Craig L. Parisher
Cc: 'Rebecca Terrell'; Eddie J. Stewart
Subject: RE: Memphis Ctr for Reproductive Health project - Drawing Question

Peter/Rebecca
Based upon your email below, is this facility anticipating the closure of the license? If so, we would require notice and direction of such.

TN Health

Ann Rutherford Reed, RN, BSN, MBA/Director of Licensure
Division of Health Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive, 2nd Floor
Nashville, TN. 37243
Main-(615)741-7221/Direct-(615)532-6595; Fax-(615)253-8798
ann.r.reed@tn.gov
tn.gov/health

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Our Mission – To protect, promote and improve the health and prosperity of people in Tennessee.

From: Peter H. Warren [redacted]
Sent: Monday, June 25, 2018 11:28 AM
To: Craig L. Parisher
Cc: 'Rebecca Terrell'; Ann R. Reed; Eddie J. Stewart
Subject: Memphis Ctr for Reproductive Health project - Drawing Question

Mr. Parisher-

We met in February when Rebecca Terrell (my client) and I visited your office to discuss our project. Recall, it is a proposed two story medical office building housing reproductive health clinic on level-1 with a birthing center on level-2. We are in the process of preparing our application materials and I would like to offer the following general recap and summary. I would also like to pose a question to you about your preferred graphic convention as relates to isolating the birth center on our drawings.

Licensure and Scope of Review – We are pursuing state DOH licensure for the Birthing Center as required by 1200-08-24. We are not pursuing ASTC licensure as it has been determined by my client's legal team and the legal team of the State of TN DOH that surgical abortions do not trigger an ASTC licensure requirement. For documentation to that effect, please see the attached PDF of the email chain between the attorneys including the Deputy General Counsel at TN DOH (Kyontze Hughes-Toombs).

C.O.N. – We understand that there is no CON required for the birthing center. And since we are not pursuing status as an ASTC, thus there is no associated CON for this project.

Forthcoming Submittal for Review – We will submit the application, fees, and drawing sets as outlined in 1200-08-24 for the birth center. Our facility is two stories with the birthing center isolated on the second floor. It shares only entry, elevator, and stairs with the rest of the facility (much like a tenant in a medical office building). However, unless you advise differently, we will submit the full drawing set for the entire building. This is 77-sheets (format 30x42) across all design disciplines. Which brings me to my final question regarding drawing graphics.

Graphic Convention – You and I previously discussed the design team isolating the birthing center in the floor plans to facilitate isolating the scope of the project subject to review. To that end, I have prepared a draft of the first and second floor plans with a hatched note for your review and comment. The hatch and note clearly covers the portion of the project that is not birthing center. The hatch is somewhat transparent so that some overall context is still visible to your reviewers. Is this acceptable to you? Alternatively we could go with a completely opaque gray hatch, however it might actually obscure building system elements that pass through other parts of the building. Do you agree that the attached hatch is acceptable? If so, I will instruct all engineers (M, P, E, etc) to use the exact same hatch on their forthcoming drawings.

Thanks,
Peter Warren, AIA, LEED AP (BD+C)

Warren Architecture / 202 S Cooper / Memphis TN 38104
901 907 9521 cell phone

Peter Warren, AIA, LEED AP (BD+C)

From: Rebecca Terrell [redacted]
Sent: Wednesday, February 14, 2018 10:44 AM
To: Peter H. Warren; Ann R. Reed; Eddie J. Stewart; Craig L. Parisher
Subject: RE: Thank You....Birth Center & ASTC Project - Memphis

Yes, we really appreciate your time!

Rebecca Terrell
Executive Director
CHOICES.
Memphis Center for Reproductive Health

1726 Poplar Ave., Memphis, TN 38104
Direct: [redacted] Fax 901-274-3551
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"You never change things by fighting the existing reality. To change something, build a new model that makes the existing model obsolete."

R. Buckminster Fuller

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From: Peter H. Warren [redacted]
Sent: Wednesday, February 14, 2018 10:27 AM
To: 'Ann R. Reed'; 'Eddie J. Stewart'; 'Craig L. Parisher'
Cc: 'Rebecca Terrell'
Subject: Thank You....Birth Center & ASTC Project - Memphis

Ann, Craig, Eddie, (and Daniel too) –

We wanted to send a quick thank you for your time yesterday. Looking forward to working with you and we will be in touch.

Thanks,

Americans United for Life

Peter Warren, AIA, LEED AP (BD+C)

From: Ann R. Reed [mailto:Ann.R.Reed@tn.gov]
Sent: Wednesday, February 07, 2018 3:22 PM
To: Peter H. Warren; 'Rebecca Terrell'
Cc: Eddie J. Stewart; Craig L. Parisher
Subject: RE: Birth Center & ASTC Project - Memphis

Yes, the meeting is on for that date and time. Mr. Parisher will be in attendance.

TN Health

Ann Rutherford Reed, RN, BSN, MBA/Director of Licensure
Division of Health Licensure and Regulation
Office of Health Care Facilities
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ann.r.reed@tn.gov
tn.gov/health

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From: Peter H. Warren [redacted]
Sent: Wednesday, February 07, 2018 11:07 AM
To: Ann R. Reed; 'Rebecca Terrell'
Cc: Eddie J. Stewart; Craig L. Parisher
Subject: RE: Birth Center & ASTC Project - Memphis

Hi Ms. Reed-

Rebecca and I are planning to be in Nashville next week on Tuesday 2/13 to discuss some of the unique aspects of our project.

Are we still on for 2pm?

I am planning to bring our current drawings and will also bring copies of the codes (IBC, NFPA, IFC, etc) should we need them.

Mr Parisher, I just left you a voicemail. Will you be in attendance? If not, would like to get a few minutes with you separately that day if possible to discuss some aspects of the plan review process.

Thanks!
Peter Warren, AIA, LEED AP (BD+C)
(901) 907-9521 cell

Americans United for Life

From: Ann R. Reed [mailto:Ann.R.Reed@tn.gov]
Sent: Monday, January 29, 2018 3:23 PM

To: Rebecca Terrell
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher
Subject: RE: Birth Center & ASTC Project - Memphis

We will try for that time. It may be dependent on meeting space here. I will let you know.

TN Health

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From: Rebecca Terrell [redacted]
Sent: Monday, January 29, 2018 3:22 PM
To: Ann R. Reed
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher
Subject: RE: Birth Center & ASTC Project - Memphis

Could we say 2:00 pm?

Rebecca Terrell
Executive Director
CHOICES.
Memphis Center for Reproductive Health

1726 Poplar Ave., Memphis, TN 38104
Direct: [redacted] Fax 901-274-3551
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R. Buckminster Fuller

Americans United for Life

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From: Ann R. Reed [mailto:Ann.R.Reed@tn.gov]
Sent: Monday, January 29, 2018 3:18 PM
To: Rebecca Terrell
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher
Subject: RE: Birth Center & ASTC Project - Memphis

Right now I am available all day that day. What time works for you?

TN Health

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From: Rebecca Terrell [redacted]
Sent: Monday, January 29, 2018 3:10 PM
To: Ann R. Reed
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher; [redacted]
Subject: RE: Birth Center & ASTC Project - Memphis

Hi Ms. Reed,

Our architect, Peter Warren, and I will be in Nashville on Feb. 13. Could we make an appointment to meet with you that afternoon to discuss our project in person?

Rebecca Terrell
Executive Director
CHOICES
Memphis Center for Reproductive Health

Americans United for Life

1726 Poplar Ave., Memphis, TN 38104
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R. Buckminster Fuller

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From: Ann R. Reed [mailto:Ann.R.Reed@tn.gov]
Sent: Monday, November 20, 2017 2:35 PM
To: Rebecca Terrell
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher
Subject: RE: Birth Center & ASTC Project - Memphis

Rebecca
You are correct on the staffing item. I would refer to Craig Parisher to address the sharing of physical space as the codes could dictate a more stringent requirement. If there is not a more stringent code requirement the licensure regulations do not prohibit the sharing of common space such as a waiting room. The two different licensed entities should be clearly identifiable for the public.

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From: Rebecca Terrell [redacted]
Sent: Monday, November 20, 2017 1:47 PM
To: Ann R. Reed
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher; [redacted]
Subject: RE: Birth Center & ASTC Project - Memphis

Hi Ann – thanks for this info. So to clarify, we could have the same staff member working in both facilities, just not at the same day/time and as long as we kept time/personnel records. Correct?

And is there any specific regulation regarding the two entities sharing physical space, e.g. common waiting room, etc.?

Rebecca Terrell
Executive Director
CHOICES.
Memphis Center for Reproductive Health

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R. Buckminster Fuller

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From: Ann R. Reed [mailto:Ann.R.Reed@tn.gov]
Sent: Monday, November 20, 2017 10:02 AM
To: Rebecca Terrell
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher
Subject: RE: Birth Center & ASTC Project - Memphis

Rebecca
I have been in conversation with our legal counsel regarding the injunction that you reference below. Based upon our legal counsel's review of the injunction, license #44 would remain in effect. This injunction does not have bearing on an already licensed ASTC.

With two separately licensed entities, there cannot be a sharing of staff i.e. staff working at the same time in both licensed facilities. Staff must be solely devoted to one licensed facility for a specified amount of time. Each licensed facility would be required to maintain separate personnel files for all employees.

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Americans United for Life

From: Rebecca Terrell [redacted]
Sent: Thursday, October 26, 2017 2:41 PM
To: Ann R. Reed
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher; [redacted]
Subject: Birth Center & ASTC Project - Memphis

Hi Ann,

Thanks so much for such a comprehensive reply. Let's put off an in-person meeting for the time being so I can do a bit more research.

I do have a couple of follow up questions:

You imply that if we were to choose to close our ASTC license #44 we would need to "discontinue the surgical aspect of first trimester abortions". My understanding of the attached injunction is that we could give up our license and still continue to provide all abortion care we are now provide. I would appreciate any clarification you can provide around that.

I'm also unclear about the source of the requirements for separation of staff and services. Is this just if there is an ASTC in addition to a licensed birth center? In other words, are there a specific set of reproductive health services that are allowed or disallowed from being provided by a licensed Birthing Center?

Thank you for your patience with all these questions – this is a new paradigm and we have a lot to figure out.

Rebecca Terrell
Executive Director
CHOICES.
Memphis Center for Reproductive Health

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From: Ann R. Reed [mailto:Ann.R.Reed@tn.gov]
Sent: Thursday, October 26, 2017 12:43 PM
To: Rebecca Terrell
Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher
Subject: RE: State of TN - Introductory Narrative - Please Review

Rebecca
I have reviewed the submitted documents and will also be sharing with Craig Parisher, Director of Facilities Construction, for review. He has also been cc'ed to this e-mail. The current facility located at 1726 Poplar Ave is licensed as an ASTC under license number #44. When relocating this facility as described in your documentation the ASTC licensure will continue to apply. In the documentation, there was no indication that the provision of surgical services i.e. first trimester abortions would be discontinued. License #44 would continue to be considered an ASTC. The relocation and replacement of a licensed healthcare facility such as an ASTC would require a CON. If MCRH determines it will close its license as an ASTC and discontinue the surgical aspect of first trimester abortions then decides at a later date to re-license as an ASTC a new CON would be required.

With the addition of a birthing center at the proposed new location and building, a license as a birthing center would be required. MCRH as a birthing center would need to submit a Birthing Center application, submit plans to the Office of Health Care Facilities' Plans Review section for review, and submit to an initial survey for occupancy. For the new ASTC, a separate set of plans will be required for submission and once approved and constructed a separate occupancy survey will be required. There will be distinct separation required between these two entities and this can be further explored with Craig Parisher. In regards to the questions and items you have relating to building requirements, use and occupancy, etc in the New Facility Discussion Items document, these will need to be directed to Craig Parisher for response.

The other aspect to address in relation to two separately licensed entities in the same physical 'four wall' space is the distribution of staff and the maintenance of files (facility and patient records). Each facility will need to have separate staffing solely dedicated to that entities services. There can be no sharing of staff. Personnel records must be clearly marked as the ASTC vs the Birthing Center and maintained in each separate licensed entity. All facility policies and procedures and patient records should be maintained in the same fashion.

If you have any further questions regarding the information I have provided above, don't hesitate to contact me.

TN Health

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From: Rebecca Terrell [redacted]
Sent: Monday, October 23, 2017 4:11 PM
To: Ann R. Reed
Cc: [redacted] Peter H. Warren
Subject: State of TN - Introductory Narrative - Please Review
Importance: High

Hi Ann,

Attached please find information on our new Comprehensive Reproductive Health Center project in Memphis. Our architect, Peter Warren, has outlined the questions we have for the licensing staff. Attachments include:

-Project Narrative (1-page)
-Items for Discussion (4-pages)
-Drawing (3-pages)

I have a Friday evening event in Nashville this week, and am pleased to drive over early if you think a face to face meeting would be the best way to communicate about the project. Peter can join me or can be available by phone during our meeting. I am also happy to schedule a conference call – please let me know which would be preferable for you and your team.

Sincerely,

Rebecca Terrell
Executive Director
CHOICES.
Memphis Center for Reproductive Health

1726 Poplar Ave., Memphis, TN 38104
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: A semi-annual licensure survey was conducted on 10/15/18. Planned Parenthood of Middle and East TN was in substantial compliance with licensure requirements for Ambulatory Surgery Centers. No deficiencies were cited.	A 002		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	10/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is not met as evidenced by: Stories: 2 Construction type: III protected No plans available Constructed: Sprinklered: Yes Census: A Life Safety Code Survey follow up was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 10/16/2018. During this Life Safety Survey, Planned Parenthood was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgicial Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	A 001	RECEIVED NOV 05 2018 BY: CK 11/6/18 corrected per email Chemaun PR	
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the overall environment. The findings included:	A 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	10/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 1 Observation on 10/16/2018 at 9:45 AM, revealed the 1st floor and 2nd floor stairwell doors were not latching within the frame. NFPA 101, 8.3.3.1 (2012 Edition), NFPA 80, 6.1.4.2 (2010 Edition) The manager was present when this deficiency was identified, and was later acknowledged in the exit conference on 10/16/2018.	A 801	Repairs were made to the both doors connected to the stairwell latch within the frame. PPINM will add checking doors to our routine assessment checks. This will be monitored and/or reviewed annually by the CQRM committee. RECEIVED NOV 05 2018 BY:	10/17/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING _____	R 11/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 001}	1200-8-10 Initial This Rule is not met as evidenced by: Stories: 2 Construction type: III protected No plans available Constructed: Sprinklered: Yes Census: A Life Safety revisit survey was conducted on 11/30/2018 for all previous deficiencies cited on 10/16/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: During the annual survey on 10/17/18, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200 -8-10, Standards for Ambulatory Surgical Treatment Centers.	A 002		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	10/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: This facility meets all requirements reviewed pertaining to ASTC regulations. No deficiencies were cited as a result of this licensure survey.	A 002		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: During the annual survey on 04/24/2018, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-10, Standards for Ambulatory Surgical Treatment Centers.	A 002		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING _____ B. WING _____	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: An annual licensure survey was conducted at this facility on 4/24/18. This facility complies with all standards for Chapter 1200-08-10, Standards for Ambulatory Surgical Treatment Center Facilities.	A 002		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: **01 - MEMPHIS REGIONAL PLANNED PARENTHOOD** B. WING _____	R **11/19/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	**2430 POPLAR AVE** **MEMPHIS, TN 38104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 001}	1200-8-10 Initial This Rule is met as evidenced by: A Life Safety revisit survey was conducted on 11/19/2018 for all previous deficiencies cited on 10/19/2018. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{A 001}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is not met as evidenced by: Stories: 3 Construction Type: II (111) No plans available on site Constructed: 2010 Sprinkled: No A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 10/15/2018. During this Life Safety Survey, Planned Parenthood of Greater Memphis was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgicial Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	A 001		
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the physical environment.	A 801		

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	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 1 The findings included: Observation on 10/15/18 at 12:10 PM, revealed there was not a sign identifying the storage of compressed medical gas cylinders in the medical supply room. NFPA 99, 11.3.4.1 (2012 Ed.), NFPA 99, 11.3.4.2 (2012 Ed.) NFPA 55, 4.10.2.3 (2010 Ed.) NFPA 55, 4.10.3 (2010 Ed.) The business office representative was present when the deficiency was identified and acknowledged the deficiency during the exit conference on 10/15/18.	A 801		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	10/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is : met as evidenced by: This facility meets all requirements reviewed pertaining to ASTC regulations. No deficiencies were cited as a result of this licensure survey.	A 002		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	04/23/2018

RECEIVED MAY 11 2018 BY: CS

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: An annual licensure survey was conducted at this facility on 4/23/18. This facility complies with all standards for Chapter 1200-08-10, Standards for Ambulatory Surgical Treatment Center Facilities.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CFO

Division of Health Care Facilities TO Bm7-23184

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 801}	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 101, 21.5.1.1 (2012 Ed.) Utilities shall comply with the provisions of Section 9.1. NFPA 101, 9.1.2 (2012 Ed.) Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 406.6 (2011 Ed.) Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 99, 6.3.3.2.1 (2012 Ed.) The physical integrity of each receptacle shall be confirmed by visual inspection. NFPA 101, 21.2.1 (2012 Ed.) Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 21.2.2 through 21.2.11.	{A 801}	Accepted 7-30-18 (PW)	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CFO — (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 801}	Continued From page 1 NFPA 101, 7.1.10.1* (2012 Ed.) Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. NFPA 101, 8.3.5.1*(2012 Ed.) Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly. Based on observations, the facility failed to maintain the physical plant. The findings included: 1. Observation during the follow-up survey on 7/3/18 at 1:15 PM, revealed a damaged receptacle cover beside the crash-cart (former area of oxygen cylinders).	{A 801}	ALL DEFICIENCIES WILL BE ADDED TO PPGMR'S MONTHLY FACILITY'S MAINTENANCE CHECKLIST, MONITORED BY ACCOUNTING MANAGER. REPLACE DAMAGED RECEPTACLE COVER 7/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 07/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 801}	Continued From page 2 NFPA 101, 21.5.1.1 (2012 Ed.) NFPA 101, 9.1.2 (2012 Ed.) NFPA 70, 406.6 (2011 Ed.) NFPA 99, 6.3.3.2.1 (2012 Ed.) 2. Observation during the follow-up survey on 7/3/18 at 1:30 PM, revealed 3 cases of water in the path of egress at the bottom of the rear exit stairs, and a 12 pack of bottled beer on the stairs. NFPA 101, 21.2.1 (2012 Ed.) NFPA 101, 7.1.10.1* (2012 Ed.) 3. Observation during the follow-up survey on 7/3/18 at 1:35 PM, revealed the following penetrations in the 1 hour fire rated drywall were not repaired per an approved ul system: a. bundle of cables outside the entry door on the south wall of room [redacted] b. 2 - 3 inch polyvinyl chloride sleeves (CPVC) above both sides of the door. c. 2 - 1 1/2 inch metal sleeves in the wall between [redacted] and [redacted] NFPA 101, 8.3.5.1*(2012 Ed.) An office employee was present when the deficiences were identified on 7/2/18.	{A 801}	REMOVED AND PLACED 7/5/18 IN SPECIFIED STORAGE. 3a,b,c - APPROPRIATE CONTRACTOR HAS BEEN SCHEDULED WEEK OF 8/13/18. 8/M/18	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is : met as evidenced by: A Life Safety revisit survey was conducted on 9/11/18 for all previous deficiencies cited on 7/03/18. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	A 001		

To BM 5-21-18

Division of Health Care Facilities

RECEIVED
MAY 11 2018
BY: CK

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING _____ B. WING MEMPHIS REGIONAL PLANNED PARENTHOOD	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 55, 7.1.8.4 (2010 Ed.) Securing Compressed Gas Containers, Cylinders, and Tanks Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.8.4.1 and 7.1.8.4.2. NFPA 55, 6.11.1 (2010 Ed.) Location. Hazard identification signs shall be placed at all entrances to locations where compressed gases are produced, stored, used, or handled in accordance with NFPA704, Standard System for the Identification of the Hazards of Materials for Emergency Response. NFPA 72, 14.2.1.2.2 (2010 Ed.) System defects and malfunctions shall be corrected. NFPA 10, 7.2.4.4 (2010 Ed.) Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. NFPA 101, 8.3.5.1*(2012 Ed.) Firestop Systems	A 801	Accepted 6-7-18 BM	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — DATE

D Kendrick — CEO — 5/10/18

STATE FORM 6899 DQ4R21 If continuation sheet Page 1 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 1 and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly. Based on observations, the facility failed to maintain the physical plant. The findings included: 1. Observation on 4/24/18 at 10:28 AM, revealed (3) unsecured oxygen cylinders in the surgery suite. NFPA 55, 7.1.8.4 (2010 Ed.) 2. Observation on 4/24/18 at 10:28 AM, revealed required signage missing for oxygen tanks being stored and used in the surgery suite and room [redacted] NFPA 55, 6.11.1 (2010 Ed.) 3. Observation on 4/24/18 at 10:42 AM, revealed blue painters tape over the smoke detector in the biohazard room on the 1st floor. NFPA 72, 14.2.1.2.2 (2010 Ed.)	A 801	A 801 SECURED STORAGE CARTS WILL BE ORDERED AND HEALTH CENTER MANAGER WILL MAINTAIN ADHERENCE. 6/15/18 A 801 PROPER SIGNAGE HAS BEEN ORDERED AND HEALTH CENTER MANAGER WILL MAINTAIN ADHERENCE. 6/1/18 A 801 TAPE REMOVED 4/24/18 AND 4/24/18 ACCOUNTING ASSISTANT WILL MONITOR MONTHLY.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 2 4. Observation on 4/24/18 at 10:20 AM, revealed the fire extinguishers thru out the building were not being signed on service tags for monthly inspections. NFPA 10, 7.2.4.4 (2010 Ed.) 5. Observations on 4/24/18 between 10:36 AM and 10:54 AM, revealed the following penetrations in the 1 hour fire rated walls listed below. a. boiler room on 1st floor (1) 1 1/2 inch copper pipe on south wall (1) flex conduit over door on west wall (1) 1 1/2 inch PVC hot water pipe on south wall b. mechanical room [redacted] on 2nd floor (2) PVC pipes marked S & R over entry door on south wall (2) flex conduit outside of mechanical room entry door c. room [redacted] 2nd floor (1) bundle of cables outside of entry door on south wall d. room [redacted] 2nd floor (2) white cables inside entry door on the right side NFPA 101, 8.3.5.1*(2012 Ed.) 6. Observation on 4/24/18 at 10:54 AM, revealed foam filled penetrations in the following locations: a. mechanical room [redacted] on 2nd floor (1) wall damper on the northwest wall	A 801	NFPA 10 7.2.4.4 APPROVES USE OF AN INSPECTION CHECK-LIST MAINTAINED ON FILE WHICH WAS PRESENTED TO TN DOH INSPECTORS. CFO WOULD REQUEST CLARIFICATION ON NFPA 10. HEALTH CENTER MANAGER/ACCOUNTING ASSISTANT WILL SIGN SERVICE TAGS WHEN INSPECTED MONTHLY. 5/1/18 5 a, b, c, d WILL BE FIRE CAULKED TO SEAL ALL PENETRATIONS. CFO AND ACCOUNTING MANAGER WILL INSPECT MONTHLY 6/30/18 SEE NEXT PAGE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING _____ 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING _____	04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 3 (1) air duct on outside wall (2) ceiling penetrations outside room [redacted] (2) 3 inch PVC pipes outside room (2) 1 1/2 inch metal sleeves outside room NFPA 101, 8.3.5.1*(2012 Ed.) An office employee was present when the deficiences were identified. The CFO acknowledged the deficiences in the exit conference on 4/24/18.	A 801	6A. ALL FOAM FILLED PENETRATIONS WILL BE REPLACED WITH FIRE CAULK SEALANT.	4/30/18

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL63515	A. BUILDING: 02 - STATE BUILDING RECEIVED B. WING APR 07 2017	03/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the physical plant. Observation on 03/21/2017 at 9:36 AM, revealed three 1.5 inch PVC sleeves in the second floor mechanical room used to run data lines, was not properly sealed between the first and second floor. 39.3.1.1 NFPA 101 (2012 Edition) 8.6.1 NFPA 101 (2012 Edition) The administrator was present for this finding and acknowledged during the exit conference on 03/21/2017.	A 801	The deficiency will be corrected by fire blocking the three 1.5 inch PVC sleeves in the second floor mechanical room used to run data lines. The deficiency will be corrected on March 27, 2017. This will be added to the quarterly facilities audit to ensure deficient practice does not recur. This corrective action will be monitored through the risk and quality managment program which is overseen by the Risk and Quality Managment Coordinator. PoC acceptable per Colbie email 4/20/17 AR	3/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Resident KEO (X6) DATE: 04/05/17

STATE FORM 6899 DWLI21 If continuation sheet 1 of

E-MAILED to CH 4/10/17 ES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: A licensure survey was completed 3/20/17. The facility was found to be in compliance with state regulations for Ambulatory Surgical Centers. No deficiencies were cited during the licensure survey.	A 002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	09/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 420	1200-8-10-.04 (16) Administration (16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges. This Rule is not met as evidenced by: Based on facility policy review, facility board minutes and interview, the facility's governing board failed to provide for reappointment of health care professionals for 3 of 5 (Medical Doctor (MD) #1, Certified Registered Nurse Anesthetist (CRNA) #1 and Family Nurse Practitioner (FNP) #1) health care professionals reviewed. The findings included: 1. Review of the facility policy, "Credentialing of Clinicians" revealed, "This document defines the specific policy and procedure to be followed to credential a clinician (MD, CNM [Certified Nurse Midwife], FNP) to provide medical care or services at [Name of facility]....7 The Medical Director will review the information described above and will make a recommendation to the Medical Services committee to grant or deny privileges 8 The Medical Services committee will review the materials and the Medical Director's recommendation, and will vote to approve or deny privileges via email vote or via in person vote at a regularly scheduled meeting. 9. The President of the Board of Directors will approve the final granting of clinical privileges..." Review of the facility policy, "Medical Services Committee policy and Procedure" revealed, ". This document defines the specific policy to be	A 420	The Medical Services Committee of the Memphis Center for Reproductive Health (MCRH) voted on 9/19/17 to approve revisions to the SOP "Credentialing of Clinicians" to include language specifying that the Board of Directors would annually review & approve the recommendations of the Medical Director and Medical Services Committee regarding the credentialing of clinicians at MCRH. The Board will review MSC recommendations for all current clinicians and will vote on credentialing approval at the upcoming meeting on Sept. 26, 2017 Accepted Kathy Langston 9-19-17	09/19/2017 09/26/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	09/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 420	Continued From page 1	A 420		

followed in governing the responsibilities and operations of the Medical Services committee which will be referred to as either "committee" or MSC throughout the remaining portion of the policy... 1. Purpose Statement: Medical Services Committee is charged with oversight, monitoring, and management of all Medical services, operations, policies, and procedures as well as the specified categories listed below in accordance with the cited T.C.A. [Tennessee Code Annotated] regulation. Operation, decision making, review of policy and procedures as well as recommendations by the [name of facility] Medical Services Committee will be made in accordance to the guidelines and policies outlined within this policy... 2) Specified Categories under Responsibility of Medical Services Committee as required by T.C.A. for ASCT [Ambulatory Surgery Treatment Centers]...e. Appointment, Reappointment, and Dismissal of clinicians providing clinical services ... The Medical Director has full final authority to approved or disapproved decisions and recommendations of the Medical Services Committee prior to submission to the Executive Director in accordance with T.C.A 1200-08-10-.04(9)..."

2. Review of the Governing Board minutes for 2017 revealed there was no documentation the Board had reviewed or approved credentials for the health care professionals

3. Review of MD #1's credential file revealed there was no documentation the governing body had granted appointment or reappointment privileges.

4. Review of CRNA #1's credential file revealed there was no documentation the governing body had granted appointment or reappointment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	09/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 420	Continued From page 2 privileges. 5. Review of FNP #1's credential file revealed there was no documentation the governing body had granted appointment or reappointment privileges. 6. During an interview in the conference area on 9/6/17 at 10:45 AM, the Executive Director verified there was no documentation by the Governing Body for appointment or reappointment of health care professionals.	A 420		

CHOICES.
Memphis Center for Reproductive Health

Medical Services Committee
Standard Operating Procedure
Credentialing of Clinicians

Effective Date: September 19, 2017	Supersedes: August 27, 2015	Prepared by: Rebecca Terrell, Executive Director
Revision No:		Approved by: Medical Services Committee, Medical Director 9/19/2017

Title: Credentialing of Clinicians

Purpose:

This document defines the specific policy and procedure to be followed to credential a clinician (MD, CNM, FNP) to provide medical care or services at CHOICES.

Scope:

This policy applies to all staff, volunteers, and contractors of CHOICES.

Policy:

Clinicians desiring to provide medical counseling or care at CHOICES, on a paid and/or volunteer basis, are required to be credentialed by the Medical Services Committee as described below.

Procedures:

1. Clinicians applying for privileges at CHOICES must complete an employee application and provide required documents as described below.
2. The Practice Manager will complete the Documents section of the **Credentialing Requirements Form** (attached) to verify that all items are complete. The Medical Director or other provider with current privileges at CHOICES will complete the Observations sections of the Credentialing Requirements Form.
3. The CHOICES Medical Director will review all documents for validity.
4. The Practice Manager will run a criminal background check on the applicant.
5. The Medical Director will conduct a personal interview with the applicant in which they will assess the applicant's relevant training and experience, current competence and the ability to perform requested privileges. Notes from this interview will be included in the applicant's credentialing file.
6. The Medical Director will personally observe the applicant providing the counseling or care as described below, and when satisfied that the applicant has demonstrated the skills and expertise required, will sign off on applicant's ability to provide specific services independently. The check off form with signatures will be included in the applicant's credentialing file.
7. The Medical Director will review the information described above and will make a recommendation to the Medical Services Committee to grant or deny privileges.

9-19-17

8. The Medical Services Committee will review the materials and the Medical Director's recommendation, and will vote to approve or deny privileges via email vote or via in person vote at a regularly scheduled meeting.
9. The Medical Director will forward the MSC's decision to the Executive Director.
10. The Executive Director will add the MSC's recommendations recommendations to grant clinical privileges at CHOICES to the Board of Directors' Agenda at least once a year (typically for the November meeting).
11. The Board will vote once each year to approve the MSC's recommendations to grant clinical privileges at CHOICES to clinicians (typically at the November meeting).
12. The President of the Board of Directors will sign all forms granting clinical privileges to CHOICES on behalf of the Board.
13. If approved, documentation of applicant's privileges at CHOICES will be included in the applicant's credentialing file.

I. **DOCUMENTS REQUIRED FOR CHECK OFF**

a. Valid Tennessee Medical License
b. Board Certification, if relevant to proposed services
c. Documentation of current local hospital privileges, if relevant to proposed services
d. Documentation of current Medical Malpractice Insurance
e. DEA number, if relevant to proposed services
f. NPI number, if relevant to proposed services
g. Other documents as requested

II. **OBSERVATIONS REQUIRED FOR CHECK OFF**

a. Counseling or patient education only: Two sessions of direct patient counseling
b. Provision of direct medical care:
    i. General gynecological examination including PAP smears, STD testing: Two exams
    ii. Transgender hormone management: Five patient visits
    iii. Colposcopies: 10 procedures
    iv. Pregnancy Terminations – Medication: Five patient education sessions for MAB
    v. Pregnancy Terminations – Surgical:
        A. Regular (<12 weeks): 10 procedures
        B. Advanced (12 – 15 weeks): 15 procedures
c. Other services: As determined by the Medical Director

The Medical Director has full final authority to approve or disapprove decisions and recommendations of the Medical Services Committee prior to submission to the Executive Director in accordance with T.C.A 1200-08-10-.04(9).

REFERENCES

T.C.A. 1200-08-10.04(16); T C A. 1200-08-10-.06 (3) Credentialing Requirements Form attached

CHOICES.
Memphis Center for Reproductive Health

Medical Services Committee
Standard Operating Procedure
Credentialing of Clinicians

CREDENTIALING REQUIREMENTS FORM PROVIDER: _____

DOCUMENT OR OBSERVATION	DATE RECEIVED OR OBSERVED	PM INITIALS
Valid Tennessee Medical License		
Board Certification, if relevant to proposed services		
Documentation of current local hospital privileges, if relevant to proposed services		
Documentation of current Medical Malpractice Insurance		
DEA number, if relevant to proposed services		
NPI number, if relevant to proposed services		
Board Certification, if relevant to proposed services		
Criminal background check completed – printed copy in file		
Other documents as requested:		
Counseling or patient education only: Two sessions of direct patient counseling		**MD INITIALS**
1		
2		
Provision of direct medical care:		
General gynecological examination including PAP smears, STD testing: Two exams		
1		
2		
Transgender hormone management: Five patient visits		
1		
2		
3		
4		
5		
Colposcopies: 10 procedures		
1		
2		
3		
4		

Americans United for Life

5		
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Pregnancy Terminations – Medication: Five patient education sessions	**DATE OBSERVED**	**MD INITIALS**
1		
2		
3		
4		
5		
Pregnancy Terminations – Surgical:		
Regular (<12 weeks): 10 procedures		
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
Advanced (12 – 15 weeks): 10 procedures		
1		
2		
3		

4		
5		
6		
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8		
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Other services:		

I certify that _____ has met all requirements and has been approved by the Board of Directors to provide medical services at CHOICES Memphis Center for Reproductive Health.

_____ _____

Medical Director **Date**

_____ _____

President, Board of Directors **Date**

Rev 08-26-15

Americans United for Life

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	03/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is · ·met as evidenced by: This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment Centers during the Licensure survey conducted on 3/21/17. No deficiencies were cited.	A 002		

Division of Health Care Facilities

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	03/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 70, 210.23 (2011 Ed.) Permissible Loads. In no case shall the load exceed, the branch-circuit ampere rating. An individual branch, circuit shall be permitted to supply any load for which it is rated. A branch circuit supplying two or more outlets or receptacles shall supply only the loads specified according to its size as specified in 210.23(A) through (D) and as summarized in 210.24 and Table 210.24. NFPA 55, 7.1.8.4 (2010 Ed.) Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.8.4.1 and 7.1.8.4.2. Based on observations, the facility failed to maintain the physical plant. The findings included: 1. Observation on 3/21/17 at 8:30 AM, revealed extension cords in the following areas:	A 801	1a. After the inspection on 3/23/2017. Clinic Coordinator,disabled extension cord from ultrasound exam room and replaced with a surge protector on 3/24/2017. Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future. (NFPA) 70,210.23 (2011 Ed) b. After the inspection on 3/23/2017. Clinic Coordinator,disabled extension cord from waiting room B, and replaced with surge protector on 3/24/2017. Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future. (NFPA) 70,210.23 (2011 Ed) c. After the inpection on 3/23/2017. Clinic Coordinator, disabled extension cord from recovery room, and replaced medical equipment with current wall outlet on 3/24/2017. Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future. (NFPA) 70,210.23 (2011 Ed.)	3/24/2017 3/24/2017 3/24/2017

Accepted 4-6-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	03/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 1 a. ultrasound exam room. b. waiting room B. c. recovery room. d. room #2. NFPA 70, 210.23 (2011 Ed.) 2. Observation on 3/21/17 at 8:45 AM, revealed an unsecured oxygen cylinder in the hallway by room #2. NFPA 55, 7.1.8.4 (2010 Ed.) The clinical manager was present when the deficiencies were identified and acknowledged the deficiencies during the exit conference on 3/21/17.	A 801	d. After the inspection on 3/23/2017. Clinic Coordinator, disabled extension cord from room #2,will be replaced with a surge protector. Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future. (NFPA) 70,210.23 (2011 Ed.) 2. After the inspection on 3/23/2017. Clinic Coordinator ordered a oxygen cart to secure the oxygen cylinder in the hallway by room #2. Clinic Coordinator will create a monthly checklist to monitor the oxygen cylinder to prevent any unusual recurring in the future. (NFPA) 22,7.1.8.4 (2010 Ed.)	3/31/2017 3/27/2017

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING _____	09/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is . met as evidenced by: During the annual survey on 09/06/2017, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-10, Standards for Ambulatory Surgical Treatment Centers.	A 002		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	09/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 001	1200-8-10 Initial This Rule is met as evidenced by: This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment Centers during the Licensure survey completed on 9/5/17. No deficiencies were cited.	A 001		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING. _____ B. WING _____	10/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: A licensure survey was completed 10/24/16. The facility was found to be in compliance with state regulations for Ambulatory Surgical Centers. No deficiencies were cited during the licensure survey.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

ASTC

PRINTED: 10/31/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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NOV 10 2016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. acceptable, per Cathy 11/16/16 AR This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the physical plant and overall environment. The findings included: 1. Observation on 10/18/2016 at 9:38 AM, revealed an exit sign falling from the ceiling by the 2nd floor reception desk. NFPA 101, 7.9.1.1 (2012 Edition) 2. Observation on 10/18/2016 at 9:43 AM, revealed 1 ceiling tile missing and 1 ceiling tile damaged in the 2nd floor communication room. 3. Observation on 10/18/2016 at 9:45 AM, revealed an extension cord in use outside of the lab. NFPA 70, 590.3 (2011 Edition) 4. Observation on 10/18/2016 at 9:48 AM, revealed an escutcheon plate missing in the storage closet of the POC room. NFPA 13, 6.2.7.1 (2010 Edition) Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/18/2016.	A 801	A801: 1. The deficiency will be corrected by securing the exit sign by the 2nd floor reception desk to the ceiling. The deficiency will be corrected on October 30, 2016. This will be added to the quarterly facilities audit to ensure deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator 2.The deficiency will be corrected by replacing the missing and damaged ceiling tiles in the 2nd floor communication room. Ventilation screens will be added to communication doors to ensure adequate ventilation. The deficiency will be corrected on October 30, 2016. This will be assessed as part of the quarterly facilities audit to ensure deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator. 3.The deficiency will be corrected by replacing the extension cord outside of the 2nd floor lab with a medical grade surge protector. The deficiency will be corrected on October 30, 2016. This will be assessed as part of the quarterly facilities audit to ensure deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Managment Coordinator. 4. The deficiency will be corrected by replacing the escutcheon plate to the sprinkler in the storage closet of the POC room. The deficiency will be corrected on October 30, 2016. This will	10/30/16 10/30/16 10/30/16 10/30/16

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

President/CEO 11/02/16

STATE FORM 6899 71T621 If continuation sheet 1 of 3

E-MAIL to CH 11/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 818	Continued From page 1	A 818	(continued from page 1) be assessed as part of the quarterly facilities audit to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator.	
A 818	1200-8-10-.08 (18) Building Standards (18) It shall be demonstrated through the submission of plans and specifications that in each ASTC a negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain negative air pressure where required. The findings included: Observation on 10/18/2016 at 9:35 AM, revealed there was no negative air pressure in the 2nd floor staff only restroom. Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/18/2016.	A 818	A818: This deficiency will be corrected by fixing the exhaust fans in the 2nd floor staff only rest room. This deficiency will be corrected on November 3, 2016. This will be assessed as part of the quarterly facilities audit to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator.	11/3/16
A1401	1200-8-10-.14 (1)(a) Disaster Preparedness (1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training	A1401	A1401: The deficiency will be corrected by conducting fire drills quarterly and maintaining a detailed log of who attended drills and specifics of what was performed during each drill. Drills will include minor fires, major fires, fighting the fire, evacuation procedures, and staff functions. The deficiency will be corrected on November 11, 2016. A HR Audit will be completed monthly to ensure appropriate drills have been completed on time and contain adequate detail. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator.	11/11/16

E-MAILED
to CH 11/15/16 RR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1401	Continued From page 2 received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually: (a) Fire Safety Procedures Plan shall include: 1. Minor fires; 2. Major fires; 3. Fighting the fire; 4. Evacuation procedures; 5. Staff functions. This Rule is not met as evidenced by: Based on document review, the facility failed to maintain a detailed log of staff training. The findings included: Document review on 10/18/2016 at 8:41 AM, revealed the facility failed to maintain a detailed log of fire plan training received by staff. Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/18/2016.	A1401	E-MAILED to CH 11/15/16 AR	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	05/02/2016

RECEIVED
MAY 12 2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 420	1200-8-10-.04 (16) Administration (16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges. This Rule is not met as evidenced by: Based on review of credentials files, the facility failed to produce proof the governing body had provided for the reappointment of a member of the medical staff and provided for the granting of clinical priveleges for 1 of 3 (Physician #3) physicians practicing at the facility. The findings included: 1. Review of the credentials file for Physician #3 revealed the privileges were expired. There was no documentation the governing body had reappointed Physician #3 and granted clinical privileges. 2. During an interview in the office on 5/2/16 at 3:05 PM, the Director of Electronic Health Records verified there was no documentation Physician #3 had been reappointed and granted clinical privileges.	A 420	The deficiency will be corrected by creating a process that requires that the board vote for the appointment, reappointment, or dismissal of all members of the medical staff and grant clinical privileges. The current form used to grant clinical privileges for all members of the medical staff that is signed by the medical director will be updated to add signature lines for the board chair and the board secretary to sign on behalf of the board after a board vote takes place. The deficiency will be corrected on May 17, 2016. The manager of human resources will ensure credentialing of providers is up to date including required board approval by maintaining the HR spreadsheet that tracks provider credentialing and completing monthly HR audits to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.	5/17/16

Accepted 5-17-16 PR

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: President/CEO DATE: 5/12/16

STATE FORM 6899 PDYQ11

Americans United for Life

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING 02 - STATE BUILDING RECEIVED B. WING MAY 12 2016	05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the overall environment. The findings included: Observation on 5/2/16 at 9:38 AM, revealed a water damaged ceiling tile in the consultation room by the fire door on the 2nd floor. This finding was verified and acknowledged by the CEO during the exit conference on 5/3/16.	A 801	The deficiency will be corrected by replacing the water damaged ceiling tile in the consultation room by the fire door on the 2nd floor. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of ceiling tiles for damage to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services. Accepted plan Kelley 5-17-16 RR	5/11/16
A 818	1200-8-10-.08 (18) Building Standards (18) It shall be demonstrated through the submission of plans and specifications that in each ASTC a negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observations and testing, the facility failed to maintain negative air pressure in toilet room.	A 818	The deficiency will be corrected by fixing the exhaust fans in the staff rest room near the surgical suite and the janitorial closet in the nurse's station to maintain negative air pressure. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of exhaust fans to ensure they are properly working and that negative air pressure is maintained to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.	5/11/16

E-MAILED to Kelley 5/17/16 RR

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 818	Continued From page 1 The findings included: Observation and testing on 5/2/16 at 9:37 AM, revealed the no negative air pressure inside the Staff Restroom near the surgical suite and the janitorial closet in the nurse's station. This finding was verified and acknowledged by the CEO during the exit conference on 5/3/16.	A 818		
A 901	1200-8-10-.09 (1) Life Safety (1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations and document review, the facility failed to comply with the required applicable building and fire safety regulations. These findings included: 1. Observation on 5/2/16 at 9:02 AM, revealed a space heater in the exam room by the rear exit. NFPA 101, 21.7.8 (2012 Edition) 2. Document review on 5/2/16 at 9:50 AM, revealed the facility failed to provide documentation for the required sensitivity testing of the smoke detectors. NFPA 72, 14.4.5.3.2 (2010 Edition)	A 901	1. The deficiency will be corrected by removing space heater in the exam room by the rear exit. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include verifying the absence of space heaters throughout the building to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services. 2. The deficiency will be corrected by having Simplex Grinnell conduct a smoke detector sensitivity inspection annually. This inspection is scheduled for June 1, 2016 and the deficiency will be corrected on this date. This Inspection will be added to the facility's contract with Simplex Grinnell to be completed on an annual basis to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.	5/11/16 6/1/16

E-MAILED to Cathy Sparks

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	05/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 2 3. Observation on 5/2/16 at 9:30 AM, revealed the switch cover for the light switch near the surgery suite door entering the waiting room was damaged. NFPA 70, 314.28 (2011 Edition) 4. Observation on 5/2/16 at 9:39 AM, revealed a sprinkler escutcheon plate missing in the secondary waiting room's restroom. NFPA 13, 6.2.7 (2010 Edition) These findings were verified and acknowledged by the CEO during the exit conference on 5/2/16.	A 901	3. The deficiency will be corrected by replacing the damaged switch cover for the light switch near the surgery suite door entering the waiting room. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of light switch covers for damage to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services. 4. The deficiency will be corrected by adding an escutcheon plate to the sprinkler in the secondary waiting room's rest room. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of sprinklers to look for missing or damaged escutcheon plates to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.	5/11/16 5/11/16

Division of Health Care Facilities

RECEIVED
OCT 18 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL63544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	09/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	1200-8-10-.09 (1) Life Safety (1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 101, 8.3.5 (2012 Ed.) The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. Based on the observations, the facility failed to comply with the required life safety and building code regulations. The findings included: Observation on 09/27/16 at 1:20 PM, revealed the following penetrations in the ceiling of the electrical/phone room above panel LB: a. unapproved fire stop around 6 conduits. b. 1 unsealed metallic flex conduit. c. unapproved fire stop around 2 - 1/2" cables. National Fire Protection Association (NFPA) 101,	A 901 Accepted 10/28/16	a. After the inspection on 9/27/2016. Nancy Shotwell,Clinic Coordinator contacted Hilti Firestop Systems on 10/3/2016 re: unapproved fire stop around 6 conduits. On 10/6/2016 Hilti Firestop Systems was on-site to evaluate the 6 conduits. System No. F-C-2071 will be used to repair. Nancy Shotwell,Clinic Coordinator will create a monthly checklist to monitor the 6 conduits in the phone/electrical room to prevent any unusual recurring in the future. (NFPA) 101,8.3.5 (2012 Ed) b. After the inspection on 9/27/2016. Nancy Shotwell, Clinic Coordinator contacted Rhodes Electric on 9/28/2016 re: 1 unsealed metallic flex conduits. On 9/30/2016 Rhodes Electric was on-site to repair and seal metallic flex conduit.	10/18/2016 9/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	09/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 1 8.3.5 (2012 Ed.) This finding was verified on 09/27/16 by a staff member from the facility.	A 901	(con't b.)Nancy Shotwell, Clinic Coordinator will create a monthly checklist to monitor the phone/electrical room for any unusual findings to prevent recurring in the future. (NFPA) 101,8.3.5 (2012 Ed) c. After the inspection on 9/27/2016. Nancy Shotwell,Clinic Coordinator contacted Hilti Firestop Systems on 10/3/2016 re: unapproved fire stop around 2-1/2" cables. On 10/6/2016 Hilti Firestop Systems was on-site to evaluate the fire stop around 2-1/2" cables. System No. F-C-2071 will be used to repair. Nancy Shotwell,Clinic Coordinator will create a monthly checklist to monitor the the fire stop around 2-1/2" cables in the phone/electrical room to prevent any unusual findings from recurring in the future. (NFPA) 101,8.3.5 (2012 Ed)	9/30/2016 10/18/2016

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	09/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEALTH	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is not met as evidenced by: This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment centers during the Licensure survey completed on 9/26/16. No deficiencies were cited.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: During the survey on 3/28/16, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200 -8-10, Standards for Ambulatory Surgical Treatment Centers.	A 002		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is : met as evidenced by: This facility complies with all requirements reviewed for Ambulatory Surgery Centers during this licensure survey conducted 3/28/16. No deficiencies were cited.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING _____	RECEIVED 09/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

OCT 27 2016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	1200-8-10-.09 (1) Life Safety (1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 10, 6.1.3.3.1 (2010 Ed.) Fire extinguishers shall not be obstructed or obscured from view. NFPA 101, 21.2.1 (2010 Ed.) Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 21.2.2 through 21.2.11. NFPA 101, 7.5.1.1 (2010 Ed.) Exits shall be located, and exit access shall be arranged, so that exits are readily accessible at all times. Based on the observations, the facility failed to comply with the required life safety and building code regulations. The findings included: 1. Observation on 09/27/16 at 2:35 PM, revealed a fire extinguisher outside the lobby waiting room was obstructed by an advertisement signage. NFPA 10, 6.1.3.3.1 (2010 Ed.) 2. Observation on 09/27/16 at 2:50 PM, revealed storage of signage in the stairway. NFPA 21.2.1 (2010 Ed.) Every aisle, passageway, corridor, exit discharge, exit location, and access	A 901 Accepted 10/28/16	DEFIENCIES 1) & 2) WERE BOTH CORRECTED AT THE TIME OF THE SITE VISIT. APPROPRIATE STORAGE FOR #2 WAS IDENTIFIED AND COMMUNICATED TO STAFF. APPROPRIATE DISPLAY FOR #1 WAS IDENTIFIED AND COMMUNICATED TO STAFF. BOTH CFO AND VP OF PATIENT SERVICES WILL MONITOR ON A DAILY BASIS TO ENSURE THE DEFICIENCY DOES NOT RECUR.	9/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	09/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 1 shall be in accordance with Chapter 7, unless otherwise modified by 21.2.2 through 21.2.11. NFPA 101, 7.5.1.1 (2010 Ed.) Exits shall be located, and exit access shall be arranged, so that exits are readily accessible at all times. The findings were verified during the survey by the business manager on 09/27/16.	A 901		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	09/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS REGIC	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is not met as evidenced by: This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment Centers during the Licensure survey completed on 9/27/16. No deficiencies were cited.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

emailed copies

PRINTED: 04/11/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING _____	03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	1200-8-10-.09 (1) Life Safety (1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, the facility failed to comply with the required building and fire safety regulations. The findings included: Observation on 3/28/16 at 9:30 AM, revealed penetrations in the fire barriers in the following locations:. a. 4 penetrations in the ceiling of generator room. b. 8 penetrations in the ceiling of 2nd floor mechanical room. National Fire Protection Association (NFPA 101, 8.3.5 2012 Edition) These findings were acknowledged by the administraitor during the tour on 3/28/16.	A 901	Accepted 5/5/16 BH ATTACHED PLEASE FIND QUOTE FOR ALL REPAIRS RECEIVED 4/20/16. VP OF FINANCE AUTHORIZED. WILL BE CHECKED QUARTERLY BY FACILITY MANAGER/ VP OF FINANCE	4/29/16

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: CEO

(X6) DATE: 4/29/16

STATE FORM 6899 9I4H21 If continuation sheet Page

Americans United for Life

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: This facility complies with all state licensure requirements reviewed during this licensure survey. No deficiencies were cited.	A 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: This facility complies with all State licensure requirements reviewed during the annual licensure survey.	A 002		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	R 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 801}	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the condition of the surgery center in a manner that the safety and well-being of the patients were assured. The findings included: Observation of the surgery center during the follow up survey on 1/26/16 revealed the elevator equipment room had multiple penetrations in fire rated walls covered with an unapproved fire stop method. (blowout patches) National Fire Protection Association (NFPA) 101, 39.3.2 (2000 edition). These findings were verified and acknowledged by the surgery center representative during the tour and exit conference on 1/26/16.	{A 801}	The wall was constructed in accordance with Tennessee Department of Health approved plans.	1/27/16

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

3/4/16

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA:	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	1200-8-10-.09 (1) Life Safety (1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations the facility failed to maintain the overall environment. The findings include: 1. Observation of the 1st floor mechanical room by staff break room on 10/7/15 at 11:33 AM, revealed three (3) penetrations in fire barrier. National Fire Protection Association (NFPA) 101: 8.3.5.1 (2012 Edition)	A 901	1. The deficiency will be corrected by having the area in question enclosed. 2. When building modifications are performed the contractor will ensure the changes are in compliance with Fire Safety regulations. 3. A service call has been placed with Life Safety and Fire Safety vendor scheduled for 10/30/15. 4. The facility has quarterly and annual fire inspections that can ensure this deficiency does not reoccur.	11/9/15
	2. Observation on 10/7/15 at 11:34 AM, revealed escutcheon plates around the sprinkler loose in the following areas: a. 2nd floor stairwell (1 of 2) b. 2nd floor hallway by waiting room c. 2nd floor waiting room 2 bathroom d. recovery room staff only closet e. 1st floor storage room across from biohazard room NFPA 13, 6.2.7.1 (2010 Edition)		1. The deficiency will be corrected by having Life Safety and Fire Safety vendor Simplex Grinnell to come replace and or tighten escutcheon plates in each of the areas in question. 2. The facility has quarterly and annual fire inspections and escutcheon plates are checked. 3. The deficiency was corrected on October, 23,2015. 4. See above answer #2	10/23/15
	3. Observation on 10/7/15 at 11:34 AM, revealed the fire rating tags were painted over on the following door frames: a. 2nd floor stairwell by elevator b. 2nd floor laundry room. NFPA 80, 4.2.2 (2010 Edition)		1. The deficiency will be corrected by having paint removed from fire rating tags. 2. The facility will notify any future contractors that fire rating tags should not be painted. 3. This deficiency will be corrected by November 9, 2015. 4. The facility will be sure that future contractors are aware that fire tags are not to be painted.	11/9/15

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Nicole Allen

TITLE: Director of Patient Services

(X6) DATE: 11/2/15

STATE FORM 6899 LFND21 If continuation sheet 1 of 2

E-MAILED
11/3/15 - PDC

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 1 4. Observation on 7/10/15 at 11:41 AM, revealed the following smoke doors did not latch within the door frame: 2nd floor near consultation office and recovery room bathroom. NFPA 80, 6.1.4.2 (2010 edition) 5. Observation on 7/10/15 at 11:59 AM, revealed the fire doors would not latch within the door frame in the following locations: 1st floor stairwell by elevator and 1st floor storage room across from biohazard room. NFPA 80, 7.1.4 (2010 Edition) These findings were verified and acknowledged by facility administrator during exit conference on 10/07/15.	A 901	1. The deficiency will be corrected by having service vendor West End Lock to adjust smoke doors. 2. Quarterly and annual fire inspections are performed and any deficiencies should be noted at inspections. 3. A service call is scheduled for 11-2-2015 with West End Lock. 4. See above action #2	11/9/15
A1400	1200-8-10-.14 Disaster Preparedness This Rule is not met as evidenced by: Based on document review the facility failed to conduct disaster drills. The finding included: During document review on 7/10/15 at 12:31 PM, revealed the facility failed to conduct the following disaster drills during 2014: a. tornado b. bomb c. earthquake This finding was verified and acknowledged by facility administrator during exit conference on 10/07/2015.	A1400	1. This deficiency will be corrected by having documented copies of the facility disaster drills that have been conducted. 2. The Center Manager along with Director of Patient Services will ensure the documentation is filed at the facility in addition to the original that is currently kept on file at the administrative office. 3. Fire safety log will be created to include the drills performed in 2014 as well as current drills. 4. This corrective action will be monitored by Center Manager and Director of Patient Services each will make sure that the log kept at the facility reflects the records kept at the administrative office.	11/6/15

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA:	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 407	1200-8-10-.04 (6) Administration (6) The ambulatory surgical treatment center shall ensure a framework for addressing issues related to care at the end of life. This Rule is not met as evidenced by: Based on interview, the facility failed to ensure a framework for addressing issues related to care at the end of life. The findings included: 1. During an interview in the office on 10/7/15 at 1:30 PM, when asked if there was a policy addressing issues related to care at the end of life, the Director of Patient Services stated, "We don't have anything like that here."	A 407	The deficient practice will be corrected by adding a written policy to PPMET Standard Operating Procedures relating to End of Life Care. 2. When PPMET annual review of Standard Operating Procedures is performed a review of the End of Life policy and procedures will be reviewed and updated as needed. 3. The policy and procedure regarding End of Life Care will be added to PPMET Standard Operating Procedures by Oct. 30,2015 4. This practice will be monitored at annual review of facilities Standard Operating Procedures.	10/30/15
A 408	1200-8-10-.04 (7) Administration (7) The ambulatory surgical treatment center shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program. This Rule is not met as evidenced by: Based on interview, the facility failed to develop an effective pain management program. The findings included: 1. During an interview in the office on 10/7/15 at 1:40 PM, when asked if the facility had a policy and procedure for managing pain, the Director of Patient Services stated, "No, we don't have anything like that."	A 408	1. The deficient practice has been corrected by further review of facilities Medical Practice Protocols that outline Pain Management for patients. 2. The facility will continue to conduct annual protocol review and ensure all staff are familiar with any updates and revisions to the guidelines. Staff training will be conducted by October 23,2015. 3. This is currently in practice as the guidelines for pain management are in the facilities Medical Practice Protocols which where implemented February 2015. 4. The facility will conduct staff meeting annually to ensure all staff is aware of any revisions and or updates have been addressed.	10/23/15
A 420	1200-8-10-.04 (16) Administration (16) The governing body shall provide for the appointment, reappointment or dismissal of	A 420		

Accepted 11/16/15 - PDC

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 420	Continued From page 1 members of the medical, dental, and other health professions and provide for the granting of clinical privileges. This Rule is not met as evidenced by: Based on review of credentials files, the facility failed to produce proof the governing body had provided for the reappointment of a member of the medical staff and provided for the granting of clinical priveleges for 1 of 4 (Physician #2) physicians practicing at the facility. The findings included: 1. Review of the credentials file for Physician #2 revealed the privileges were expired. There was no documentation the governing body had reappointed Physician #2 and granted clinical privileges. 2. During an interview in the office on 10/7/15 at 2:30 PM, the Director of Patient Services verified there was no documentation Physician #2 had been reappointed and granted clinical privileges.	A 420	1. The facility has been in direct contact with Physician #2 to obtain verification of privileges while current credentialing warehouse processes provider information. 2. The Manager of HR will ensure credentialing of providers is up to date by maintaining and monitoring detailed spreadsheet that tracks credentialing due dates including licensing and privileging. 3. The practice of the monitoring and tracking credentialing has begun August 20, 2015. 4. A monthly audit will be completed by the Manager of HR to determine that credentialing is current for each provider. Credentialing paperwork will be given to providers two months in advance and paperwork will be filed no later than thirty days prior to renewal date.	10/30/15
A 614	1200-8-10-.06 (1)(n) Basic Services (1) Surgical Services. (n) Properly executed informed consent, advance directive, if available, and organ donation forms, if available, must be in the patient ' s chart before surgery, except in emergencies. This Rule is not met as evidenced by:	A 614		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 614	Continued From page 2 Based on medical record review and interview, the facility failed to have an informed consent in the record for 1 of 9 (Patient #10) patients undergoing a surgical procedure and failed to document advanced directives and organ donation for 2 of 9 (Patients #3 and 5) sampled patients undergoing surgical procedures. The findings included: 1. Medical record review for Patient #10 documented an admission date of [redacted] with a diagnosis of Legally Induced Abortion. There was no documentation of consent for the procedure. During an interview in the office on 10/7/15 at 10:45 AM, the Health Center Manager stated, "It has not been scanned into the electronic medical record yet. I'll have to get the hard copy of the consent." This document was never produced after multiple requests. 2. Medical record review for Patient #3 documented an admission date of [redacted] with a diagnosis of Legally Induced Abortion. There was no documentation of an advanced directive and organ donation for Patient #3. 3. Medical record review for Patient #5 documented an admission date of [redacted] with a diagnosis of Legally Induced Abortion. There was no documentation of an advanced directive and organ donation for Patient #5. 4. During an interview in the office on 10/7/15 at 10:40 AM, the Health Center Manager verified there was no documentation of advanced directives and organ donation statements for Patients #3 and #5.	A 614	1. The facility will conduct additional staff training to ensure proper informed consent is obtained and documented and that advance directive, and organ donation information is being documented into the Electronic Health Record. Additional staff has been designated to scanning patient records to ensure this is completed in a timely fashion. 2. Chart audit will be performed to ensure advance directive, organ donation, and informed consent are included in each chart. 3. The deficiency will be completed by Oct 23,2015 to allow each provider to receive training. 4. Twenty surgical charts will be audited quarterly by the RQM Coordinator to ensure ongoing compliance.	10/23/15

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 624	Continued From page 3	A 624		
A 624	1200-8-10-.06 (1)(r) Basic Services (1) Surgical Services. (r) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to include an operative report for 2 of 9 (Patients #3 and 8) sampled patients who had undergone surgical procedures. The findings included: 1. Medical record review for Patient #3 documented an admission date of [redacted] with a diagnosis of Legally Induced Abortion. There was no documentation of an operative report for Patient #3. 2. Medical record review for Patient #8 documented an admission date of [redacted] with a diagnosis of Legally Induced Abortion. There was no documentation of an operative report for Patient #8. 3. During an interview in the office on 10/7/15 at 10:50 AM, the Health Center Manager verified there was no documentation of operative reports for Patients #3 and #8.	A 624	1. The deficiency will be corrected by performing additional provider training on completion of operative report. 2. The Center Manager will review 100% of Surgical charts at the end of clinic session to ensure operative report has been completed. 3. This process will be implemented on Nov.17,2015 to correct deficiency. 4. Ongoing compliance will be monitored by a quarterly audit of twenty surgical charts by the RQM Coordinator.	11-17-15

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1301	Continued From page 4	A1301		
A1301	1200-8-10-.13(1) Pol. & Proced. for Health Care Dec. Making (1) Pursuant to this Rule, each ambulatory surgical treatment center shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual patients. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises. This Rule is not met as evidenced by: Based on interview, the facility failed to develop policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity. The findings included: 1. During an interview in the office on 10/7/15 at 2:10 PM, the Director of Patient Services verified there were no policies and procedures governing the designation of a health care decision-maker.	A1301	1. This deficiency will be corrected by creating an End of Life policy to address the designation of a health care decision maker for making health care decision for a patient who is incompetent or who lacks capacity and does not have a living will and/or Durable Power of Attorney for health care. Information about Living Wills and advance directives will be made available to patients at the facility upon request. 2. The facility will conduct additional staff training to ensure that it is documented in Electronic Health Record if the patient has an advance directive and/or living will to direct end of life care. 3. The facility will have documents available for patients October 19,2015. 4. The End of Life Policy will be reviewed annually and updated as needed. This will be added to the RQM work plan.	10-19-15

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 454	1200-8-10-.04(25) Administration (25)"No smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to post "No Smoking" signs at 2 of 3 (main entrance and staff entrance) entrances to the facility. The findings included: Upon entering the facility on 10/5/15 at 9:00 AM, it was noted that there was no signs at the public entrance to indicate this was a "No Smoking" area. During a tour of the facility at 12:30 PM with the Practice Manager, it was noted there were no signs at one of the staff entrances to the facility that indicated this was a "No Smoking" area. In an interview with the Practice Manager on 10/5/15 at 1:15 PM, she verified there were no signs at 2 of 3 entrances to indicate this was a "No Smoking" area.	A 454	CHOICES Facilities Mgr installed a "No Smoking" sign at each of the two bldg. entrances where they were missing. CHOICES Facilities Mgr has added "check for No Smoking signs at each clinic entrance" to her list of semi-annual facilitiies inspections. accepted Kathy Griffin 11-4-15	10/12/2015

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 10/29/2015

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the condition of the surgery center in a manner that the safety and well-being of the patients were assured. The findings included: During the initial tour of the facility on 10/5/15, the following areas revealed: 1. A penetration in the electrical room around a flexible electrical conduit. National Fire Protection Association (NFPA) 101, 39.3.2.2 (2000 edition). 2. A packaged canopy was stored in front of the electrical panel, obstructing the door. National Fire Protection Association (NFPA) 70, 110 (26) (a) (1999 edition). 3. The electrical panel did not have the breakers identified in the electrical panel. National Fire Protection Association (NFPA) 70, 408.4 (1999 edition). 4. An automatic hand sanitizer had been installed over the light switch in the employee break room. Code of Federal Regulations (CFR) 416.44 Condition for coverage. 5. The combination battery back-up exit and emergency light fixture over the waiting area would not illuminate when tested by the facility	A 801 accepted 10/28/15 RD	1) After the inspection on 10/5/2015. Nancy Shotwell, Clinic Coordinator contacted Rhodes Electric re: the penetration around the flexible electrical conduit. Rhodes Electric will be on site to repair on 11/2/2015 Regulation 1200-8-10-8 (1) (NFPA) 101, 39.3.2.2 (2000 edition) 2) After the inspection on 10/5/2015. The packaged canopy was moved from in front of the electrical panel on 10/5/2015 by Rebecca Terrell, Executive Director Regulation 1200-8-10-8 (1) (NFPA) 70, 110 (26) (a) (1999 edition)	11/2/2015 10/5/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 1 representative. National Fire Protection Association (NFPA) 101, 7.8, 7.9, and 7.10 (2000 edition). 6. The battery back-up exit light by by the phone room would not illuminate when tested by the facility representative. National Fire Protection Association (NFPA) 101, 7.10 (2000 edition). 7. A former restroom was being used as a storage room and did not have a self closing device to keep the door closed. (NFPA) 101, 21.3.7.6 (2000 edition). 8. The facility could not provide documentation of a current sensitivity test on the smoke detectors since 7/19/11. National Fire Protection Association (NFPA) 72, 7.3.2.1 (1999 edition). 9. The facility could not provide documentation for the (30 second) monthly and (90 minute) annual testing of the exit and emergency lighting fixtures. Fire Protection Association (NFPA) 101, 7.9.3 (2000 edition).	A 801	3) After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator contacted Rhodes Electric re: electrical panel breaker need identified. Rhodes Electric will be on site to complete on 11/2/2015 Regulation 1200-8-10-08 (1) (NFPA)70, 408.4 (1999 edition)	11/2/2015
			4) After the inspection on 10/5/2015 William Hart (maintenance) removed the automatic hand sanitizer from over the light switch in employee break room. Regulation 1200-8-10-08 (1) (CFR) 416.44	10/14/2015
			5)After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator contacted Don Sills with (City Fire Extinguisher Co) re: emergency light fixture over the waiting area would not illuminate. On 10/12/2015, Don Sills replaced batteries and lights for the fixture. Regulation 1200-8-10-8 (1) (NFPA) 101, 7.8, 7.9, and 7.10 (2000 edition)	10/12/2015
			6) After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator contacted Don Sills with (City Fire Extinguisher Co) re: battery back-up exit light by the phone room. On 10/12/2015, Don Sills replaced batteries in the back-up exit light. Regulation 1200-8-10-08 (1) (NFPA) 101, 7.10 (2000 edition)	10/12/2015

10-20-15

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 2 These findings were verified during the tour, and acknowledged by the facility representatives during the exit conference on 10/5/15.	A 801	7) After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator contacted William Hart (maintenance) re: installing self closing device to restroom. William Hart will be on-site 10/26/2015 to install. Regulation 1200-8-10-08 (1) (NFPA) 101, 21.3.7.6 (2000 edition) 8) After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator e-mail and faxed Wanda Browning, FSS1 on 10/7/2015, providing (2014 & 2015) documentation on current sensitivity test on smoke detectors Regulation 1200-8-10-08 (1) (NFPA) 101, 21.3.7.6 (2000 edition) 9) After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator contacted Don Sills with (City Fire Extinguisher Co) on 10/12/2015 re: servicing and inspecting exit and emergency lighting fixtures, monthly and annual testing. Regulation 1200-8-10-08 (1) (NFPA) 101,7.9.3 (2000 edition)	10/26/2015 10/7/2015 10/12/2015

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OCT 26 2015

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL63547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING _____	R 11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 801}	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the condition of the surgery center in a manner that the safety and well-being of the patients were assured. The findings included: Observation of the surgery center during the follow up survey on 11/24/15 revealed the following: 1. Observation of the elevator equipment room revealed multiple penetrations in 3 of 4 walls. National Fire Protection Association (NFPA) 101, 39.3.2 (2000 edition). 2. Observation of the soiled storage room revealed no exhaust fan had been provided for negative air pressure. National Fire Protection Association NFPA 90 A (1999 Edition). These findings were verified and acknowledged by the surgery center representative during the tour and exit conference on 11/24/15.	{A 801} accepted 12/14/15 RS	Please see attached response from our architecture firm. Service call placed for repair/ replacement	1/8/16 1/8/16

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Molly Affreda — CEO — 12/8/15

STATE FORM 6899 EN0322

OPTIONS DESIGN

December 8, 2015

Wanda Browning
State of Tennessee Department of Health
2975 Highway 45 Bypass, Suite #C
Jackson, TN 38305

Re: Architectural Response to Life Safety Survey
Planned Parenthood of Greater Memphis
2430 Poplar Avenue, Suite 100
Memphis, TN 38112

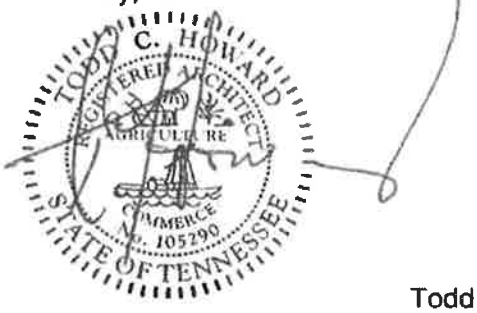
Mrs. Browning,

In response to your letter dated November 25, 2015, I have been retained to review and comment on the observations prepared for the aforementioned facility and conclude the following:

Item 1 – ***Observation of the elevator equipment room revealed multiple penetrations in 3 of 4 walls National Fire Protection Association (NFPA) 101, 39.3.2 (2000 edition).***
Response: Penetrations in the existing walls will be sealed to provide the necessary fire protection rating per UL standards. This work will be completed prior to January 8, 2016.
Item 2 – ***Observation of the soiled storage room revealed no exhaust fan had been provided for negative air pressure. National Fire Protection Association NFPA90 (1999 edition).***
Response: After further investigation, the exhaust fan motor need replacement. This work will be performed and completed prior to January 8, 2016.

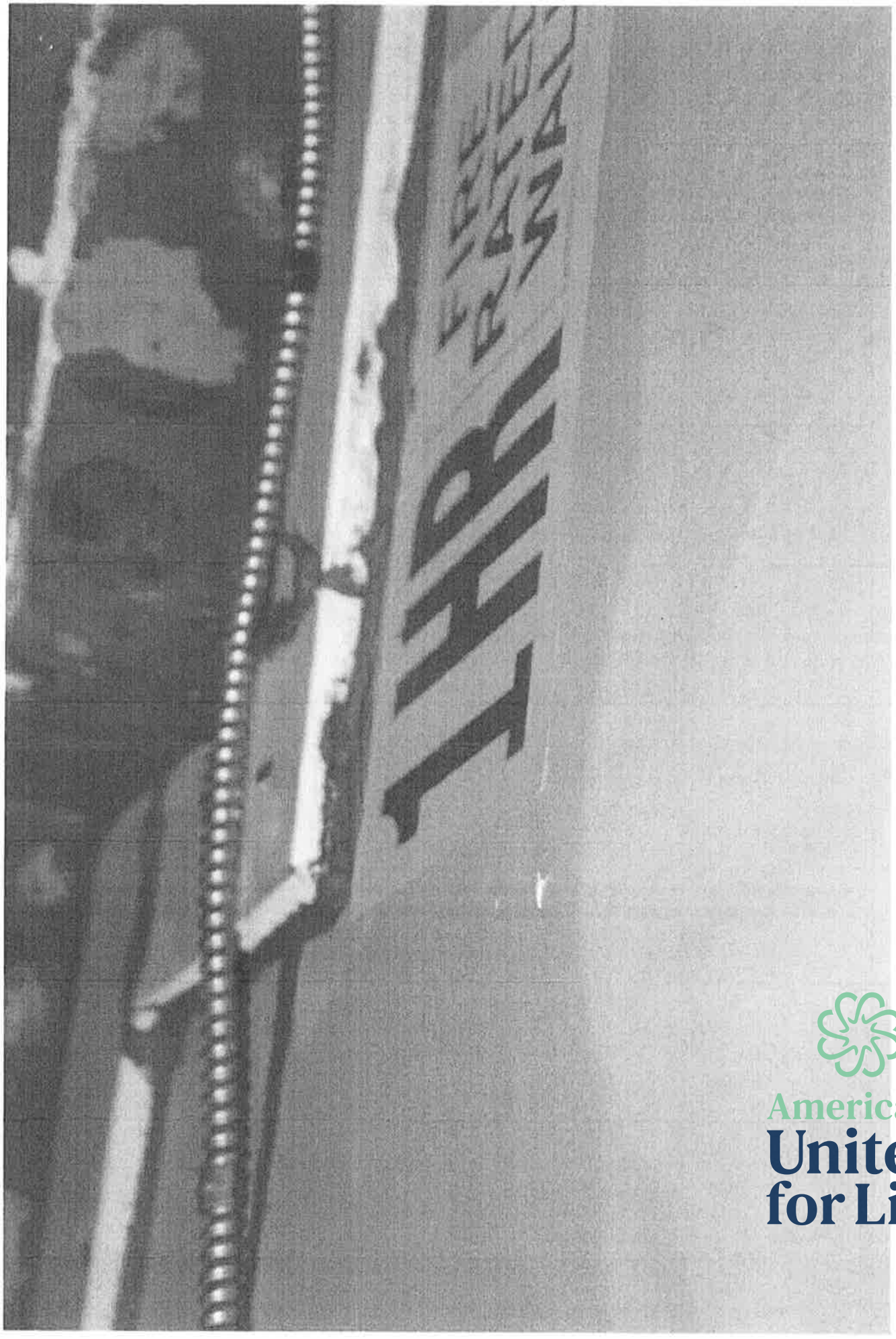
Additionally, there was mention of the integrity of the rated assemblies as constructed in the existing second floor shell space. Upon inspection of the information provided by the site manager and research of rated assemblies, it is my professional opinion that the assemblies do not jeopardize the health, safety, or welfare of the occupants of the building. While a specific UL assembly is not identified, the walls are believed to be constructed in compliance with UL assembly U419. An additional layer of 5/8" Type X gypsum has been added to the top 4" of the wall. The building has received a Certificate of Occupancy by the City of Memphis and there are no outstanding Fire Department deficiencies.
Should you have any further questions regarding this firm's observations, please do not hesitate to contact me at 903-337-8522.

Sincerely,



Todd C. Howard, AIA, NCARB, LEED AP
Tennessee Architectural License #105290

Americans United for Life



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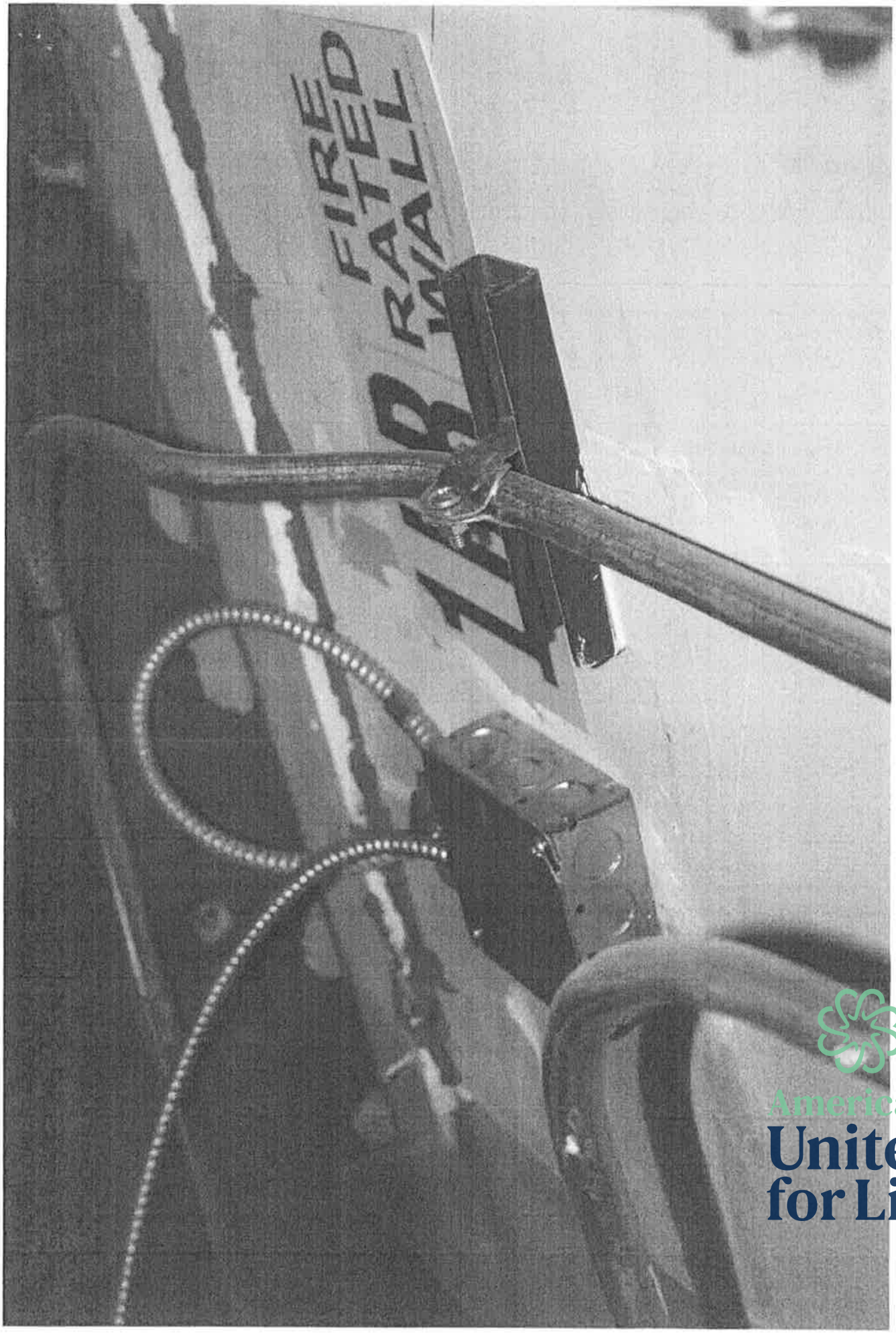

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the condition of the surgery center in a manner that the safety and well-being of the patients were assured. The findings included: Observation of the surgery center on 10/5/15 revealed the following: 1. Storage room doors, and doors in the paths of egress were obstructed with rubber wedges. National Fire Protection Association (NFPA) 101, 21.2.2.3, (2000 edition). 2. An automatic hand sanitizer had been installed over the light switch in the employee break room. Code of Federal Regulations (CFR) §416.44 (f). 3. Observation of the elevator equipment room revealed multiple penetrations in 3 of 4 walls. National Fire Protection Association (NFPA) 101, 39.3.2 (2000 edition). 4. Observation of the corridor electrical receptacles revealed a damaged cover located by the elevator room door. National Fire Protection Association (NFPA) 70 B, 16-6.2 (1998 edition). 5. Observation of the facilities ceiling light fixtures in the following areas did not have bulb protection: the elevator room, the housekeeping	A 801	CORRECTIVE ACCTION FOR PREVENTION AND MONITORING: PPGMR's VP of Finance is responsible for monitoring and compliance with survey items. Item one will be monitored daily. Items 2 and 6 will require no further action. Items 3,4, and 5 have been added to PPGMR's quarterly maintenance checklist to ensure that the deficient practices are monitored/timely corrected and do not recur. accepted 11/23/15 RJ 1. Wedges removed and supervisors monitor daily for compliance 2. Contractor hired to reinstall sanitizer 3. Contractor hired to seal penetrations 4. Replaced damaged cover 5. Contractor hired to install bulb protection	10/5/15 11/21/15 11/21/15 11/5/15 11/21/15

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RECEIVED
NOV 19 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	Continued From page 1 rooms on the 1st and 2nd floor, and the computer control room on the 2nd floor. National Fire Protection Association (NFPA) 70 E, 3, 1.2.3.6 (2000 edition). 6. Observation of the soiled storage room revealed the exhaust fan was not functioning. National Fire Protection Association NFPA 90 A (1999 Edition). soiled processing Room for instruments Based on record review, the facility failed to provide documentation of a 4 year fire damper inspection. The findings included: During the document review, the facility failed to provide documentation that fusible link fire dampers had been inspected. National Fire Protection Association NFPA 90 A (1999 Edition). These findings were verified and acknowledged by the surgery center representative during the tour and exit conference on 10/5/15.	A 801 6.	Contractor stated the observation is a return unit (not an exhaust fan) and is functioning properly Contractor performed damper inspection and provided documentation (attached), Next inspection due 11/1/2019	10/26/15 11/12/15

Dillard

Door & Entrance Control

4 Year Fire Damper Inspection

Site Name: PPGMR
Location: 2430 Poplar
Memphis,TN 38104

Inspection Performed By: Mike Morrissett 11/12/15
Report Prepared By: W. David Hobbs 11/13/15
Next Inspection Due: 11/01/19

Floor: First

Damper #	Location	Type	Operation	Result	Action
025	Storage	Fire	Fuse Link	Pass	
026	Storage	Fire	Fuse Link	Pass	
027	Elevator Room	Fire	Fuse Link	Pass	
028	Elevator Room	Fire	Fuse Link	Pass	
029	Main Entrance	Fire	Fuse Link	Pass	

Americans United for Life

788 East Street
Memphis, TN 38104
(901) 775-2143 Fax (901) 948-7434

Dillard

Door & Entrance Control

4 Year Fire Damper Inspection

Site Name: PPGMR
Location: 2430 Poplar
Memphis,TN 38104

Inspection Performed By: Mike Morrissett 11/12/15
Report Prepared By: W. David Hobbs 11/13/15
Next Inspection Due: 11/01/19

Floor: Second

Damper #	Location	Type	Operation	Result	Action
001	Women's Bath	Fire	Fuse Link	Pass	
002	Men's Bath	Fire	Fuse Link	Pass	
003	Middle Hallway	Fire	Fuse Link	Pass	
004	Training Room	Fire	Fuse Link	Pass	
005	Training Room	Fire	Fuse Link	Pass	
006	Storage Room	Fire	Fuse Link	Pass	
007	Storage Room	Fire	Fuse Link	Pass	
008	Storage Room	Fire	Fuse Link	Pass	
009	Storage Room	Fire	Fuse Link	Pass	
010	Storage Room	Fire	Fuse Link	Pass	
011	Storage Room	Fire	Fuse Link	Pass	
012	1st Floor Feed	Fire	Fuse Link	Pass	
013	Hall South end	Fire	Fuse Link	Pass	
014	Data Room	Fire	Fuse Link	Pass	
015	Data Room	Fire	Fuse Link	Pass	

Americans United for Life

788 East Street
Memphis, TN 38104
(901) 775-2143 Fax (901) 948-7434

Dillard

Door & Entrance Control

4 Year Fire Damper Inspection

Site Name: PPGMR
Location: 2430 Poplar
Memphis,TN 38104

Inspection Performed By: Mike Morrissett 11/12/15
Report Prepared By: W. David Hobbs 11/13/15
Next Inspection Due: 11/01/19

Floor: Second

Damper #	Location	Type	Operation	Result	Action
016	Mechanical Room	Combo	Electric	Pass	
017	Mechanical Room	Combo	Electric	Pass	
018	Mechanical Room	Fire	Fuse Link	Pass	
019	Mechanical Room	Fire	Fuse Link	Pass	
020	Mechanical Room	Fire	Fuse Link	Pass	
021	Mechanical Room	Fire	Fuse Link	Pass	
022	Mechanical Room	Fire	Fuse Link	Pass	
023	Air Handler	Fire	Fuse Link	Pass	
024	Air Handler	Fire	Fuse Link	Pass	

Americans United for Life

788 East Street
Memphis, TN 38104
(901) 775-2143 Fax (901) 948-7434

Fax Received 12/16/14

Division of Health Care Facilities

2nd PoC

PRINTED: 10/29/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 614	1200-8-10-.06 (1)(n) Basic Services (1) Surgical Services. (n) Properly executed informed consent, advance directive, and organ donation forms must be in the patient ' s chart before surgery, except in emergencies. This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the Ambulatory Surgery Center (ASC) failed to obtain organ donation preference for 6 of 6 (Patients #1- 6) sampled patients. The findings included: Medical record review for Patients #1 through 6 revealed no documentation of organ donation preference in the medical records. During an interview on 10/20/14 at 1:45 PM the Clinical Manager stated she does not ask patients if they have an organ donation preference.	A 614	Accepted 12/31/14 RD Organ donation preference will be documented in each medical record. This question has been added to the Demographic page completed by each patient. Organ donation will be added to our Medical Record Audit Categories.	6Nov14
A1101	1200-8-10-.11 (1) Records and Reports (1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required. This Rule is not met as evidenced by: Based on interview the facility failed to submit a Joint Annual Report (JAR) to the state. The findings included: During an interview in the Managers officeon	A1101	The Joint Annual Report will be completed and returned to the Dept. The JAR will be added to the COO's Work Plan RECEIVED DEC 11 2014	12Dec14

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Adrienne [signature] TITLE: COO (X6) DATE: 12/11/14

STATE FORM 6899 BQ9111 If continuation sheet 1 of 2

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1101	Continued From page 1 10/20/14, the Clinical Manager confirmed the facility did not submit a JAR to the state. She further stated the facility had been told they were not required to do so.	A1101		
A1405	1200-8-10-.14 (2) Disaster Preparedness (2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation. This Rule is not met as evidenced by: Based on interview it was determined the facility failed to provide documentation of participation with the Tennessee Emergency Management Agency (TEMA). The findings included: During an interview in the conference room on 10/20/14 at 1:45 PM, the Clinical Manager verified the facility had not participated with TEMA.	A1405	PPMET will partizpate with TN Emergency Management Agency. their Basic Health Care Facility Information form has been Completed and submitted to TEMA. Documentation of this annual partzipation has been added to our RAM audits.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING _____	10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA:	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 818	1200-8-10-.08 (18) Building Standards (18) It shall be demonstrated through the submission of plans and specifications that in each ASTC a negative air pressure shall be maintained in the soiled utility area, toilet room, janitor ' s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms. This Rule is not met as evidenced by: Based on observations and testing, it was determined the facility failed to maintain negative pressure where required. The finding included: Observation and testing on 10/20/2014 at 11:06 AM, revealed the biohazard room on the first floor had positive pressure. This finding was verified by employee #1 and acknowledged by the administrator during the exit conference on 10/20/2014.	A 818	The biohazard room on the 1st floor will have negative pressure. Our vendor is scheduled to correct this on Monday, Nov 3rd. The negative pressure will become part of the vendor's regular audit.	Nov 3, 2014
A 901	1200-8-10-.09 (1) Life Safety (1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.	A 901		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jon Teague — TITLE: President/CEO — (X6) DATE: 11/3/14

STATE FORM 6899 XZ0Z21 If continuation sheet 1 of 2

RECEIVED

E-MAILED 11/20/14 - PDC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING _____	10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 1 This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain life safety codes where required. The findings included: 1. Observation on 10/20/2014 at 11:08AM, revealed a fire extinguisher not secured in the 1st floor electrical closet. National Fire Protection Association (NFPA) 10, Standard for Portable Fire Extinguishers, 6.1.3.4(1), 2010 Edition. 2. Observation on 10/20/14 at 11:12 AM, revealed escutcheon plates were missing in the following rooms: 2nd floor snack storage room, soiled laundry closet, and 2nd floor storage room. NFPA 13, Standard for the Installation of Sprinkler Systems, 6.2.7.1, 2011 Edition. These findings were verified by employee #1 and acknowledge by the administrator during the exit conference on 10/20/2014.	A 901	The fire extinguisher in the 1st floor electrical closet has been secured. Review of this item has been added to our monthly fire extinguisher audit. Escutcheon plates will be added to the sprinklers on the 2nd flr storage room, soiled laundry closet, and 2nd flor snack closet. Review of this will be added to our monthly sprinkler audit	Oct 23, 2014 Nov 8, 2014

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING Per rule	10/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

FURNISHED

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1101	1200-8-10-.11 (1) Records and Reports (1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure the Joint Annual Report (JAR) was filed with the department. The findings included: During an interview on 10/15/14 at 12:00 PM the Director of Clinical Services stated they were not required to file a JAR. There was no evidence the facility filed a JAR.	A1101	**How the Deficiency will be corrected:** Assign Completion of JAR to Practice Manager. **How the facility will prevent the same deficiency from occuring:** CHOICES Director of Clinical Services will continue to communicate annually with the TN Department of Health Division of Policy, Planning and Health Statistics if JAR is not received annually as anticipated. **Date Deficiency will be corrected** 11/05/2014 **On Going Monitoring** Completion of JAR report will be component of Practice Manager annual evaluation.	

accepted Kathy Leeper 1-20-15

RECEIVED
JAN 16 2015

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

M. Hastings CW, Director of Clinical Services 1/15/15

STATE FORM 6899 OX9911 If continuation sheet 1 of 1

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING	10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 900	1200-8-10-.09 Life Safety This Rule is not met as evidenced by: Based on observation it was determined the facility failed to conduct monthly inspections on 6 of 6 fire extinguishers. NFPA 10, 6.3.1 The findings included: Observation of the facility on 10/17/14 revealed all 6 fire extinguishers had not been inspected and recorded monthly on the extinguisher's tags since the annual fire extinguisher inspection conducted on May 2014.	A 900	RECEIVED Accepted 11/25/14 RS After the inspection on 10/17/2014- A complete walk through on 10/21/2014 was performed on all fire extinguisher's. All 6 fire extinguisher's were inspected and documented by Nancy Shotwell, Clinic Coordinator. The task will be assigned monthly by Nancy Shotwell, Clinic Coordinator- Regulation 1200-8-10-09 NFPA 10, 6.3.1	10/21/2014
	Based on observation it was determined the facility failed to provide ground fault circuit interrupter receptacles serving wet areas. NFPA 70, 210-8 (b) (1) The findings included: Observation of the break room on 10/17/14 revealed the receptacles at the counter were not ground fault circuit interrupters.		After the inspection on 10/17/2014- G&R Services installed ground fault circuit interrupters in the break room area on 10/24/2014. The installment is a permanent change/fix for the facility. All maintenance will be monitored by Nancy Shotwell, Clinic Coordinator Regulation 1200-8-10-09 NFPA 70, 210-8 (b) (1)	10/24/2014
	Based on observation, it was determined the facility failed to maintain smoke resistant assemblies in the facility. NFPA 101, 8.3.4.3		NFPA 101, 8.3.4.3 continued on page 2 of 2	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 900	Continued From page 1 The findings included: Observation of the facility on 10/17/14 revealed 5 smoke resistant doors with kick down doorstops attached and in use preventing the self closing of the doors.	A 900	After the inspection on 10/17/2014- On 10/21/2014, Christopher Lott disassembled all 5 door stops attached to the doors, assigned by Nancy Shotwell, Clinic Coordinator. All staff were informed to not secure the doors with a doorstop attachment. Regulation 1200-8-10-09 NFPA 101, 8.3.4.3	10/21/2014
	Based on record review it was determined the facility failed to provide annual testing of the fire alarm systems. NFPA 72, 7-3.2 The findings included: During the record review on 10/17/14, the facility failed to provide documentation of an annual fire alarm system test. These findings were verified and acknowledged by the facility director during the tour and exit conference on 10/17/14.		After the inspection on 10/17/2014- Nancy Shotwell, Clinic Coordinator contacted Richard Roberts with Stanley Security on,10/21/2014 to request a fire system inspection and smoke detector sensitivity test report. Richard Roberts submitted report to Nancy Shotwell on 10/29/2014 via fax. Nancy Shotwell faxed Wanda Browning, FSS1, the report on 11/5/2014 at 9:30am. Richard Roberts will provide Choices with an annual report. Nancy Shotwell, Clinic Coordinator will properly file report in life safety binder as assigned. Regulation 1200-8-10-09 NFPA 72, 7-3.2	10/29/2014

RECEIVED

Executive Director 11-13-2014

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 614	1200-8-10-.06 (1)(n) Basic Services (1) Surgical Services. (n) Properly executed informed consent, advance directive, and organ donation forms must be in the patient ' s chart before surgery, except in emergencies. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure organ donation forms were properly executed before surgery for 6 of 6 (Patients #1, 2, 3, 4,5 and 6) sampled patients. The findings included: 1. Medical record review for Patients' #1, 2, 3, 4, 5 or 6 revealed there was no information documented for organ donation information. During an interview on 10/14/14 at 2:05 PM the Vice President of Patient Services stated the forms were not transferred to the facility's new electronic record.	A 614	Intake form updated on 2/1/15 to capture organ donor status. This form is scanned into our EMR and becomes a permanent part of their record. Please see attached intake form. accepted Kathy Lewis 2-23-15	
A1101	1200-8-10-.11 (1) Records and Reports (1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure the Joint Annual Report (JAR) was filed with the department.	A1101	The JAR was completed on 2/6/15 and will be submitted on 2/6/15.	

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marsha Tollett — TITLE: VP of Patient Services — (X6) DATE: 2/4/15

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: _____ B. WING _____	10/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1101	Continued From page 1 The findings included: During an interview on 10/14/14 at 10:25 AM the Vice President of patient Services stated they were not required to file a JAR. There was no evidence the facility filed a JAR.	A1101		
A1405	1200-8-10-.14 (2) Disaster Preparedness (2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to provide evidence of participation with the Tennessee Emergency Management Agency (TEMA). The findings included: During an interview on 10/14/14 at 1:15 PM the Vice President of Patient Services stated they had not contacted TEMA for participation.	A1405	On October 14, 2014, spoke @ [redacted], Shelby County's TEMA contact. PPGMR has complied with TEMA. This was our 1st acknowledgement of deficiencies from our visit on 10/14/14. It was received to PPGMR on 2/4/15.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING	10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 900	1200-8-10-.09 Life Safety This Rule is not met as evidenced by: Based on observation it was determined the facility failed to conduct monthly inspections on 3 of 3 fire extinguishers. NFPA 10, 6.3.1 The findings included: Observation of the facility on 10/17/14 revealed all 3 of the fire extinguishers had not been inspected and recorded for the month of September 2014, on the extinguisher's tags since the annual inspection on August 2014. These findings were verified and acknowledged by the facility director during the tour and exit conference on 10/17/14.	A 900	accepted 11-13-14 RH Fire extinguishers were evaluated once a month. Please see emails from Health Center manager that supports monthly inspection. Desk review WB RECEIVED NOV 10 2014	11/6/14

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sarsha Tellutt, BSN, RN — TITLE: VP of Patient Services — DATE: 11/6/14

STATE FORM 6899 LY9621 If continuation sheet 1 of

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	06/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 453	1200-8-10-.04 (24) Administration (24)All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance: (a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney ' s office; (b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and (c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height. Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height. Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, and 71-6-121. This Rule is not met as evidenced by: Based on interview it was determined the facility failed to ensure the required signage was posted in accordance with these regulations. The findings included:	A 453	Accepted 6/25/13 - PDC Planned Parenthood of Middle + East TN (PPMET) will create a poster that provides the toll-free number of the division of adult protective services, and the number for the local district attorney's office. In addition, a statement that a person of advanced age may be the victim of abuse, neglect, or exploitation may seek assistance of file a complaint concerning abuse, neglect, or exploitation. This information will be provided in a poster that is at least 11"x17". The poster will be located near the main entrance before 1 July 2013. The required information on this poster has been added to the PPMET Annual Audit	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

President/CEO 06/19/13

STATE FORM 6899 5S1L11 RECEIVED Continuation sheet 1 of 2

JUN 24 2013

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	06/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 453	Continued From page 1 During an interview on 6/3/13 the Director of Patient Services stated the facility did not have posted signage with statewide toll-free number of the division of adult protective services and the number for the local district attorney's office; a statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint; a statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline.	A 453	Audit check list to ensure that this deficiency does not recur. PPMET will create a poster that provides the statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline. This information will be provided in a poster that is at least 8½"x11". The poster will be located near the main entrance before 1 July 13. The required information on this poster has been added to the PPMET Annual Facility Audit check-list to ensure that this deficiency does not recur.	
A 454	1200-8-10-.04(25) Administration (25)"No smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance. This Rule is not met as evidenced by: Based on interview it was determined the facility failed to ensure "no smoking" signs were posted at every entrance. The findings included: During an interview on 6/3/13 the Director of Patient Services stated the facility was a "no smoking" facility but failed to have signs indicating such clearly and conspicuously posted at every entrance.	A 454	PPMET will create a poster that provides the international symbol for "No Smoking." This information will be on a poster that is 8½"x11". The poster will be located	
A 455	1200-8-10-.04(26) Administration (26)The facility shall develop a concise statement	A 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: _____ B. WING _____	06/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 455	Continued From page 2 of its charity care policies and shall post such statement in a place accessible to the public. Authority: T.C.A. §§4-5-202, 4-5-204, 39-17-1803, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-268, and 71-6-121. This Rule is not met as evidenced by: Based on interview it was determined the facility failed to have a posted statement regarding charity care in a place accessible to the public. The findings included: During an interview on 6/3/13 the Director of Patient Services stated the facility did offer charity care but did not have a sign posted of that policy/statement in a place accessible to the public.	A 455	near the main entrance before 1 July 2013. The required information on this poster has been added to the PPMET Annual Facility Audit check-list to ensure this deficiency does not recur. PPMET will create a poster that provides the Charity Care Policy for PPMET. The poster will be located near the main entrance before 1 July 13. The required information on this poster has been added to the PPMET Annual Facility Audit check-list to ensure that this deficiency does not recur.	

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING: 02 - STATE BUILDING B. WING _____	06/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is met as evidenced by: Based on observations, testing, and records review it was determined the facility had no life safety deficiencies.	A 002		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 420	1200-8-10-.04 (16) Administration (16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges. accepted Kathy Griffin 7-9-13 This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure clinical privileges were granted for the Medical Director. The findings included: Review of the Medical Director's employee record revealed no documentation of current clinical privileges. During an interview on 5/29/13 at 1:50 PM the Clinical Services Coordinator verified there was no documentation of the current clinical privileges for the Medical Director.	A 420	1) Clinical Services Coordinator contacted Medical Director to request updated verification of clinical privileges. 2) E-mail correspondence verifying current, up-to-date privileges received by CHOICES Clinical Services Coordinator from Methodist Staff Services Coordinator. See Attachment 1 of 1 3) Director of Human Resources and Leadership will review current CHOICES policy and Procedure for verifying current, updated licensure, credentialing, and/or certifications for all staff, contractors and personnel employed by or contracted to provide clinical services at CHOICES to ensure that current policy addresses systemic review of all appropriate personnel files annually. 4) CHOICES policy and procedure addressing personnel, contractors and employees of CHOICES will be amended by Leadership Team to ensure that policy addresses systemic, ongoing annual review of employee, personnel and contractor files. 5) Annual report regarding state of employee, personnel and contractor files in regards to licensure, certification and/or credentialing as appropriate and any identified deficiencies will be made and documented during Leadership Team meeting. For 2013, meeting will be scheduled to occur 09/11/2013. Meeting will be scheduled in September annually on an ongoing basis.	05/29/2013 05/29/2013 07/10/2013 07/10/2013
A 435	1200-8-10-.04 (20)(c)4. Administration (20) Infection Control. (c) The chief executive officer or administrator shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develops guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the committee shall include the establishment of: 4. Written procedures concerning food handling, laundry practices, disposal of environmental and patient wastes, traffic control and visiting rules in	A 435	A435 Plan of Correction 1) CHOICES current policy and procedure related to Infection Control and 1200-8-10-.04 will be scheduled to occur at meeting of CHOICES infection Control Committee. Documentation of review of pertinent literature and findings as well as recommendations of Infection Control Committee will be documented in meeting notes of Medical Services Committee.	07/13/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE N. Hastings CNM TITLE 07/10/2013 (X6) DATE

Clinical Services Coordinator

RECEIVED

JUL 05 2013

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

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A 435	Continued From page 1 high risk areas, sources of air pollution, and routine culturing of autoclaves and sterilizers; This Rule is not met as evidenced by: Based on Center for Disease Control Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, and interview, it was determined the facility failed to monitor the sterilizer temperature during usage. The findings included: Review of the Center for Disease Control Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, page 59 documented, "...sterilizers usually are monitored using a printout (or graphically) by measuring temperature, the time at the temperature, and pressure..." During an interview in the conference room on 5/29/13 at 3:25 PM the Clinical Services Coordinator stated there was no documentation of the temperature the autoclave digitally reads during usage.	A 435	2) CHOICES policy and procedure regarding Infection Control specific to operation, cleaning, and monitoring as well as maintenance of autoclave will be reviewed to ensure CHOICES policy and procedure meets relevant guidelines. Specific guidelines which will be utilized for review are as follows: a) Center for Disease Control Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 b) MidMark M9 Ultraclave Steam Sterilizer Installation and Operation Manual. c) National Abortion Federation Clinical Policies Committee: Infection Prevention Policy Guidelines (2013/Rev. September 2012). d) Henry Schein AutoClave Tape product Information (LP-052 Rev A) e) Henry Schein Self Seal Sterilization Pouch with Internal and External Indicators Product Information (Current Lot Version) 3) All recommendations for amendments to CHOICES Policy and Procedure regarding infection control policy and procedure relevant to autoclave and sterilization process proposed at meeting on 07/13/2013 will be incorporated and documented as amendments to current CHOICES Infection Control policy and Procedure. Clinical Services Coordinator will be charged with incorporating any recommendations for amendments and presenting draft of updated policy and procedure at Medical Services Committee Meeting scheduled for August 2013. Anticipate review and final approval of updated policy and procedure by both Medical Director and Infection Control Committee by 08/17/2013. 4) Annual review of CHOICES policy and procedure August 2013 related to Infection Control and specifically to Autoclave and Sterilization process will be scheduled to occur annually by August on-going. Amendments to CHOICES policy to Infection Control or procedures will be conducted according to CHOICES policy on amending Medical Policy and Procedures.	07/13/2013 08/17/2013
A 436	1200-8-10-.04 (20)(c)5. Administration (20) Infection Control. (c) The chief executive officer or administrator shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develops guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the committee shall include the establishment of:	A 436		

M. Gettings, CNA 06/10/2013
Clinical Services Coordinator

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: _____ B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 436	Continued From page 2 5. A log of incidents related to infectious and communicable diseases; This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure it maintained a log of incidents related to infectious and communicable diseases. The findings included: During an interview in the conference room on 5/29/13 at 3:35 PM the Clinical Services Coordinator stated there was no log of incidents related to infections and communicable diseases due to the nature of the procedures performed at the facility.	A 436	PLAN OF CORRECTION 1) Documentation of CHOICES Infection Review Committee review of infection incidents (no reported incidents) was shown to inspector at time of site visit. 2) CHOICES current policy and procedure related to Infection control specific to 1200-8-10-.04(20)(c)5 will be reviewed during Medical Service Committee Meeting by Medical Director and Infection Control Committee to ensure that policy and procedure appropriately addresses regulation specific to log of incidents related to infections and communicable diseases.	07/13/2013
			3) Clinical Services Coordinator will be charged with coordinating and drafting any recommended changes identified by CHOICES Infection Control Committee and updating current CHOICES Infection Control Policy and Procedure for review and approval by Medical Director, Medical Services Committee and Infection Control Committee by 08/17/2013. 4) Clinical Services Coordinator will report quarterly to Infection Control Committee during Medical Services Committee Meeting on any incidents related to infections or communicable diseases. Documentation of report, review and findings as well as any additional recommendations by Infection Control Committee will be in CHOICES Medical Services Committee Meeting notes. 5) Annual review of CHOICES infection Control Policy and procedure as well as annual review of previous year report will be scheduled to occur annually during September Medical Services Committee Meeting.	

A. Hastings CNM 06/10/2013
Clinical services coordinator

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1401	1200-8-10-.14 (1)(a) Disaster Preparedness (1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually: (a) Fire Safety Procedures Plan shall include: 1. Minor fires; 2. Major fires; 3. Fighting the fire; 4. Evacuation procedures; 5. Staff functions. This Rule is not met as evidenced by: Based on observations during the record review on 5/29/13, the facility failed to conduct fire drills in every quarter of 2012. The findings included: During the fire drill record review, the facility did not have a fire drills during the 2nd and 3rd	A1401 accepted 7/29/13 RS	(1) CHOICES has scheduled staff trainings for Disaster preparedness: Fire Safety Procedure for 2013. Training will be conducted by Director of Purchasing & Facilities. Staff attendance will be documented along with detailed log of agenda and topics covered. (2) Nonattendance will be managed according to CHOICES current policy on staff trainings. Individual staff not in attendance will be required to review and document review of CHOICES Fire Safety Disaster Training manual in accordance with CHOICES policy. (3) CHOICES has conducted Fire Drills on 3/21/13 and 6/4/13, and additional quarterly drills have been scheduled. These have and will be conducted by the Director of Purchasing & Facilities. Unannounced drills have also been scheduled for 2013 for a total of 1 Fire drill per quarter according to requirements of regulation 1200-8-10.14(1)(a). (4) CHOICES has scheduled a review to revise our policies and procedures related to Disaster Preparedness for 2013. This review and revision will be conducted by the Leadership Team. The Director of of Purchasing and Facilities will report to the Leadership Team all dates for trainings, drills and any deficiencies for the year. Non-compliance by any employee will be managed according to CHOICES Employee Review policy and will be reflected in staff annual reviews per CHOICES policy. Any amendments or deficiencies identified by the Director of Purchasing and Facilities or during Leadership Team's review of CHOICES policies will be reflected in Leadership Team meeting notes and will be amended and/or a plan of correction implemented and reviewed annually.	07/10/13 07/10/13 07/10/13 07/10/13

Division of Health Care Facilities

Rebecca Terrell — TITLE Exec. Director — (X6) DATE 7-23-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN PL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1726 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1401	Continued From page 1 quarters of the year 2012.	A1401		
A1404	1200-8-10-.14 (1)(d) Disaster Preparedness (1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually: (d) Earthquake Disaster Procedures Plan: 1. Staff duties; 2. Evacuation procedures; 3. Safety procedures; 4. Emergency services. This Rule is not met as evidenced by: Based on observations on 5/29/13, it was determined the facility failed to conduct disaster drills during 2012. The findings included: During the record review on 5/29/13, the facility	A1404	A1404 (1) CHOICES has scheduled a staff training for Disaster Preparedness: Earthquake Safety Procedure for 2013. Training will be conducted by the Director of Purchasing and Facilities. Staff attendance will be documented with staff signatures along with a detailed log of training agenda and topics. (2) Earthquake Safety Training attendance is mandatory. Nonattendance will be managed according to CHOICES policy on staff training. Individual staff not in attendance will be required to update training by reviewing and documenting review of CHOICES Earthquake Safety Disaster Preparedness Training Manual according to CHOICES policy. (3) Earthquake drills have been scheduled for 2013 and training will be conducted by the Director of Purchasing and Facilities. (4) A review of CHOICES policy and procedures related to Disaster Preparedness has been scheduled to be conducted by the Leadership Team. Director of Purchasing and Facilities will report to Leadership Team the dates and attendance of all required training and safety drills as well as staff attendance at each session. Nonattendance will be managed according to CHOICES policy on staff training. Individual staff not in attendance will be required to update	07/10/13 07/10/13 07/10/13 07/10/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53544	A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING _____	05/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMPHIS CENTER FOR REPRODUCTIVE HEA	1728 POPLAR AVENUE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A1404	Continued From page 2 failed to conduct a earthquake drill during the 2012 year. The finding was acknowledged by the Assistant Administrator at the exit interview.	A1404	A1404 (4) Continued training by reviewing and documenting review of CHOICES Earthquake Safety Disaster Preparedness Training Manual according to CHOICES policy. Any amendments or deficiencies identified by the Director of Purchasing and Facilities or during Leadership Team's review of CHOICES Disaster Preparedness policies will be reflected in Leadership Team meeting notes and will be amended and/or a plan of correction implemented immediately & reviewed annually.	
A1405	1200-8-10-.14 (2) Disaster Preparedness (2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation. This Rule is not met as evidenced by: Based on observations on 5/29/13, it was determined the facility failed to participate in a local county emergency plan on a annual basis. The findings included: During the record review on 5/29/13, the facility did not have documentation showing participation in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. The finding was acknowledge by the Assistant Administrator at the exit interview on 5/29/13.	A1405	A1405 (1) Contacted Shelby County Chairman of TN Emergency Preparedness by telephone, requested information re/ Regulation 1200-8-10-14(2) — 05/29/13 (2) Contacted Director of TN Emergency Management by telephone, requested information re/ Regulation 1200-8-10-14(2) — 07/02/13 (3) Received and completed Basic Health Care Facility Survey form and submitted to Director of TN Emergency Management (See attachment 1, 1 of 1 pages) — 07/02/13 (4) Reviewed information and report regarding Regulation 1200-8-10-14(2) and follow up steps. Scheduled review with Leadership Team along with draft of policy to address regulation. Review will be documented in Leadership Team mtg notes. — 07/10/13 (5) Scheduled annual review of Disaster Preparedness Policies and Procedures to be conducted on ongoing basis by Leadership Team. Any amendments or deficiencies identified by the Director of Purchasing and Facilities or during Leadership Team's review of CHOICES Disaster Preparedness policies will be reflected in Leadership Team meeting notes and will be amended and/or a plan of correction implemented immediately & reviewed annually. — 07/10/13	

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	TNPL53547	A. BUILDING: _____ B. WING _____	05/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 420	1200-8-10-.04 (16) Administration (16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges. This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure clinical privileges were granted for the Medical Director. The findings included: Review of the Medical Director's employee record revealed no documentation of current clinical privileges. During an interview on 5/28/13 at 2:25 PM the Vice President of Patient Services verified there was no documentation of the current clinical privileges for the Medical Director.	A 420	accepted Kathy Leigh 8.20.13 Please see attached, a copy of clinical privileges for Dr. M. Stack.	
A 624	1200-8-10-.06 (1)(p)3. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 3. atropine 0.1 mg/ml This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have atropine on the crash cart.	A 624	Atropine was on back order through the vendor, but is now in stock. The vendor is sending the Atropine 0.1mg/ml and it should be at PPGMR no later than 8/15/13 in our crash cart.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tarsha Tellis

TITLE: VP Patient Services

(X6) DATE: 8/13/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 624	Continued From page 1 The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no atropine available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner (NP) verified there was no atropine available for emergency use. The NP stated, "...on back order..."	A 624		
A 626	1200-8-10-.06 (1)(p)5. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 5. calcium chloride 10%; 10ml amp This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have calcium chloride available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no calcium chloride available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no calcium chloride available for emergency use.	A 626	PPGMR will develop a protocol specifying the required emergency cart drugs and why we exclude calcium chloride. This protocol will be reviewed and approved by the Medical Director and the CEO by September 15, 2013. This protocol will be reviewed and updated annually by the Medical Director.	

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PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

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A 628	Continued From page 2	A 628		
A 628	1200-8-10-.06 (1)(p)7. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 7. dilantin (phentoin) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have dilantin available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no dilantin available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no dilantin available for emergency use.	A 628	PPGMR will develop a protocol specifying the required emergency cart drugs and why we exclude dilantin. This protocol will be reviewed and approved by the Medical Director and CEO by September 15, 2013. This protocol will be reviewed and updated annually by the Medical Director.	
A 629	1200-8-10-.06 (1)(p)8. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 8. dopamine This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have dopamine available on the crash cart.	A 629	PPGMR will develop a protocol specifying the required emergency cart drugs and why we exclude dopamine. This protocol will be reviewed and approved by the Medical Director + CEO by 9/15/13. This protocol will be reviewed and updated annually by the Medical Director.	

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PLANNED PARENTHOOD GREATER MEMPHIS	2430 POPLAR AVE MEMPHIS, TN 38104

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A 629	Continued From page 3 The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no dopamine available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no dopamine available for emergency use.	A 629		
A 630	1200-8-10-.06 (1)(p)9. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 9. heparin This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have heparin available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no heparin available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no heparin available for emergency use.	A 630	PPGMR will develop a protocol specifying the required emergency cart drugs and why we excluded heparin. This protocol will be reviewed and approved by the Medical Director + CEO by 9/15/13. This protocol will be reviewed and updated annually by the Medical Director	

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A 631	Continued From page 4 1200-8-10-.06 (1)(p)10. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 10. inderal (proprandolol) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have inderal available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no inderal available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no inderal available for emergency use.	A 631	PPGMR will develop a protocol specifying the required emergency cart drugs and why Inderal was excluded. This protocol will be reviewed and approved by the Medical Director and CEO by 9/15/13. This protocol will be reviewed and updated annually by the Medical Director.	
A 632	1200-8-10-.06 (1)(p)11. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 11. isuprel	A 632	PPGMR will develop a protocol specifying the required emergency cart drugs and why we excluded Isuprel. This protocol will be reviewed and approved by the Medical Director + CEO. This protocol will be reviewed and updated annually by the Medical Director. Protocol developed by [illegible]	

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A 632	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have isuprel available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no isuprel available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no isuprel available for emergency use.	A 632		
A 633	1200-8-10-.06 (1)(p)12. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 12. lanoxin (digoxin) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have lanoxin available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no lanoxin	A 633	PPGMR will develop a protocol specifying the required emergency cart drugs and why we excluded Digoxin. This protocol will be reviewed and approved by the Medical Director and CEO by 9/15/13. This protocol will be reviewed and/or updated annually by the Medical Director.	

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A 633	Continued From page 6 available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no lanoxin available for emergency use.	A 633		
A 634	1200-8-10-.06 (1)(p)13. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 13. lasix (furosemide) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have lasix available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no lasix available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no lasix available for emergency use.	A 634	PPGMR will develop a protocol specifying the required emergency cart drugs and why we excluded Lasix. This protocol will be reviewed and approved by the Medical Director + CEO by 9/15/13. This protocol will be reviewed and/or updated annually by the Medical Director	
A 635	1200-8-10-.06 (1)(p)14. Basic Services 1. Surgical Services. (p) A crash cart must be available and include at	A 635	PPGMR will develop a protocol specifying the required crash cart drugs and why we excluded Lidocaine. This protocol will be reviewed and approved by the Medical Director	

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A 635	Continued From page 7 a minimum the following medication and supplies: 14. xylocaine (lidocaine) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have xylocaine available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no xylocaine available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no xylocaine available for emergency use.	A 635	and CEO by 9/15/13. The Medical Director will review and/or update annually.	
A 636	1200-8-10-.06 (1)(p)15. Basic Services 1. Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 15. magnesium sulfate 50% This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have magnesium sulfate available on the crash cart. The findings included:	A 636	PPGMR will develop a protocol specifying the required crash cart drugs and why we excluded Magnesium Sulfate. This protocol will be reviewed and approved by the Medical Director + CEO. This protocol will be reviewed and/or updated annually by the Medical Director. The protocol will be completed by 9/15/13.	

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A 636	Continued From page 8 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no magnesium sulfate available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no magnesium sulfate available for emergency use.	A 636		
A 638	1200-8-10-.06 (1)(p)17. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 17. pronestyl (procainaimide) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have pronestyl available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no pronestyl available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no pronestyl available for emergency use.	A 638	PPGMR will develop a protocol specifying the required crash cart drugs and why we excluded Pronestyl. The protocol will be reviewed and approved by the CEO & Medical Director by 9/15/13. This protocol will be reviewed and/or updated annually by the Medical Director.	
A 639	1200-8-10-.06 (1)(p)18. Basic Services	A 639		

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A 639	Continued From page 9 (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 18. sodium bicarbonate 50 mEq/50ml This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have sodium bicarbonate available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no sodium bicarbonate available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no sodium bicarbonate available for emergency use.	A 639	Sodium Bicarbonate is in the emergency crash cart currently @ PPGMR.	
A 640	1200-8-10-.06 (1)(p)19. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 19. solu-medrol (methylprednisolone) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have solu-medrol	A 640	PPGMR will develop a protocol specifying the required crash cart drugs and why we excluded Solu-medrol. The protocol will be reviewed and approved by the CEO. This protocol will be reviewed and/or updated annually by the Medical Director.	

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A 640	Continued From page 10 available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no solu-medrol available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no solu-medrol available for emergency use.	A 640		
A 641	1200-8-10-.06 (1)(p)20. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 20. verapamil hydrochloride This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have verapamil hydrochloride available on the crash cart. The findings included: 1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no verapamil hydrochloride available. 2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no verapamil hydrochloride available for emergency use.	A 641	PPGMR will develop a protocol specifying the required crash cart drugs and which are excluded Verapamil Hydrochloride. The protocol will be reviewed and/or updated annually by the Medical Director.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING: **02 - MEMPHIS REGIONAL PLANNED PARENTHOOD** B. WING _____	**05/28/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS REGI(	**2430 POPLAR AVE MEMPHIS, TN 38104**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is not met as evidenced by: During the annual survey on 5/28/13, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-10.	A 002		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING _____ B. WING _____ RECEIVED JAN 06 2012	11/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 614	1200-8-10-.06 (1)(n) Basic Services (1) Surgical Services. (n) Properly executed informed consent, advance directive, and organ donation forms must be in the patient ' s chart before surgery, except in emergencies. This Rule is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to execute advance directive and organ donation forms for 6 of 6 (Patient #1, 2, 3, 4, 5, and 6) sampled patients. The findings included: 1. Medical record review for Patients #1, 2, 3, 4, 5, and 6 did not document if the patients had advance directives or if they were organ donors. 2. During an interview in the Vice President of Patient Services office on 11/8/11 at 3:00 PM, the Nurse Practitioner stated the clinic did not ask about advance directives or organ donation due to the age of the patients served.	A 614	Accepted 1/18 -pix PPMET will develop an advance directive and organ donation form. This form will be reviewed with each surgical pt. and maintained in her chart. This form will be implemented by Jan 1, 2012. It will also become part of our quarterly chart audit.	
A 626	1200-8-10-.06 (1)(p)5. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 5. calcium chloride 10%; 10ml amp This Rule is not met as evidenced by: Based on observation and interview, it was	A 626	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude Calcium Chloride 10%. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012.	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President/CEO — (X6) DATE: 12-23-11

STATE FORM 6899 VNV811 If continuation sheet 1 of 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING _____ B. WING _____	11/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 626	Continued From page 1 determined the facility failed to have calcium chloride available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no calcium chloride available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no calcium chloride available for emergency use.	A 626	protocol will be reviewed and updated annually by the Medical Director.	
A 627	1200-8-10-.06 (1)(p)6. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 6. dextrose. 50% This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have dextrose 50% available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no dextrose 50% available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no dextrose 50% available for emergency use.	A 627	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude dextrose 50% This protocol will be reviewed and approved by the Medical Director and the CEO by Jan, 2012. This protocol will be reviewed and updated annually by the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING _____ B. WING _____	11/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 628	1200-8-10-.06 (1)(p)7. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 7. dilantin (phentoin) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have Dilantin available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no Dilantin available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no Dilantin available for emergency use.	A 628	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude dilantin. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.	
A 629	1200-8-10-.06 (1)(p)8. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 8. dopamine This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have dopamine available on the crash cart.	A 629	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude dopamine This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 2012. This protocol will be reviewed and updated	

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	TNPL53515	A. BUILDING _____ B. WING _____	11/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 629	Continued From page 3 The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no dopamine available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no dopamine available for emergency use.	A 629	annually by the Medical Director.	
A 630	1200-8-10-.06 (1)(p)9. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 9. heparin This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have heparin available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no heparin available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no heparin available for emergency use.	A 630	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude heparin. This protocol will be reviewed and approved by the Medical Director and the CEO by June, 2012. This protocol will be reviewed and updated annually by the Medical Director.	

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	TNPL53515	A. BUILDING _____ B. WING _____	11/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 631	Continued From page 4	A 631	PPMET will develop a protocol specifying the required emergency Cart drugs and why we exclude inderal. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.	
A 631	1200-8-10-.06 (1)(p)10. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 10. inderal (proprandolol) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have inderal on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no inderal available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no inderal available for emergency use.	A 631		
A 632	1200-8-10-.06 (1)(p)11. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 11. isuprel	A 632	PPMET will develop a protocol specifying the required emergency Cart drugs and why we exclude isuprel. This protocol will be reviewed by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and	

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PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 632	Continued From page 5 This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have isuprel available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no isuprel available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no isuprel available for emergency use.	A 632	updated annually by the Medical Director.	
A 633	1200-8-10-.06 (1)(p)12. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 12. lanoxin (digoxin) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have lanoxin available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed	A 633	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude lanoxin. This protocol will be reviewed and ~~updated~~ approved by the Medical Director and CEO by Jan 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 633	Continued From page 6 there was no lanoxin available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no lanoxin available for emergency use.	A 633		
A 634	1200-8-10-.06 (1)(p)13. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 13. lasix (furosemide) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have lasix available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no lasix available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no lasix available for emergency use.	A 634	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude lasix. This protocol will be reviewed and approved by the Medical Director and the CEO by June 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.	
A 636	1200-8-10-.06 (1)(p)15. Basic Services 1. Surgical Services. (p) A crash cart must be available and include at	A 636	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude	

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PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 636	Continued From page 7 a minimum the following medication and supplies: 15. magnesium sulfate 50% This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have magnesium sulfate 50% available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no magnesium sulfate 50% available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no magnesium sulfate 50% available for emergency use.	A 636	magnesium sulfate 50%. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.	
A 638	1200-8-10-.06 (1)(p)17. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 17. pronestyl (procainaimide) This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have pronestyl available on the crash cart. The findings included:	A 638	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude pronestyl. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.	

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PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 638	Continued From page 8 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no pronestyl available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no pronestyl available for emergency use.	A 638		
A 639	1200-8-10-.06 (1)(p)18. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 18. sodium bicarbonate 50 mEq/50ml This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have sodium bicarbonate 50 mEq/50ml on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no sodium bicarbonate 50 mEq/50ml available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no sodium bicarbonate 50 mEq/50ml available for emergency use.	A 639	PPMET will develop a protocol specifying the required emergency Cart drugs and why we exclude sodium bicarbonate 50 mEq/50ml. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A 641	Continued From page 9	A 641		
A 641	1200-8-10-.06 (1)(p)20. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 20. verapamil hydrochloride This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to have verapamil hydrochloride available on the crash cart. The findings included: 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no verapamil hydrochloride available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no verapamil hydrochloride available for emergency use.	A 641	PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude verapamil hydrochloride This protocol will be reviewed and approved by the Medical Director and the CEO by June 2012. This protocol will be reviewed and updated annually by the Medical Director.	
A 672	1200-8-10-.06 (3)(c) Basic Services (3) Medical Staff. (c) Clinical privileges shall be granted based on the practitioners ' qualifications and the services provided by the facility, and shall be reviewed and/or revised at least every two (2) years. This Rule is not met as evidenced by:	A 672	PPMET will document the Annual Reviews completed by the Medical Director. These reviews will be maintained in each physician's personnel file. PPMET will be a Human Resources employee to monitor,	

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A 672	Continued From page 10 Based on review of physician information and interview, it was determined the facility failed to maintain current privilege information for 4 of 5 (Physician #2, 3, 4, and 5) physicians on staff. The findings included: 1. Review of a one page document that listed credentialling information documented Physician #2 had no current Drug Enforcement Agency (DEA) number, no current privileges, and no current background check. 2. Review of a one page document that listed credentialling information documented Physician #3 had no current DEA number and no current background check. 3. Review of a one page document that listed credentialling information documented Physician #4 had no current DEA number and no current background check. 4. Review of a one page document that listed credentialling information documented Physician #5 had no current DEA number, no current privileges, and no current background check. 5. During an interview in the Vice President of Patient Services (VPPS) office on 11/8/11 at 3:30 PM, the VPPS stated they have a company hired that credentials the physicians. The clinic verifies the Medical Director's DEA number is current because medications are ordered under his number. He stated the clinic only began doing background checks during the past year.	A 672	review, and audit all employee files to ensure proper documentation is maintained and updated. Annual HR audits will be conducted. Copies of all DEA licenses will be in each physicians file by Jan 1, 2012. Copies of the Medical Director review for each physicians will be completed by Jan 1, 2012. Background checks for each physician shall be completed by Jan 1, 2012.	
A1101	1200-8-10-.11 (1) Records and Reports (1) The Joint Annual Report of Ambulatory	A1101	In 2008. Janice Gilbert, with TDH, informed	

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PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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A1101	Continued From page 11 Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure the Joint Annual Report (JAR) of Ambulatory Surgical Treatment Centers was filed with the department for the 2010 year. The findings included: The facility was unable to provide a copy of the JAR for the 2010 year. During an interview in the Vice President of Patient Service's office on 11/8/11 at 3:10 PM, he stated he would have to call the corporate office to see if the JAR was submitted for the 2010 year.	A1101	PPMET that per her Supervisor, Loxelle Matthews, abortion providers do not need to complete the Report according to TCA internal guidelines and to protect the confidentiality of abortion providers	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 802	1200-8-10-.08 (2) Building Standards (2) The condition of the physical plant and the overall Ambulatory Surgical Treatment Center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the overall Ambulatory Surgical Treatment Center environment. The findings include: On 11/9/11 at 9:35 AM, observation within the Director's office revealed there was a 3" by 4" cut-out penetration within the sheetrock wall. 2. On 11/9/11 at 10:00 AM, observation within the supply storage revealed a penetration within the left-side wall. These findings were acknowledged and verified by the Assistant Director during the exit interview on 11/9/11.	A 802	PPMET has corrected the penetration within the left side wall of the supply room. The cut-out in the Director's office will be repaired by Jan 1, 2012. In addition, the Asst Dir, or her designee, will monitor and document issues with the building quarterly.	
A 901	1200-8-10-.09 (1) Life Safety (1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations. This Rule is not met as evidenced by: Based on observations, it was determined the	A 901	PPMET has corrected the electrical outlet. It now has a cover. In addition, the Asst Dir, or her designee, will monitor and document issues with the building quarterly.	

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

E-MAILED 12/6/11 - PDC to NR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53515	A. BUILDING 02 - STATE BUILDING B. WING _____	11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF MIDDLE AND EA	412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 901	Continued From page 1 facility failed to maintain the electrical system. The findings include: On 11/9/11 at 9:45 AM, observation within consulting room [redacted] revealed an electric outlet behind the entry door without a cover plate. This finding was acknowledged and verified by the Assistant Director during the exit interview on 11/9/11.	A 901		

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING _____ B. WING _____	03/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	1407 UNION AVENUE 3RD FLOOR MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficiencies This Rule is, met as evidenced by: This facility complies with all requirements reviewed for Ambulatory Surgical Treatment Centers surveyed during the annual licensure survey conducted 3/1/2010. No deficiencies were cited.	A 002		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	A. BUILDING 01 - MEMPHIS REGIONAL PLA B. WING _____	03/04/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD GREATER MEMPHIS	1407 UNION AVENUE 3RD FLOOR MEMPHIS, TN 38104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 801	1200-8-10-.08 (1) Building Standards (1) The Ambulatory Surgical Treatment Center must be constructed, arranged, and maintained to ensure the safety of the patient. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the Ambulatory Surgical Treatment Center in a manner that would ensure the safety of the patients. The findings included: Observations during the facility tour on 3-4-10 beginning at 9:00 AM, the following deficiencies were found: 1. The exit light was inoperative in the Administration hall rear. 2. The emergency light in exam room [redacted] was broken. 3. The emergency generator testing reports are not on site for review.	A 801	1.) Spoke with building management, Dave Disney, and this has been corrected on 3/9/10 2.) The exam room [redacted] emergency light was repaired by Mid South Emergency Lights on 3/9/10. 3.) I have attached the e-mail from the building manager, Dave Disney, in regards to the generator. We do not have a tenative completion date. To assure that the deficient practice does not recur, we will continue to notify building management in a timely fashion and we will continue to do our routine clinic inspections which includes visual inspections of the sited observations.	3/9/10 3/9/10

acceptable POC
3/26/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jarsha Tellitt, Director of Clinic Services — 3/12/10

Barry Cleveland CEO

FORM CMS-2567(02-99) 6899 DQ2521 If continuation sheet 1 of