

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 57243

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,

of Theague Jeff Teague President/CEO





April 8, 2010

APR 1 3 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

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1 leacher

Sincerely,

Jeff Teague President/CEO



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

Transaction No. 000002527 Telephone No. 615-345-0952

File ID: 00000015

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 Rulas and Regulations of the State of Tannessee for this type of locility.

SIGNATURE

DATE

DO NOT WRITE BELOW THIS LINE ---- DO NOT SEPARATE ANY PART OF THIS FORM DCF300 10083



MAKE CHECK OR MONEY ORDER PAYABLE TO THE DEPARTMENT OF HEALTH **DO NOT SEND CASH**

RDA-1694

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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 EAS 50 VANTAGE WAY SUITE 102 **Americans** NASHVILLE TN 37228

Total Amount Due: \$

1,080.00

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
		TNPL53526	B, WING			₹ 01/2019
	PROVIDER OR SUPPLIER	PRODUCTIVE HE 1547 WE	DDRESS, CITY, S'EST CLINCH AN	/ENUE	***************************************	
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(A 001)	1200-8-10 Initial		{A 001}			
	was conducted for on 8/27/19. All defined no new noncor	ne Plan of Correction (POC) all previous deficiencies cited iciencies have been corrected npliance was found. The ince with all regulations				
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ion at Ho	alth Care Facilities				— Ame	rica

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

United of the continuation sheet 1.61 for Life

TITLE

09/12/2019 01:35PM 8656370222 RECEIVED 09/05/2019 02:15PM 8656371169 09/05/2019 THU 13:27 PAX \$655942168 pept of health

KIM DENISON - KORH 2002/002

PRINTED: 09/05/2019 FORM APPROVED

INPLS3526 STREET ADDRESS, CITY, SIATE, AIP CODE. (NOXVILLE CENTER FOR REPRODUCTIVE HI KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DETICIENCILE (I.A.O) ID SUMMARY STATEMENT OF DETICIENCILE (I.A.O) ID (I.A.O) RESCIDENTIFYING INFORMATION) 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 Liconsure and Regulation Office of Health Care Facilities on 8/27/2019, During this file safety survey, this facility was found in substantial compliance with the requirements for participation in Madicare/Medicaid with chapter 1200-08-10, Standards for Altibulatory Surgical Treatment Centers. Life Safety form Fire, and the related National Fire Protection Association (NFPA) standard 101-2012.		8/27/2019
(MOXVILLE CENTER FOR REPRODUCTIVE HI 1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DETICIENCIAL ID PROVIDENS PLAN OF CEACH CORRECTIVES TO AN OFFICIAL REGULATORY OR LSC (DENTIFYING INFORMATION) A 001 1200-8-10 Initial A 001 This Rule is not met as evidenced by: Construction Type: H (111) Stories: 1 Constructed: 1950's (no drawlings 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 Altibulatory Surgleal Treatment Centers. Life Stifety from Fire, and the related National Fire Protection Association (NFPA)	1 04	014114018
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During the Life Safety portion of the annual Licensure survey conducted on 8/27/2018, no deficiencies were cited under 1200-08-10, Slandards for Ambulatory Surgical Treatment Centers.		



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Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
A 001, 1200-8-10 Initial	1 A 001	
This Rule is not met as evidenced by: An annual Licensure survey was conducted or 3/4/19 - 3/5/19 at Knoxville Center for Reproductive Health. The facility was found to be in substantial compliance with Chapter 1200-8-10, Standards for Ambulatory Surgery Treatment Centers.	not	
A 425: 1200-8-10-,04(20)(b) Administration	A 425	Syringes shall be 3/18/19
. (20) Infection Control.		properly identified with
 (b) The physical environment of the ambulate surgical treatment center shall be maintained safe, clean and sanitary manner. 	in a	the required information
4 0	10 (0	will be responsible for
This Rule is not met as evidenced by: Based on review of review of review of the Association of Professionals in Infection Cont and Epidemiology (APIC) guidelines, observal and interview, the facility failed to ensure prefi syringes were properly labeled for 8 of 8 synn in 1 of 1 pre-procedure work areas observed.	tion, lled	to ensure all suringes are properly identified and prepared in accordance with the standard to ensure compliance.
The findings included:		Companies.
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 hourafter drawing up the medicationlabel a syringes containing medication if not immedia administered. Include patient identification information, names and amounts of all	ali	All staff responsible for handling and Prejoring the syringes have been trained and educated in the gractice noted 15/15/16

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

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STATE FORM

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45 Day PAGE 02/10 PRINTED: 09/03/2019 FORM APPROVED

Division	of Health Care Faci	lifies		10/11/19	
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING		COMPLETED
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A 001	1200-8-10 Initial		A 001		. //
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	Ø.			T.C. 1: 601 h	Se Coursell
	This Rule is not me	et as evidenced by:		Testestion control.	" Hicki - Cr
		was conducted on 8/26/19 -	1	be responsible -6	
1		Center for Reproductive		Compliance of	il deficiencia
3		was found to not be in		C. Ed.	1
1		nce with Chapter 1200-8-10,	i		ì
4		ulatory Surgery Treatment	ļ		
ì	Centers.		ļ		
اسميد				Per facility poli	9/30/19
A 4251	1200-8-1004(20)(b) Administration	A 425		
	(20) Infoation Cont	ral		All multi-dose via	I'medications
1	(20) Infection Cont	[0].		shall be opened,	Juted timed
	(b) The physical er	vironment of the ambulatory		1	nursine
1		enter shall be maintained in a	ì		
	safe, clean and san			Personnel. The No	rsing Supervisor
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1				responsible for oun	script this
1				facility rolley is	foll; Bed
1	This Color is a second			Take of the state of the	1000000000
į	This Rule is not me			by completing the	119 Legicagos
		facility policy, review of the Control and Prevention	l'	herself or monit	crine and/or
¥		eview of the Association of	1.	I WE SHOULD NAME OF	. \
1		stered Nurses (AORN)		opposition the Se	active is
		tion, and interview, the facility		being Property >	ertormed
		erile technique during 1 of 1			
		and failed to ensure an		by others.	į.
		vial of medication was dated,		101 1. 1-	
		n 1 (pre-operative prep area)		Education 11-5	ETVICE TOW
-	of 9 patient care are	as observed,		handling of MDI	's sectioned
	The findings include	,		3/1-110 27	1 1
	The manga monde	•		1/19/12 1 WE 3124	PLOK SKEEL
	Review of the facility	policy "Medication		is attached of all	, projecting
	Administration Polic			Staff The Draw	handline Is
		cations must be labeled with			
		N [Registered Nurse] initials		THE WEIGHT IN	Ne de la
		expire 28 days after initially		KN checklist, To	Verity
nvision of He	ally Care Facilities	CALCADE A CONTRACTOR OF THE CALCADA	LAWLIDE.		mericans
ARCHAHORY	DIRECTOR'S OR PROVIDE	ENSUPPLIER REPRESENTATIVE'S SIGN	MIURE	TITLE	
	Lana liber	4507		Ministration	12/19
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Division	n of Health Care Fac	lities			
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A 425	Continued From pa	ge 1	A 425	a 12- Had	41-29/30/19
	opened regardless expiration date"	of manufacturer listed	8	log will be review	and wheekly
	dated 6/20/19 revea	delines for "Injection Safety" aled ",If a multi-dose has		Intedien Control	
		cessed (e.g., [for example]	,	If copy of the i	M Chocklist
		the vial should be dated and days unless the manufacturer	1	is attached Th	le log is
	specifies a different	(shorter or longer) date for	!	also reviewed b	4 The
	that opened vial"			BAJPI Commi	Eter anville
		Suidelines for Perioperative	,	The weekly info	
		6, revealed "Items		200 00 00	40
Ÿ		erile field should be opened, isferred by methods that		monitoring sheet	512 or CPO
ì	maintain the sterility	and integrity of the item and	!	attached.	
		rile items that are not opened.	1		
:		sferred by methods that dintegrity may contaminate	•		ì
į	the sterile field"	a integrity may contain mate	10	1	!
2	0		î:	10 1 1. 1	ion will be
		erview with Surgical Assistant at 1:00 PM, in treatment room		J	Ten and Off
:	#1. revealed SA #1	was setting up the procedure		Provided By the	cowning
:		rocedure. Continued	i.	Superviser/intection	in control
i		d a covered sterile stainless	1	officer to all sum	gery assistants
		on a table. Further	ì	recarding Concep	.1
:		d SA#2 removed the cover		practices for est	
:		teel tray, which contained uments and then retrieved a		praecises Tor es	-docznin d
;		trument from the countertup,		and maintaining	a steer la
:		ackage, and dropped the	1	field. She will of	2006 - 18 m
	sterile instrument in	to the stainless steel tray with			
:	the other surgical in	struments, Continued		Practices and Pr	oceduras to
		the SA then touched the		ensure Sterile +	technique
		iments that were located		is being maintain	ned-601
		steel tray with the outside of		Shall Moniter the	
		aging。Interview with SA #1 as not aware the instrument			
		as not aware the instrument		by routine eval	sation.

Amoricans United for Life

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Division of Health Care Facilities

packaging had touched the sterile surgical

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: TNPL53526 B. WING 08/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1547 WEST CLINCH AVENUE KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A 425 Continued From page 2 A 425 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. NONS.L 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 300 the Lidocaine was opened and undated. Continued interview confirmed the facility failed to follow facility policy. A 436| 1200-8-10-04 (20)(c)6, Administration A 436 (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; i Division of Health Care Facilities STATE FORM

	n of Health Care Fac		T (VO) A41 B MIE	I E CONCIDUCTION	(X3) DATE SURVEY
	NT OF DEFICIENCIES FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION 3:	COMPLETED
		TNPL53526	B. WING		08/27/2019
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY	STATE, ZIP CODE	
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		NNOXV	ILLE, TN 379	PROVIDER'S PLAN OF CORRE	CTION (YS)
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A 436	Continued From pa	ige 3	A 436		9/20/19
	Based on review of review of a facility of a facility since the facility's proced interview, the facility sterilization log booreading of a biological microorganism inaction (used for steam steam). The findings including the facility assurance of recommend that are be used to monitor supplies. record resterilization"	e: ufacturer's Instruction Manual	die	The biological to that were not week of 8/19 while the stern technician was The individual for overseine during her about a ensure propies noted. Our policy follows to should be each sterilize	incorded the contraction or vacation or vacation or vacation this procedured the concel training or decumental the follow.
	8-19-19 revealed no number, date and to and time out of the results of the control	o documentation of the load ime in the incubator, dated incubator, and whether the ols (indicales if sterilization had positive or negative		weekly."	1.30
100	results.			sterilization to	
1	surgical procedures	y's procedure log revealed were performed on	1	1	surveyer
!	Technician #1 on 8/	erview with Sterilization 26/19 at 1:30 PM, of the k in the Sterilization Room,	i	Stevilization (on bekin

Americans United for Life

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STATE FORM

IND PLAN	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:	A BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
y.,,		TNPL53526	B, WING	***	08/27/2019
	PROVIDER OR SUPPLIER	ERRODUCTIVE HE 1547 WE	ADDRESS, CITY, ST EST CLINCH AV ILLE, TN 37916	/ENUE	
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A 438	confirmed surgical and the log book was in documentation in t	age 4 procedures were done on Further interview confirmed and there was no the sterilization log book to testing was performed.		Sterilization This log provocation of medianica andicators an each procedu of the logi The nursing infection co infection co will review weekly to procedures of the document	ion states 9/30/1 I the dicator long to provide or with the Maintenance Indicator long I and chemical ad is completed as attached Supervisor / Supervisor / Confirm are being and results ited as attached at is attached. So attached at is attached.

Americans United for Life

9CTK11

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.



Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: **B. WING** 04/03/2019 TNPL53526 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1547 WEST CLINCH AVENUE** KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {A 001} (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.

If continuation sheet 1 and

Division of Health Care Facilities

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

TITLE

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING: 01 - MAIN		
		TNPL53526	B. WING		03/04/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
KNOXVIL	LE CENTER FOR RI	PRODUCTIVE HI	EST CLINCH A' ILLE, TN 3791			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE COMPLÉTE THE APPROPRIATE DATE	
	Licensure survey c deficiencies were c	ciencies ety portion of the annual onducted on 3/4/19, no sited under 1200-8-10 al Treatment Centers.	A 002			

Division of Health Care Facilities

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

TITLE

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STATE FORM

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING. TNPL53526 03/05/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1547 WEST CLINCH AVENUE KNOXVILLE CENTER FOR REPRODUCTIVE HI KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) , A 425 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.

Division of Health Care Facilities

STATE FORM

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		TNPL53526	B WING		R 08/01/2018
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	ATE, ZIP CODE	00/01/2010
(NOXVIL	LE CENTER FOR R	EPRODUCTIVE HE 1547 W	EST CLINCH AV	ENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
{A 001]:	1200-8-10 Initial		{A 001}		
	previous deficienci deficiencies have t compliance was fo	conducted on 8/1/18 for all es cited on 6/19/18. All been corrected and no new und. The facility is in I regulations surveyed.			
					SS

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

TITLE



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

IDENTIFICATION NUMBER:

A BUILDING: 01 - MAIN

COMPLETED

TNPL53526

B WING

06/18/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1547 WEST CLINCH AVENUE

KNOXVILLE, TN 37916

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

KNOXVILLE CENTER FOR REPRODUCTIVE HE

A 002

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.

Division of Health Care Facilities

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

STATE FORM

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KIM DENISON

PAGE 02/04 PRINTED: 06/25/2018

FORM APPROVED Division of Health Care Facilities (X2) MULTIPLE CONSTRU STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEDCUA (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING **VVINT** TNPL53526 06/19/2018 NAME OF PROVIDER OR SUPPLIER STREET ADORESS, CITY, STATE, 2IP CODE 1547 WEST CLINCH AVENUE KNOXVILLE CENTER FOR REPRODUCTIVE HI KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL IEACH CURRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 001 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 425 1200-8-10-.04(20)(b) Administration A 425 (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

Division of Health Care Facilities

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

treatment areas. This is to prevent inadvertent

STATE FORM

TITLE

Division	of Health Care Faci	lities					as a series A. Leis (ES.)
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIFICATION NO.		(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		TNPL53526		B WING			06/19/2018
HAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE ZIP CODE		
			1547 WES	T CLINCH A	VENUE		
KNOXVII	LE CENTER FOR RE		KNOXVILI	LE, TN 3791	6		
(X4) ID PREFIX TAG	/FACH DEFICIENCY	TEMENT OF DEFICIENCIE YMUST BE PRECEDED BY SO IDENTIFYING INFORM	FULL	ID PREFIX TAG	(EACH CORE	RES PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPEL DEFICIENCY)	DE COMPLETE ATE DATE
A 425	Continued From pa	ge 1		A 425	Betadin	. Solution sl	rall , 4/25/15
	contamination of th	e vial through direct	or indirect		he Down	ed into a st	erile 8/1/18
	contact with potent	ially contaminated si	urfaces or	!	Contrain	er dedicate	4
	equipment that cou	ld then lead to infec	lions in	Ka:			
	subsequent patient	s. If a multi-dose via	il enters an			de Patient u	ise only.
	, immediate patient t	reatment area, it she e-patient use only the	la		On Jun	e 20 1 2018	the
	multi-dose has bee	n opened or access	ed (e.g., 🔠	ř.	Surviva		
	needle-punctured)	the vial should be da	ated"	i i	3.	ch Al	I Marked
	la e au	0/40 -144.47 AM in			ack and	change. Al	1 State
	Procedure Room	8/18 at 11:17 AM, in			7	edged unders	Landing.
	1. One opened 5	0 milliliter (ml) multi-	dose vial	1	ine We	dient Direct	or shall
	of 1% Lidocaine (no	umbing medicine)			be rest	ensible for	routinal
		50 ml multi-dose via	als of 1%	į.	observi	rg, monitor	2 19
	Lidocaine	stainless steel bowl	of betadine		Dorticis	ating in thi	3
	solution (surgical s		01 00(00),14	1	1 - 000	cente in the	3 Bracgica
	Interview with Sura	ery Assistant #1, on	6/18/18 at		ED 61620	re complian	s.e
	11:25 AM, in Proce	dure Room conf	irmed the		n		
	betadine solution a multiple patients.	nd the Lidocaine we	te asea on				
	inumpie padents.						Ž.
4	Observation on 6/1	8/18 at 12:15 PM, in	1		,		:
	Procedure Room	revealed:					7
		ml multi-dose vial	OF 170	i			
3	Lidocaine 2 One unopened	50 ml multi-dose via	al of 1%	v.			
	Lidocaine						3
		stainless steel bowl	of betadine				1
	solution	ery Assistant #2, wit	h the				9
Ų.	Director of Nursing	(DQN) pres <u>ent,</u> ол	5/18/18 at	i.			•
	12:20 PM, in Proce	dure Room 🚾 cont	irmed the	[•			4
	betadine solution a	nd the Lidocaine we	re used on				-CC-
	multiple patients.						(745)
	Observation and in	terview with Family	Nurse				CHO
4	Practitioner (FNP)	#1 on 6/18/18 at 2.0	0 PM, in				
	the sterilization roo	m, revealed 1 opens	ed undated	20		A	
	50 ml multi-dose vi	al of 1% Lidocaine.	Interview	V	I	AI	uerican

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United for Life

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PAGE 04784 RINTED: 06/25/2018

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אט ויטא	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A, BUILDING:	CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED
		TNPL53526	B' MING	1	06/19/2018
NOXVII (X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	EPRODUCTIVE HE KNOXVI ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	DDRESS, CITY, S' EST CLINCH AN LLE, TN 37910 ID PREFIX TAG	PROVIDERS PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLE DATE NCY)
A 425	and undated and of to be dated when confirmed the multiplaced in the procedure patients. Continue betadine solution vito the first procedure multiple patients the Observation and in 6/18/18 at 2:30 revealed eight 11 religit Curettes (instinuents) in 6/18/18. Intervie	med the Lidocaine was opened opened vials of medication were opened. Further interview indose vials of Lidocaine were adure rooms each day, occdure room throughout all is, and were used on multiple of interview confirmed the was poured into the bowl prior are of the day and was used on incoughout the day. Interview with the Administrator PM; of Procedure Room intillimeter (mm) Disposable trument used to remove outerus) with an expiration date we with the Administrator with the Administrator and were expired and were	e. : :	the following	wetters tound wat ion for worth shall separately from It not used worth, they worded.

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Americans United for Life

45 Day 1/13/018

PRINTED: 12/04/2017 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X/2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING TNPL53526 11/29/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1547 WEST CLINCH AVENUE KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 12/11/17 A 424 1200-8-10-.04 (20)(a) Administration A 424 1200-8-10-04 (20)(a) (20) Infection Control. P.O.C. A monthly inspection log (a) The ASTC must provide a sanitary environment to avoid sources and transmission has been created of infectious and communicable diseases. There ensure no expired item. must be an active performance improvement program for the prevention, control, and are available investigation of infections and communicable use. Staff membe diseases. be responsible all items in their desi areas, removing an This Rule is not met as evidenced by: items as needed 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 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 revealed two bottles of hand sanitizer with an

Division of Health Care Facilities

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expiration date of 10/2016. Interview with the

Administrator

for Life

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SUI	
AIAD LEVIA	OF CORRECTION	IDENTIFICATION NOMBER.	A BUILDING:	A_BUILDING:		'
		TNPL53526	B. WING		11/29/2	2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KNOXVII	LLE CENTER FOR RE	PRODUCTIVE HA	T CLINCH A			
04.0.15	CHAMAADV CTA	TEMENT OF DEFICIENCIES	LE, TN 3791	PROVIDER'S PLAN OF CORRECTION	ON I	(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE 0	(X5) COMPLETE DATE
A 424	Continued From pa	ge 1	A 424			
	Administrator confir	rmed the hand sanitizer was			1	
		ility failed to ensure expired				
	supplies were not a	vailable for use.				
		terview with the Advance				
		N) on 11/29/17 at 10:20 AM, Cart in the Recovery Room,				
		sterile latex surgical gloves				
	with an expiration d	ate of 9/2017. Interview with				
		the gloves were expired and ensure expired supplies were				
	not available for pat					
		terview with the APN on				
		M, in the lab, revealed seven ood specimen tubes with an				
	expiration date of 1	0/31/17. Interview with the				
		blood specimen tubes were ility failed to ensure expired				
		vailable for patient use.				
A 680	1200-08-1006 (12)(a) Basic Services	A 680	1200-08-1006(12)(3) 17	2/11/17
,,,,,,,					.	
	(12)Medical Record	ls.		An inquiry has been n with the Office of V	rade	ï
		comply with the Medical		to determine if the	carre	ords
	Records Act of 1974	4, T.C.A. § 68-11-301, et seq.		in question was rece	wed or	
				if we inadvertently	failed	
				to submit it. It was		
				a copy may have been	Culmal .	. 13
				or misplaced. At the	reque	st
	This Rule is not me	et as evidenced by:		or misplaced. At the of the Office of Vit	al Riece	ords,
	Based on review of	the State of Tennessee Laws,		a second report was to compare against	250/10	
		ew, and interview, the facility aduced termination of		We are awaiting the	cir Col	Grosa?
		ient (#5) of 10 medical) ~~		75

Division of Health Care Facilities

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Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING TNPL53526 11/29/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1547 WEST CLINCH AVENUE KNOXVILLE CENTER FOR REPRODUCTIVE HI KNOXVILLE, TN 37916 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 12/11/17 1200-08-10-.06(12)(3) A 680 A 680 Continued From page 2 P.O.C. records reviewed. Each Procedure day 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 Mar. and she will confirm termination of pregnancy was performed..." Medical record review revealed Patient #5 was equals the number of patients) seen. She is then responsible admitted to the facility on for an abortion. Further review revealed the patient was for mailing them to the Office of Vital Records. If the discharged home the same day. Continued medical record review revealed a Tennessee Department of Health, Report of Induced Director of Counseling is about the staff member is Termination of Pregnancy was not in the medical record. designated to complete this task 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.

Division of Health Care Facilities

STATE FORM



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ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TNPL53526		B. WING		DEI	DEIONICO	
NAME OF PROVIDER OR SUPPLIER KNOXVILLE CENTER FOR REPRODUCTIVE HI KNOXVILLE KNOXVILLE				TATE, ZIP CODE /ENUE	1 00/1	9/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	THE	(X5) COMPLETE DATE
A 001	1200-8-10 Initial		A 001			
	health deficiencies	e survey completed on 5/9/17 at or Reproductive Health, no were cited under Chapter ards for Ambulatory Surgical				
20 20 20 20 20 20 20 20 20 20 20 20 20 2			1:		8	
RATORY	elth Care Facilities DIRECTOR'S DR PROVID	ERVSUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	Ame	(X6) DATE
E FORM	_ Asga	Devision	6900 S7	Administrator		
			-			

PRINTED: 05/11/2017 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 01 - MAIN COMPLETED B. WING TNPL53526 05/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1547 WEST CLINCH AVENUE** KNOXVILLE CENTER FOR REPRODUCTIVE HI KNOXVILLE, TN 37916 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DATE DEFICIENCY) A 824 1200-8-10-.08 (24) Building Standards A 824 s noted in the tindi (24) The department requires the following alarms that shall be monitored twenty-four (24) hours per day. (a) Fire alarms; entrol senel n (b) Generators (if applicable); and (c) Medical gas alarms (if applicable). view and a pero - Dest. of Heal el will be res This Rule is not met as evidenced by: Based on observation, record review and of equipment is attach interview, the facility failed to maintain the fire alarm. 6/22/17 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.

Division of Hoalth Care Facilities

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		TNPL53526	B. WING		11/	14/2016
	PROVIDER OR SUPPLIER LLE CENTER FÖR RE	EDPODUCTIVE HE 1547 WE	DDRESS, CITY, S ST CLINCH A' LLE, TN 3791			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
A 001	1200-8-10 Initial		A 001			
	November 14, 2016 Reproductive Healt	survey conducted on 6, at Knoxville Center for th, no deficiencies were cited Standards for Ambulatory Centers.				
						CO
						SS
	ealth Care Facilities				Am	eric

TITLE



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

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PRINTED: 04/29/2016 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53526	B. WING_		04/18/2016
NAME OF PROVIDER OR SUPPLIER KNOXVILLE GENTER FOR R	EPRODUCTIVE HE 1547 WES	DRESS, CITY, IT CLINCH A LE, TN 379		1 04/10/2010
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE COMPLETE
(b) Pathological wildisposed of, or plathis Rule is not in Based on observation document, and intrensure biological wilding included in the findings included in the facility. Continuous of the facility. Continuous of the facility. Continuous of the facility. Continuous of the facility in the freezer contain. Review of a facility Room Freezer te 2016, revealed no temperatures for the fat 2:05 PM, in the stemperature is to be day and they failed interview confirment the 1st, 4th, 8th, 9th.	the facility tour with the facility 18/16 at 11:30 AM, revealed a storage area on the first floor tinued observation revealed ed regulated biological waste. document " Storage mperatures" dated April documented freezer is month of April. acility administrator on 4/18/16 oreak room, confirmed "a e recorded every procedure to do so" Continued to procedure days in April were	A1020	as the temperature adheres to the tep forezer For ease of The Medica Direct town and Sign of each Month to en compliance.	econding pres have to wree each folder identified a fag he fuse.

865-637-1169

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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 A. BUILDING: 01 - MAIN

(X3) DATE SURVEY COMPLETED

TNPL53528

B. WING

04/19/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

X4) ID REFIX 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) (XX	
A 805	(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.	A 805	The following individuals 6/2, have been contacted and are working to gether to determine if having the FACT commicating the smitter interface modified from the to collider service requires I to collider service requires I to collider service requires the Plans Herial Fire Safety Section Health Care Facilities Health Care Facilities City of Knokville Fire Inspection State of TN	and a
	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		Fire Marshalls Offen Service Manager Simplex Ovinnell We have been working to resolve this issue from the date of the sorvey. Once we have been notified by the proper authorities if Connective action is necessary use will do so.	-27

Asion of Health Care Facilities

BORATORY DIRECTORS OR PROVIDER SUPPLIER REPRESENTATIVES SIGNATURE

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STATEMEN AND PLAN	AND COMMON CONNECTION I INFINITERIATION UNMEDI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01 - MAIN	(X3) DATE SURVEY COMPLETED	
		TNPL53526	B. WING		04/1	9/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KNOXVII	LE CENTER FOR RE		IT CLINCH A LE, TN 3791			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X6) COMPLETE DATE
A 805	Officer on 4/19/201 were not aware that approval were required. These findings were Officer and acknow	6 at 2:25 PM revealed they t submittal, review and	A 805	DEFICIENCY)		
Division of He	alth Care Facilities				ame	rican

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 01 - MAIN B. WING TNPL53526 11/16/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1547 WEST CLINCH AVENUE** KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX ΙD PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) A 002 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.

Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MAIN B. WING TNPL53526 10/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1547 WEST CLINCH AVENUE KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) A 817: 1200-8-10-.08 (17) Building Standards A 817 (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 degrees F. 115 The findings include: Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MAIN B, WING TNPL53526 10/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1547 WEST CLINCH AVENUE** KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 817 Continued From page 1 A 817 1200-8-10-08 (17) Bldg, Standards (c) Observation and interview with the Administrator, Maintenance was contacted on 10/20/2015 at 1:22 PM confirmed the hot water temperatures in 2 of 2 procedure rooms to lower the water h 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. to verily the Standard range of 105-1150 F

Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 - MAIN B. WING TNPL53526 10/20/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1547 WEST CLINCH AVENUE** KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Page 2 of 2 A 817 1200-8-10-.08 (17) Building Standards A 817 (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 degrees F. 115 The findings include: Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Lewers

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN		(X3) DATE SURVEY COMPLETED	
		TNPL53526	B. WING		10/20/2015
	PROVIDER OR SUPPLIER LLE CENTER FOR RE	EPRODUCTIVE HE 1547 WES	DRESS, CITY, ST CLINCH A LE, TN 379		
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A 817	on 10/20/2015 at 1 water temperatures and the instrument between 130 to 13/ This finding was ve Supervisor and act	terview with the Administrator, :22 PM confirmed the hot is in 2 of 2 procedure rooms cleaning room ranged 4 degrees F. irifled by the Maintenance	A 817	1200-8-10".05 (M) (c) Maintenance was to lower the wo temperature. Upon the water temperature tested and me Completion Do Annual testing sha to verify the Star cf 105-1150 F	contacted ter heater completion, evature was acced 110°F.
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Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIENCLE (X1) PROVIDER/SUPPLIENCE.		ER/CLIA IMBER	(X2) MULTI A, BUILDIN	PLE CONSTRUCTION	COMPLETED		
	TNPL53526		8 WING 02/21/20				
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				EST CLINCH AVENUE LLE, TN 37916			
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A 001	1200-8-10 Initial			A 001			
	On-site completed 29091 and conduct	et as evidenced by: to investigate compl t licensure survey, cited for the complai	1				
A 407	1200-8-10-,04 (6) Administration			A 407	Advance Directive		
	(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.			house been crowd of the Apparent Care glan Formation of the formation of the complete of the c	next of Advances of and Advances of the surject of the surject on dinatherties he forms are he forms are he will be		
A 424	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. 4 424 1200-8-1004 (20)(a) Administration			A 424	for Fly care or Doily chart ran grante ly chart	super services well and audit Tiles	
	(20) Infection Cor	ntrol.			Shall encere Con?	varie.	
ovision of H	ealth Care Facilities		**************************************		TILE KIMIN	TAG (OX) DATE	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMPLETED
			B. WING		02/21/2012	
NAME OF PA	ROVIDER OR SUPPLIER				STATE, ZIP CODE	
	LE CENTER FOR R	EPRODUCTIVE HE	1547 WES	T CLINCH A LE, TN 3791	AVENUE. 16	
MONTE				10	BROWNER'S PLAN OF COR	RECTION (X5)
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A 424	Continued From p	age 1		A 424	To ensure inte	1/0/12
-	(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.				biological noter stored sogorate medications b	and and be in a shall be in from lall with courtal cines only
	Based on observation failed to ensure in	net as evidenced by: ation and interview, th fection control standa laboratory (lab), exar very room.	ie facility ards were		together and Patient use of De dissorded.	extred extered terms shall
	The findings inclu	ided:				1800 ONG
	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.			brotonical conto	ied and being hely and signs	
	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				informed of ac Practices for a Patient cared	enstable itan

Division of Health Care Facilities

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	of Health Care Fac	(X1) PROVIDER/SUPPLIE	R/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE S	
	F CORRECTION	IDENTIFICATION NU	MBER.	A. BUILDIN		1	
				B, WING _		n2/2	1/2012
		TNPL53526		0.550	DYATE BUY CODE		
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
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A 424	Continued From p	age 2		A 424			4/6/12
	with clean or steril sutures had expire patient use	e patient care Items; ed and were available	and the for				
	C/Q #29091						1.1.1
A 680	1200-8-1006 (5)	Basic Services		A 680	All medication	s shall be	14/6/12
	provide drugs and effective manner i standards of prac- biologicals must b	al Services. The AS biologicals in a safe in accordance with actice. Such drugs and se stored in a separal be kept locked at a	and ccepted I te room or	e u	the facility A what house in medication or which will	ate, sice anner th anner th atrace Cont & const occupant occupant	Count Count
	Based on observa failed to ensure m throughout the fac medications were which were not of	met as evidenced by: ation and interview, to nedications were secutility; failed to ensure a not stored in areas wean in the medication are expired medication at use.	ne facility ured with items n closet;		it is intended	H Medin bered with 12 and w towner H Lowked	eas at
	The findings inclu	ided:					
	the Administrator 8:50 a.m. and 10: unsecured medic pills, vitamins, ov- prescription antac medication storag laboratory, exam surgical recovery		2, between e following: control esics, and unlocked the is, and the				ÇÇ
	Continued observed medication storage realth Care Facilities	vation revealed the dege closet contained it	esignated tems such				Cr

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STATEMENT AND PLAN C	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU TNPL63526	ER/CLIA MBEK:	(X2) MULT A BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
MAME OF D	ROVIDER OR SUPPLIER	THI COULD	STREET ADD	DRESS, CHY.	STATE, ZIP CODE	
	LE CENTER FOR RE	EPRODU CTIVE HI		T CLINCH LE, TN 379		
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A 680	and various types of continued observations are expired medication located in the example 2010; and a bottle located in the surgexpired November the expired November the expired November a.m., confirmed the were not secured; maintained in an alignmedication stopping and sonly medication stopping and sonly medication and any medication stopping and sonly sonl	ano keyboard, manu- of dusty office equipr ation revealed the foll his: a box of birth con- of over the dust as exp- ery recovery room di- 2011. unselor's office with the predications in the the medications were his appecifically designorage; and various mility had expired and	ment. lowing trol pills ired April d in the bired July analgesic aled as the 10:50 facility e not gnated for nedications	A 680	Medication sture will be inventor marthly loads medications of Compliance with Stundard of	to the bove

Division of Health Care Facilities

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Division of Health Care Facilities

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(X3) DATÉ SURVEY STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND FLAN OF CURRECTION A. BUILDING 01 - MAIN B WING 02/22/2012 TNPL53526 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1547 WEST CLINCH AVENUE KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CF:OSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY 4/6/12 A 802 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 (exated at failed to assure safety equipment was Hairwell will have maintained. Kinga roplaced Paint duand label will be remove The findings include: The door will be Observation and interview with the lab tech at to clear to a positive lateh. 11:00 am on February 22, 2012 confirmed the waiting room fire door to the stairwell was missing - (- Leodies 1 t the center hinge, the label was painted over, and will be attached to a migrate the door failed to close to a positive latch (NFPA door helder and will chairse 80, 15.2) the event the alarm spends. Observation and interview with the lab tech at In addition two smoke detectors linked to the system will be 11:40 am on February 22, 2012 confirmed the crawl space 1-1/2 hour rated fire door failed to installed as recommended. close to a positive latch and was not self closing. (NFPA 80, 15.2). The Grawl Space 1-1/2 hr. valed These findings were acknowledged by the fire door will be altered to administrator during the exit conference on restorm as Salf-Claring and February 22, 2012. Will close to a protive A 823 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. Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

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	T OF DEFIGIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU TNPL53526		(X2) MULT A. BUILDI B. WING		(X3) DATÉ SURVEY COMPLETED 02/22/2012
	ROVIDER OR SUPPLIER		1547 WE	DRESS, CITY ST CLINCH LLE, TN 379		
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A 823	Based on observed failed to assure di exhaust per the A The findings inclu Observation and i February 22, 2012 the soiled utility roadjacent to the do provided with an of This finding was a Administrator duri February 22, 2012	net as evidenced by: atton and interview, the rty areas had an oper IA guidelines de: nterview with the lab to p.m. at 11:00 a.m. co porn and two bathroon pwnstairs stairwell were perable exhaust; acknowledged by the ing the exit conference	able ech , on onflittled as e not	A 823	the soiled of	ectrosans los tod the downstairs the armountairs
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Americans United for Life

Division of Health Care Faci STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMF	PLETED
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NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, S			
PLANNED PARENTHOOD OF	TENNESSEE ANI	. TODD BOUL LLE, TN 3720:			
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A 001 1200-8-10 Initial		A 001			
An onsite licensure The facility demons regulations reviewe licensure survey. The	et as evidenced by: survey was completed 6/3/19 strated compliance with the defor health portion of the he facility is in compliance with ambulatory Surgical Treatment	1			
				Ame	erican
Division of Health Care Facilities				IIn	ita
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PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING: 02 - STATE BUILDING

(X3) DATE SURVEY COMPLETED

TNPL63515

B. WING

06/03/2019

NAME OF PROVIDER OR SUPPLIER

BY:

STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD

(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 OATE
≅ A 001	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 Surgicial Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	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.	6/20/19
	* 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.		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.	6/19/19
A 801	1200-8-10-,08 (1) Building Standards	A 801		
	(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.			FV.

Division of Health Care Facilities

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

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CEO

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Division of Health Care Facilities (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: 02 - STATE BUILDING B. WING 06/03/2019 TNPL63516 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF TENNESSEE ANI NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X6) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUIATORY OR LSC (DEN LIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY A 801 Continued From page 1 A 801 The findings included: 6/14/19 Quarterly sprinkler inspection performed. 1. Document review on 06/03/2019 between 2:15 6/24/19 Deficiencies noted: 4 sidewall sprinkler PM = 3:00 PM, revealed the facility failed to " heads will be replaced by COB 6/24/19. provide documentation of a 1st quarter sprinkler inspection for 2018 and 2019. NFPA 101, 6/14/19 2. Document review on 06/03/2019 between 2:15 Annual fire inspection performed and passed. 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 Inspection performed in 2018 but 10/25/18 PM - 3:00 PM, revealed the facility failed to documentation could not be located until after provide documentation of the annual backflow exit conference. Properly filed. preventer inspection for 2018. (The last Inspection date was August 2017.) Fire Stop vendor scheduled and work was 6/19/19 4. Observations on 06/03/2019 at 3:00 PM, completed pn 6/19/19. CCO and HCM to revealed the rated fire/smoke barrier (above the perform quartely inspections, as well as after celling) in the mechanical room had multiple any work is performed in affected areas. 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 elxt conference on 06/03/2019. A 803 A 803 1200-8-10-,08(3) BUILDING STANDARDS No ambulatory surgical treatment center shall horeafter be constructed, nor shall major alterations be made to existing ambulatory surgical treatment centers, or change in an ambulatory surgical treatment center type be

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;

(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - STATE BUILDING

(X3) DATE SURVEY COMPLETED

TNPL63515

B, WING

06/03/2019

NAME OF	PROVIDER OR SUPPLIER STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
PLANNE	D PARENTHOOD OF TENNESSEE AND	TODD BOUL LE, TN 3720		,
(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)	(XS) 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.	A 803	ti (++++++++++++++++++++++++++++++++++++	10, 13 to
	This Rule is not met as evidenced by: Based on observations, the facility falled obtain written approval for alterations.		,	
	The finding included:		i	
	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.		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	6/11/19
	The office manager was present when this deficiency was identified on 06/03/2019. Altempt was made to contact the office manager on 06/06/2019 without success.		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	
A1403	1200-8-1014 (1)(c) Disaster Preparedness	A1403	sincerely apologizes and regrets the error. CCO will request guidance from TN Dept. of Health	-00
	(1) The administration of every facility shall have in effect and available for all supervisory		for any future projects.	S

Division of Health Care Facilities

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United for Life

Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 02 - STATE BUILDING COMPLETED B. WING 06/03/2019 TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF TENNESSEE ANI NASHVILLE, TN 37203 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREPIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY A1403 A1403 Continued From page 3 HCM has documented PPTNM's Flood 6/14/19 Procedure Plan and the required drill was personnel and staff, written copies of the performed. CCO and HCM will ensure all following required disaster plans for the drills are performed and properly documented protection of all persons in the event of fire and in the future. GOODS GOODS & 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 dutles; 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 falled 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. Division of Health Care Friellitles

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FORM APPROVED Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 02 - STATE BUILDING B. WING ... TNPL53515 06/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF TENNESSEE ANI NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XI) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A1404 Continued From page 4 A1404 HCM has documented the Earthquake 6/14/19 A1404 1200-8-10-14 (1)(d) Disaster Preparedness Disaster Procedures Plan and the required drill was performed. CCO and HCM will ensure all (1) The administration of every facility shall have drills are performed and properly documented In effect and available for all supervisory in the future. 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; Evacuation procedures; Safety procedures; Emergency services. This Rule is not met as evidenced by:

Division of Health Care Facilities

Based on document review, the facility falled to

Document review on 06/03/2019 between 2:15 PM - 3:00 PM, revealed the facility falled to provide documentation of the annual earthquake

perform disaster drills.

The finding included:

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TA EMENT OF DEFICIENCIES
NO PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - STATE BUILDING (X3) DATE SURVEY COMPLETED

BY:

TNPL63515

B. WING ...

06/03/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(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 (EAGH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DAYE
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-		
	я			S.S.

Division of Health Care Facilities

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 02 - STATE BUILDING B. WING TNPL53515 07/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF TENNESSEE ANI NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE DATE PREFIX TAG DEFICIENCY) (A 001) 1200-8-10 Initial {A 001} 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.

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

TITLE



Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING TNPL53544 04/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1726 POPLAR AVENUE** MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 002 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.

Division of Health Care Facilities

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

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION 77 - MEMPHIS CENTER FOR TIVE HEALTH	COMF	SURVEY
		TNPL53544	8 WING		04/	10/2019
NAME OF I	PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, S	STATE, ZIP CODE		
	S CENTER FOR REP	PODUCTIVE USA 1720	6 POPLAR AVENU	E		
WEWPH	S CENTER FOR REP	MEN MEN	WPHIS, TN 38104			
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A 002	1200-8-10 No Defic	ciencies	A 002			
	During the annual s was found to be in Safety Code requir Department of Hea Care Facilities, Cha	as evidenced by: survey on 04/10/19, this fa compliance with the Life ements of the Tennessee Ith, Board for Licensing H apter 1200 -8-10, Standard gical Treatment Centers.	ealth			
	callii Care Facilities	DEDIGLIER DEPRESENTATIV	YE'S SIGNATURE	TITLE	Am	erica

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for Life

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** R B. WING 07/11/2019 TNPL53547 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD OF TENNESSEE ANI MEMPHIS, TN 38104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (A 001) {A 001} 1200-8-10 Initial met as evidenced by: This Rule is 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. Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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To Born 6/24/19 19

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

TNPL53547

(X2) MULTIPLE CONSTRUCTION

A BUILDING: 01 - MEMPHIS REGIONAL PLANNED

PARENTHOOD

(X3) DATE SURVEY COMPLETED

> 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

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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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 001}

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 801} 1200-8-10-.08 (1) Building Standards

{A 801}

(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.)

VOUDOR CORRECTED PATCH. CFO WILL MODITOR OD MODRILY IDSPECTION

Division of Health Care Facilities

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

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Division of Health Care Facilities
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AND CAR OF GRINGE STEPN (119

(81) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:

TNPL53547

(X2) MULTIPLE CONSTRUCTION

A, BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD

(X3) DATE SURVEY COMPLETED

B. WING

06/04/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

2430 POPLAR AVE

X4) ID REFIX 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 801}		
	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.			
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				SVS
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Division of Health Care Facilities

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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

A BUILDING 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD

(X3) DATE SURVEY COMPLETED

TNPL53547

STREET ADDRESS, CITY, STATE, ZIP CODE

B WING

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)

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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

NAME OF PROVIDER OR SUPPLIER

PLANNED PARENTHOOD OF TENNESSEE ANI

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 801 1200-8-10-.08 (1) Building Standards

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:

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 001

A 801

Based on observations, the facility failed to maintain the physical plant.

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER RESUPPLIER REPRESENTATIVE'S SIGNATURE

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FORM APPROVED Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING 04/16/2019 TNPL53547 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD OF TENNESSEE ANI MEMPHIS, TN 38104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Continued From page 1 A 801 A 801 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.) Observation on 4/16/19 at 3:25 PM, revealed a receptacle cover missing in Room #6. maintenance 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 818 A 818 1200-8-10-.08 (18) Building Standards

Division of Health Care Facilities

(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,

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Division of Health Care Facilities

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING TNPL53547 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COUE 2430 POPLAR AVE PLANNED PARENTHOOD OF TENNESSEE ANI MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 818 Continued From page 2 A 818 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.

Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNPL53547	B WING		04/22/2019
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DIDERTY (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION 9 CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
An annual health lic on 4/22/19. An entr 4/22/19 at 8:00 AM An exit conference PM with the Clinica A 002: 1200-8-10 No Defice This Rule is an An annual licensure facility on 4/22/19. Standards reviewed Treatment Center F	ciencies et as evidenced by: e survey was conducted at this This facility complies with all d for Ambulatory Surgical	A 002	Dries is you Records you mot youe this state	udb Co Cetwn Gorn Co Americans
Division of Health Care Lacilities LABORATORY DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SM	GNATURE.	NTLE	United
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Mae Copeland

From:

Rebecca Terrell

Sent:

Tuesday, June 26, 2018 2:52 PM

To:

Ann R. Reed; Peter H. Warren; Craig L. Parisher

Cc: Subject: Eddie J. Stewart; Autumn Katz 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**

Memphis Center for Reproductive Health

Buce

1726 Poplar Ave., Memphis, TN 38104 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. United for Life



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

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 <u>draft</u> of the first and second floor plans with a <u>hatched note</u> 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 ac epilable 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 eighter (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 (6D r C)

From: Rebecca Terrell

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!

Buce

Rebecca Terrell Executive Director

CHOACES.

Memphis Center for Reproductive Health

1726 Poplar Ave., Memphis, TN 38104 Direct: 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. Warrer

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 Cray Eddie (and Deniction) =

Just wanted to so of a quick thank you for your brob yestornay according forward to seeming with your and we will be in Touch

July 1



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.



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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From: Peter H. Warren

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?

Lam planning to being our current drawings and will also bring copies of the codes (BC, NFPA, FG, etc) should we need them.

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

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

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.



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From: Rebecca Terrell

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

CHOÀCES. Memphis Center for Reproductive Health

Buce

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existing model obsolete."

R. Buckminster Fuller



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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?



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From: Rebecca Terrell

Sent: Monday, January 29, 2018 3:10 PM

To: Ann R. Reed

Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher; 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

CHOACES.

Memphis Center for Reproductive Health

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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

Sent: Monday, November 20, 2017 1:47 PM

To: Ann R. Reed

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

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 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 wait

Ribine

Rebecca Terrell
Executive Director



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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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From: Rebecca Terrell

Sent: Thursday, October 26, 2017 2:41 PM

To: Ann R. Reed

Cc: Peter H. Warren; Eddie J. Stewart; Craig L. Parisher;

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

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From: Ann R. Reed [mailto:<u>Ann.R.Reed@tn.gov</u>]
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 relicense 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.



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From: Rebecca Terrell

Sent: Monday, October 23, 2017 4:11 PM

To: Ann R. Reed

Cc: Peter H. Warren

Subject: State of TN - Introductory Narrative - Please Review

Importance: High

*** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. ***

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

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Memphis Center for Reproductive Health

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Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING TNPL53547 10/15/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) A 801 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.

Division of Health Gare Facilities

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL53547		1	CONSTRUCTION	GOM	(X3) DATE SURVEY COMPLETED	
		B. WING		10/	15/2018	
AME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE			
LANNED PARENTHOOD GR		OPLAR AVE HIS, TN 38104				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
A 002 1200-8-10 No Defic	ciencies	A 002				
This facility meets pertaining to ASTC	et as evidenced by: all requirements reviewed regulations. No deficiencies sult of this licensure survey.					
1						
		1				
					T	
					CO	
					SIS	
					J	
				—— Am	erica	



PRINTED: 05/02/2018 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL53547	(X2) MULTIPLE A BUILDING: B. WING	MAY 11 708	DATE SURVEY COMPLETED 04/23/2018
IAME OF P	ROVIDER OR SUPPLIER	}	DRESS, CITY, STA	ARYZIIA CODE	VALCOTO
	PARENTHOOD GR	FATER MEMPHIS 2430 POF		NE TO SOUTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
	An annual licensure facility on 4/23/18. standards for Chap	et as evidenced by: e survey was conducted at this This facility complies with all oter 1200-08-10, Standards for al Treatment Center Facilities.	A 002		
				Aı	SS merica
	alth Care Facilities DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	nite
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Division of Health Care Facilities TO Bm 7-33-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD

(X3) DATE SURVEY COMPLETED

07/03/2018

TNPL53547

B WING BY:

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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)

PREFIX TAG

{A 801}

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

PLANNED PARENTHOOD GREATER MEMPHIS

(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

NFPA 101, 9.1.2 (2012 Ed.)

Section 9.1.

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.

TITLE

Division of Health Care Facilities

LABORATORY DIRECTORS OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING TNPL53547 07/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {A 801} Continued From page 1 {A 801} 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 ALL DEFICIENCIES WILL electrical, mechanical, plumbing, and BE ADDED TO PPEMR'S MONTHLY FACILITY'S MAINTENANCE CHECKUST, MONITORED BY ACCOUNTING 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: REPLACE DAMAGED RECEPTACLE COVER 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

Division of Health Care Facilities

area of oxygen cylinders).

STATE FORM



Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD 07/03/2018 TNPL53547 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {A 801} Continued From page 2 {A 801} 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.) Observation during the follow-up survey on REMOVED AND PLACED 7/5/18 IN SPECIFIED STORAGE. 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 3a,b,c-APPROPRIATE 8/19/19 7/3/18 at 1:35 PM, revealed the following penetrations in the 1 hour fire rated drywall were CONTRACTOR HAS BEEN not repaired per an approved ul system: a. bundle of cables outside the entry door on the CHEDVED WEEKOF south wall of room 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 and NFPA 101, 8.3.5.1*(2012 Ed.) An office employee was present when the deficiences were identified on 7/2/18.

Division of Health Care Facilities STATE FORM

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(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD R B. WING TNPL53547 09/11/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) A 001 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. Division of Health Care Facilities

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

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MUL A BUILDIN

(X3) DATE SURVEY COMPLETED

TNPL53547

B. WING

04/24/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CHE STATE, ZIP CODE

PARENTEDO

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)

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

Division of Health Care Facilities

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

TITLE

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING TNPL53547 04/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 801 | Continued From page 1 A 801 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 secured storage carts (3) unsecured oxygen cylinders in the surgery WILL BE ORDERED AND HEALTH suite. CENTER MANAGER WILL MANATAW ADHERENCE. NFPA 55, 7.1.8.4 (2010 Ed.) 2. Observation on 4/24/18 at 10:28 AM, revealed PROPER SIGNAGE HAS BEEN required signage missing for oxygen tanks being stored and used in the surgery suite and room NFPA 55, 6.11.1 (2010 Ed.) A801 3. Observation on 4/24/18 at 10:42 AM, revealed

Division of Health Care Facilities

blue painters tape over the smoke detector in the

biohazard room on the 1st floor.

NFPA 72, 14.2.1.2.2 (2010 Ed.)

STATE FORM

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MODITOR MONTH!



PRINTED: 04/27/2018 FORM APPROVED Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING TNPL53547 04/24/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 801 Continued From page 2 A 801 NEPA 10.7.2.4.4 APPROVES USE OF AN INSPECTION CHEC LIST MAINTAINED ON FILE 4. Observation on 4/24/18 at 10:20 AM, revealed WHICH WAS PRESENTED TO the fire extinguishers thru out the building were TN DON INSPENTORS. CFC not being signed on service tags for monthly inspections. WOULD REQUEST CLAR NFPA 10, 7.2.4.4 (2010 Ed.) CATION ON N FPA, 10. H CENTER MANAGERIACCE 5. Observations on 4/24/18 between 10:36 AM ASSISTANT WILL SIGH and 10:54 AM, revealed the following TARS WHEN INSPECTED MODIFICY penetrations in the 1 hour fire rated walls listed below. a. boiler room on 1st floor SE, b, c, d WILL BE FIRE CAUKED TO SEAL ALL PENETRATIONS. CFO AND 6/30/18 (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 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 2nd floor (1) bundle of cables outside of entry door on south wall d. room 2nd floor (2) white cables inside entry door on the right side NFPA 101, 8.3.5.1*(2012 Ed.)

Division of Health Care Facilities

a. mechanical room

Observation on 4/24/18 at 10:54 AM, revealed foam filled penetrations in the following locations:

(1) wall damper on the northwest wall

on 2nd floor

STATE FORM

6899

DQ4R21

SEE NEXT PAGE



Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MUL1 (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING OF - MEMPHIS REGIONAL PLANNED B. WING 04/24/2018 TNPL53547 STREET ADDRESS, CITE YSTATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) PENETRATIONS WILLBE REPLACED WITH FIRE, A 801 A 801 Continued From page 3 (1) air duct on outside wall (2) ceiling penetrations outside room (2) 3 inch PVC pipes outside room (2) 1 1/2 inch metal sleeves outside room CAULK SEALANT. 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.

Division of Health Care Facilities

STATE FORM

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If continuation short 4 of 4 for Life

Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION RECEIVED
A. BUILDING: 02 - STATE BUILDING STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED APR 07 2017 TNPL63515 03/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) A 801 1200-8-10-.08 (1) Building Standards A 801 The deficiency will be corrected by 3/27/17 fire blocking the three 1.5 inch (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and PVC sleeves in the second floor the overall ASTC environment in such a manner mechanical room used to run that the safety and well-being of the patients are data lines. The deficiency will be assured. corrected on March 27, 2017. This will be added to the quarterly This Rule is not met as evidenced by: facilities audit to ensure deficient Based on observation, the facility failed to practice does not recur. This maintain the physical plant. corrective action will be monitored through the risk and quality Observation on 03/21/2017 at 9:36 AM, revealed three 1.5 inch PVC sleeves in the second floor management program which is mechanical room used to run data lines, was not overseen by the Risk and Quality properly sealed between the first and second Managment Coordinator. 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. Division of Health Care Facilities

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

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	ATEMENT OF DEFICIENCIES DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		SURVEY PLETED	
		TNPL53515	B. WING	3. WING		03/20/2017	
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
PLANNE	D PARENTHOOD OF	- MILITI III ANILI II A'	TODD BOULI LE, TN 37203				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
A 002	1200-8-10 No Def	iciencies	A 002				
	A licensure survey facility was found t regulations for Am	net as evidenced by: was completed 3/20/17. The to be in compliance with state bulatory Surgical Centers. No cited during the licensure					
						55	
dos et la	alth Care Facilities	1111			Am	erica	

STATE FORM

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

TITLE



ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	TNPL53544	B WING		09/06/2017	
ME OF PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, S	STATE, ZIP CODE		
EMPHIS CENTER FOR REP	RODUCTIVE HEA	POPLAR AVENU PHIS, TN 38104	E		
RÉFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE	
A 420 1200-8-10-04 (16)	Administration	A 420	The Medical Services Comm	itlee of the 09/19/201	
(16) The governing	body shall provide for the		Memphis Center for Reprod	uctive Health (MCRH)	
(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.		ealth	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.		
Based on facility po minutes and intervi board failed to prov health care profess Doctor (MD) #1, Ce Anesthetist (CRNA	et as evidenced by: licy review, facility board ew, the facility's governing ide for reappointment of ionals for 3 of 5 (Medical artified Registered Nurse) #1 and Family Nurse #1) health care professional		The Board will review MSC recommendations for all current clinicians and vote on credentialing approupcoming meeting on Sept.	val át the 26, 2017	
The findings includ	ed:		Rosely 25	ed ude	
Clinicians" revealed specific policy and credential a clinicial Midwifej, FNP) to poservices at (Name of Director will review above and will make Medical Services of privileges 8. The will review the mate Director's recomme approve or deny priperson vote at a registre.	cility policy, "Credentialing I, "This document defines procedure to be followed to I (MD, CNM [Certified Nurrovide medical care or of facility]7 The Medical the information described e a recommendation to the mmittee to grant or deny Medical Services committee to will you to vileges via email vote or vileges via email vote or vileges via email vote or vileges via email rivote or vileges via email vote the orse al e ee ia in . 9.	9-19-17			
Committee policy a	y policy, "Medical Service: nd Procedure" revealed, efines the specific policy t	I		Silve	

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STATEME	n of Health Care Fac NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIII TIOU	CONCTOURTION	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
			W SOUTHING:		OOM ELIED
		TNPL53544	B. WING		09/06/2017
IAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE ZIP CODE	03/00/2017
AIC AAD LI	IC CENTER FOR BEE	4500.00	PLAR AVENU		
NICIAIL LI	IS CENTER FOR REP		IIS, TN 38104	_	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH_CORRECTIVE ACTION SHOULD	BE COMPLETE
******	11232 11311, GIVE	SO IDENTIFY HAG HAP ORIGINATION	TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	RIATE DATE
A 420	Continued From pa	nge 1	A 420	527761217017	
		_	A420		
	followed in governing	ng the responsibilities and	1		
	operations of the M	ledical Services committee	1 1		
	: William will be referre	ed to as either "committee" or	4 1		
	i NiSC throughout the	e remaining portion of the	1 /		
	Committee is above	Statement: Medical Service	S		
	committee is charg	ed with oversight, monitoring,	. 1		
	operations policies	of all Medical services,	1 8		
	the specified estace	, and procedures as well as	1 1		
	accordance with the	ories listed below in	1		
	Code Appotated) co	cited T.C.A. [Tennessee	1		
:	making review of p	gulation. Operation, decision			
;	as recommendation	olicy and procedures as well as by the [name of facility]			
	Medical Services C	ommittee will be made in			
	accordance to the o	juidelines and policies outlined			
	within this policy	2) Specified Categories under			
	Responsibility of Me	edical Services Committee as	1 i		
	required by T.C.A. for	or ASCT (Ambulatory Surgery			
	Treatment Centers]	A Appointment	1		
	Reappointment and	Dismissal of clinicians	1		
	providing clinical ser	vices The Medical	W		
	Director has full fina	authority to approved or	4		
	disapproved decisio	ns and recommendations of			
	the Medical Services	s Committee prior to	i .		
	submission to the E	xecutive Director in			
	accordance with T.C	CA 1200-08-1004(9)"			
			1		
	∠. Review of the Go	overning Board minutes for			
	201/ revealed there	was no documentation the	1 1		
	Roard had reviewed	or approved credentials for	Ti I		
	the health care profe	essionals	1 1	*	
	3. Review of MD #1	's credential: file revealed	j 1		
	there was no docum	entation the governing body	1		
14	had granted appoint	ment or reappointment	4		
- 1	privileges.	or reappointment			
	W 100 100 100 100 100 100 100 100 100 10				r(1)
•	4. Review of CRNA	#1's credential file revealed	1 6		23
1	there was no docum	entation the governing body			
1	had granted appoints	ment or reannointment			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			IN BUILDING.		
		TNPL53544	B. WING		09/06/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, ST	TATE, ZIP CODE	
MEMPHI	S CENTER FOR REP	1726 POE	LAR AVENUE		
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A 420	Continued From pa	ige 2	A 420		
	privileges.		! !		
	5 Review of FNP:	#1's credential file revealed	1		
	there was no docur	nentation the governing body	. 1		
	had granted appoir privileges.	tment or reappointment			
	6. During an interv	iew in the conference area on	1		
	9/6/17 at 10:45 AM	, the Executive Director	1		
	Governing Body for	no documentation by the rappointment or			
	reappointment of h	ealth care professionals.	1		
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United for Life

Effective Date:	Supersedes:	Prepared by:
September 19, 2017	August 27, 2015	Rebecca Terrell, Executive Director
Revision No:	L	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.

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- 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
- 13. If approved, documentation of applicant's privileges at CHOICES will be included in the applicant's credentialing

DOCUMENTS REQUIRED FOR CHECK OFF ١.

- a. Valid Tennessee Medical License
- **b.** Board Certification, if relevant to proposed services
- 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

11. **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





CREDENTIALING REQUIREMENTS FORM

PROVIDER:			

DOCUMENT OR OBSERVATION	DATE RECEIVED OR OBSERVED	PM INITIALS
Valid Tennessee Medical License		
Board Certification, if relevant to proposed services		1
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
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Provision of direct medical care:		
General gynecological examination including PAP smears, STD testing: Two exams		
2	+	
Transgender hormone management: Five patient visits 1		
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Colposcopies: 10 procedures		Con
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Pregnancy Terminations – Medication: Five patient education sessions	DATE OBSERVED	MD INITIALS
	DATE ODJEKVED	WID HATTIALS
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regnancy Terminations – Surgical:		
Regular (<12 weeks): 10 procedures		
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Advanced (12 – 15 weeks): 10 procedures		
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President, Board of Directors	Date		
Medical Director	Date	The state of the s	
Oirectors to provide medical services at CHOICES Memph	nis Center for Reproductive Health.		
I certify that	has met all requirements and has bee	n approved by the Board of	
Other services:			
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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING:	CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		TNPL53544	B. WING		03/2	21/2017
NAME OF	PROVIDER OR SUPPLIER	J. T. E. T. T.	DDRESS, CITY, S			
MEMPHI	S CENTER FOR REP	KODUCTIVE HEA	PLAR AVENUE IS, TN 38104			
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A 002	This facility complice participation review Treatment Centers	et as evidenced by: es with all requirements for ved for Ambulatory Surgery during the Licensure survey /17. No deficiencies were	A 002			

Division of Health Care Facilities

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

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Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 77 - MEMPHIS CENTER TO 2 REPRODUCTIVE HEALTH TNPL53544 03/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1726 POPLAR AVENUE** MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE TAG DEFICIENCY) A 801 A 801 1200-8-10-.08 (1) Building Standards 3/24/2017 1a. After the inspection on 3/23/2017. (1) An ASTC shall construct, arrange, and Clinic Coordinator, disabled extension cord maintain the condition of the physical plant and from ultrasound exam room and replaced the overall ASTC environment in such a manner with a surge protector on 3/24/2017. that the safety and well-being of the patients are assured. Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future. This Rule is not met as evidenced by: (NFPA) 70,210.23 (2011 Ed) National Fire Protection Association (NFPA) 70, 210.23 (2011 Ed.) Permissible Loads. In no case shall the load b. After the inspection on 3/23/2017. Clinic 3/24/2017 exceed, the branch-circuit ampere rating. An Coordinator, disabled extension cord from individual branch, circuit shall be permitted to waiting room B, and replaced with surge supply any load for which it is protector on 3/24/2017. rated. A branch circuit supplying two or more outlets or receptacles shall supply only the loads Clinic Coordinator will create a monthly specified according to its size as specified in checklist to monitor the area to prevent 210.23(A) through (D) and as any unusual recurring in the future. summarized in 210.24 and Table 210.24. (NFPA) 70,210.23 (2011 Ed) 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 c. After the inpection on 3/23/2017. Clinic 3/24/2017 being knocked over by corralling them and Coordinator, disabled extension cord from securing them to a recovery room, and replaced medical cart, framework, or fixed object by use of a equipment with current wall outlet on restraint, unless 3/24/2017. otherwise permitted by 7.1.8.4.1 and 7.1.8.4.2. Clinic Coordinator will create a monthly Based on observations, the facility failed to checklist to monitor the area to prevent maintain the physical plant. any unusual recurring in the future. The findings included: (NFPA) 70,210.23 (2011 Ed.)

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extension cords in the following areas:

1. Observation on 3/21/17 at 8:30 AM, revealed



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STATEME	of Health Care Fac IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A BUILDING	LE CONSTRUCTION 5: 77 - MEMPHIS CENTER FOR CTIVE HEALTH	-	LETED
	PROVIDER OR SUPPLIER	PRODUCTIVE HEA 1726 PO			03/2	1/2017
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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.)		A 801	d. After the inspection on 3/23/2017. Clinic Coordinator, disabled extension corfrom 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.)		3/31/201
	deficiencies were is	er was present when the dentified and acknowledged ring the exit conference on		After the inspection on 3/23/2 Coordinator ordered a oxygen of secure the oxygen cylinder in the by room #2. Clinic Coordinator will create a checklist to monitor the oxygen prevent any unusual recurring it (NFPA) 22,7.1.8.4 (2010 Ed.)	cart to ne hallway monthly cylinder to	3/27/2017
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING TNPL53547 09/06/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE **PLANNED PARENTHOOD GREATER MEMPHIS** MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 002 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.

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

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		TNPL53547	B. WING		09/	05/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
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A 001	1200-8-10 Initial		A 001	i C			
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	This facility complie	et as evidenced by: es with all requirements for					
	participation review	ed for Ambulatory Surgery during the Licensure survey					
	completed on 9/5/1	7. No deficiencies were cited.					
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Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING. B. WING TNPL53515 10/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 002 1200-8-10 No Deficiencies A 002 met as evidenced by: This Rule is 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. Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - STATE BUILDING

(X3) DATE SURVEY COMPLETED

TNPL53515

B. WING

10/18/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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PLANNED PARENTHOOD OF MIDDLE AND EA:

412 D. B. TODD BOULEVARD NASHVILLE, TN 37203

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(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

10/30/16

10/30/16

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 and overall environment.

The findings included:

- 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)
- 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.

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

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

Division of Health Core Facilities

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FORM APPROVED Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 02 - STATE BUILDING TNPL53515 B. WING 10/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) (continued from page 1) be assessed as part of A 818 Continued From page 1 A 818 the quarterly facilities audit to ensure the A 818 A 818, 1200-8-10-.08 (18) Building Standards deficient practice does not recur. This corrective action will be monitored through the risk and : (18) It shall be demonstrated through the quality management program which is overseen. submission of plans and specifications that in by the Risk and Quality Management each ASTC a negative air pressure shall be Coordinator. maintained in the soiled utility area, tollet room, 11/3/16 A818: This deficiency will be corrected by fixing janitor 's closet, dishwashing and other such the exhaust fans in the 2nd floor staff only solled spaces, and a positive air pressure shall rest room. This deficiency will be corrected on be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility November 3, 2016. This will be assessed as rooms. 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 This Rule is not met as evidenced by: overseen by the Risk and Quality Management Based on observations, the facility failed to Coordinator. maintain negative air pressure where required. 11/11/16 A1401: The deficiency will be corrected by conducting fire drills quarterly and maintaining a The findings included: detailed log of who attended drills and specifics Observation on 10/18/2016 at 9:35 AM, revealed of what was performed during each drill. Drills there was no negative air pressure in the 2nd will include minor fires, major fires, fighting the floor staff only restroom. fire, evacuation procedures, and staff functions. The deficiency will be corrected on November Maintenance staff was present when the 11, 2016. A HR Audit will be completed monthly deficiencies were identified, and acknowledged to ensure appropriate drills have been completed by the administrator during the exit conference on on time and contain adequate detail. This 10/18/2016. corrective action will be monitored through the risk and quality management program which is A1401 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





MAGD

Coordinator.

overseen by the Risk and Quality Management



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: 02 - STATE BUILDING

(X3) DATE SURVEY COMPLETED

TNPL53515

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

A1401

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X6) 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.

to CH 1/15/16 02

Division of Health Care Facilities

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Division of Health Care Facilities (X2) MULTIPLE CONSTRUCTION ECEIVED (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: B WING 05/02/2016 TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 420 1200-8-10-.04 (16) Administration A 420 5/17/16 The deficiency will be corrected by creating a process that requires that the board vote for (16) The governing body shall provide for the the appointment, reappointment, or dismissal appointment, reappointment or dismissal of of all members of the medical staff and grant members of the medical, dental, and other health clinical privileges. The current form used to professions and provide for the granting of clinical grant clinical privileges for all members of the privileges. 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 This Rule is not met as evidenced by: sign on behalf of the board after a board vote Based on review of credentials files, the facility failed to produce proof the governing body had takes place. The deficiency will be corrected provided for the reappointment of a member of on May 17, 2016. The manager of human the medical staff and provided for the granting of resources will ensure credentialing of providers clinical priveleges for 1 of 3 (Physician #3) is up to date including required board approval physicians practicing at the facility. by maintaining the HR spreadsheet that tracks provider credentialing and completing monthly The findings included: HR audits to ensure the deficient practice does not recur. This corrective action will be 1. Review of the credentials file for Physician #3 monitored through the risk and quality revealed the privileges were expired. There was management program which is overseen by no documentation the governing body had the Director of Patient Services. 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. nvision of bleath Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Division of Health Care Facilities A BUILDING 02 - STATE BUILDING (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION MAY 1.2 2016 05/02/2016 B. WING TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA! NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) The deficiency will be corrected by replacing 5/11/16 A 801 A 801 | 1200-8-10-.08 (1) Building Standards the water damaged ceiling tile in the consultation room by the fire door on the 2nd (1) An ASTC shall construct, arrange, and floor. The deficiency will be corrected on May maintain the condition of the physical plant and the overall ASTC environment in such a manner 11, 2016. A quarterly facilities audit will be that the safety and well-being of the patients are conducted by the facilities manager which will assured. 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 This Rule is not met as evidenced by: program which is overseen by the Director of Based on observation, the facility failed to Patient Services. maintain the overall environment. accepted to 1212 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. The deficiency will be corrected by fixing the 5/11/16 A 818 1200-8-10-.08 (18) Building Standards A 818 exhaust fans in the staff rest room near the (18) It shall be demonstrated through the surgical suite and the janitorial closet in the nurse's station to maintain negative air pressure. submission of plans and specifications that in each ASTC a negative air pressure shall be The deficiency will be corrected on May 11, maintained in the solled utility area, toilet room, 2016. A quarterly facilities audit will be janitor 's closet, dishwashing and other such conducted by the facilities manager which will soiled spaces, and a positive air pressure shall include examination of exhaust fans to ensure be maintained in all clean areas including, but not they are properly working and that negative limited to, clean linen rooms and clean utility air pressure is maintained to ensure the deficient rooms. practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by This Rule is not met as evidenced by: the Director of Patient Services. Based on observations and testing, the facility failed to maintain negative air pressure in toilet room. Division of Health Care Facilities

Division of Health Care Facilities
LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

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Division of Health Care Facilities (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: 02 - STATE BUILDING B WING 05/02/2016 TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 818 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 ianitorial closet in the nurse's station. This finding was verified and acknowledged by the CEO during the exit conference on 5/3/16. A 901 1. The deficiency will be corrected by removing 5/11/16 A 901 1200-8-10-.09 (1) Life Safety space heater in the exam room by the rear exit. Any ambulatory surgical treatment center The deficiency will be corrected on May 11, which complies with the required applicable building and fire safety regulations at the time the 2016. A quarterly facilities audit will be board adopts new codes or regulations will, so conducted by the facilities manager which will long as such compliance is maintained (either with or without waivers of specific provisions), be include verifying the absence of space heaters considered to be in compliance with the throughout the building to ensure the deficient requirements of the new codes or regulations. practice does not recur. This corrective action will be monitored through the risk and quality This Rule is not met as evidenced by: management program which is overseen by Based on observations and document review, the facility failed to comply with the required the Director of Patient Services. applicable building and fire safety regulations. 6/1/16 2. The deficiency will be corrected by having These findings included: Simplex Grinnell conduct a smoke detector sensitivity inspection annually. This inspection 1. Observation on 5/2/16 at 9:02 AM, revealed a is scheduled for June 1, 2016 and the space heater in the exam room by the rear exita deficiency will be corrected on this date. This NFPA 101, 21.7.8 (2012 Edition) Inspection will be added to the facility's contract with Simplex Grinnell to be completed 2. Document review on 5/2/16 at 9:50 AM, on an annual basis to ensure the deficient revealed the facility failed to provide practice does not recur. This corrective actlor documentation for the required sensitivity testing will be monitored through the risk and quality of the smoke detectors. NFPA 72, 14.4.5.3.2 management program which is overseen by (2010 Edition) the Director of Patient Services Division of Health Care Facilities

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DIVISION OF Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

TNPL53515

NAME OF PROVIDER OR SUPPLIER

TNPL53515

STREET ADDRESS, CITY, STATE, ZIP CODE

412 D. B. TODD BOULEVARD

NASHVILLE, TN 37203

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST' BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)

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(X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)

(X5) COMPLETE DATE

COMPLETE DATE

X4) ID REFIX 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	A 901	The deficiency will be corrected by replacing the damaged switch cover for the light switch	5/11/16
	3. Observation on 5/2/16 at 9:30 AM, revealed the		near the surgery suite door entering the waiting	
	switch cover for the light switch near the surgery		room. The deficiency will be corrected on May	
	suite door entering the waiting room was damaged. NFPA 70, 314.28 (2011 Edition)		11, 2016. A quarterly facilities audit will be	
			conducted by the facilities manager which will	
	4. Observation on 5/2/16 at 9:39 AM, revealed a sprinkler escutcheon plate missing in the		include examination of light switch covers for	
	secondary waiting room's restroom. NFPA 13,		damage to ensure the deficient practice does	
	6.2.7 (2010 Edition)		not recur. This corrective action will be	
These findings were verified and acknowledged	ed	monitored through the risk and quality		
	by the CEO during the exit conference on 5/2/16.		management program which is overseen by	
			the Director of Patient Services.	
			4. The deficiency will be corrected by adding	5/11/
			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	i
			damaged escutcheon plates to ensure the	
		1	deficient practice does not recur. This corrective	e
			action will be monitored through the risk and	
			quality management program which is oversee	iu
			by the Director of Patient Services.	

Division of Health Care Facilities

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RECEIVED DATE SURVEY Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 77 - MEMPHIS CENTER F REPRODUCTIVE HEALTH B. WING 09/27/2016 TNPL53544 STREET ADDRESS, CITY, STATE, ZIP COUG. NAME OF PROVIDER OR SUPPLIER 1726 POPLAR AVENUE **MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) A 901 1200-8-10-.09 (1) Life Safety A 901 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 After the inspection on 9/27/2016. 10/18/2016 walls, and fire resistance-rated horizontal Nancy Shotwell, Clinic Coordinator assemblies. The provisions of 8.3.5 shall not contacted Hiltl Firestop Systems on apply to approved existing materials and methods 10/3/2016 re: unapproved fire stop of construction used to protect existing around 6 conduits. On 10/6/2016 through-penetrations and existing membrane Hilti Firestop Systems was on-site penetrations in fire walls, fire barrier walls, or fire to evaluate the 6 conduits. System resistance-rated horizontal assemblies, unless No. F-C-2071 will be used to repair. otherwise required by Chapters 11 through 43. Based on the observations, the facility failed to Nancy Shotwell, Clinic Coordinator will comply with the required life safety and building create a monthly checklist to monitor the code regulations. 6 condults in the phone/electrical room to prevent any unusual recurring in the The findings included: future. Observation on 09/27/16 at 1:20 PM, revealed the (NFPA) 101,8.3.5 (2012 Ed) following penetrations in the celling of the electrical/phone room above panel LB: b. After the inspection on 9/27/2016. a, unapproved fire stop around 6 conduits. Nancy Shotwell, Clinic Coordinator 9/30/2016 contacted Rhodes Electric on 9/28/2016 b. 1 unsealed metallic flex condult. re: 1 unsealed metallic flex conduits. On 9/30/2016 Rhodes Electric was on-site c. unapproved fire stop around 2 - 1/2" cables. to repair and seal metallic flex conduit. National Fire Protection Association (NFPA) 101, Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE, SIGNATURE

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Division of Health Care Facilities

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH 09/27/2016 TNPL53544 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1726 POPLAR AVENUE** MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (con't b.) Nancy Shotwell, Clinic Coordinator 9/30/2016 A 901 A 901 Continued From page 1 will create a monthly checklist to monitor the phone/electrical room for any unusual 8.3.5 (2012 Ed.) findings to prevent recurring in the future. This finding was verified on 09/27/16 by a staff (NFPA) 101,8.3.5 (2012 Ed) member from the facility. c. After the inspection on 9/27/2016. 10/18/2016 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) RECEIVED OCT 1 8 2016

Division of Health Care Facilities

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Division of Health Care Facilities

STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		TNPL53544	B. WING		09/26/2016	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MEMPHIS	CENTER FOR REPROD	DUCTIVE HEALTH	PLAR AVENUE IS, TN 38104			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMP HE APPROPRIATE DATE	LETE
A 002	1200-8-10 No Deficie	encies	A 002			
	This Rule is not met	as evidenced by:				
	participation reviewe Treatment centers du	with all requirements for d for Ambulatory Surgery uring the Licensure survey 6. No deficiencies were cited.				
					Sign	3
ivision of Hea	olth Care Facilities				Ameri	'

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

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH 03/28/2016 TNPL53544 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1726 POPLAR AVENUE

MEMPHIS CENTER FOR REPRODUCTIVE HEA

MEMPHIS, TN 38104

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

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

A 002

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.

Division of Health Care Facilities

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

TITLE

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Division of Health Care Facilities (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING TNPL53544 03/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1726 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA** MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) A 002, 1200-8-10 No Deficiencies A 002 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. Division of Health Care Facilities

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

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING TNPL53547 RFAFIREZN2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE OCT 27 2016 PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S FLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 1200-8-10-.09 (1) Life Safety A 901 PEFIEDUES 1)& BOTH CORRECTED AT Any ambulatory surgical treatment center which complies with the required applicable TIME OF THE SITE VISI building and fire safety regulations at the time the board adopts new codes or regulations will, so APPROPRIATE STORAGE long as such compliance is maintained (either FOR#2 WAS IDEDTIFIED with or without waivers of specific provisions), be considered to be in compliance with the AND COMMUNICATED TO requirements of the new codes or regulations. STAFF. APPROPRIATE DISPLAY FOR# | WAS This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 10. IDEDTIFIED AND COMMUNICATION 6.1.3.3.1 (2010 Ed.) Fire extinguishers shall not be obstructed or obscured ICATED TO STAFF. from view. BOTH CFO AND UP OF NFPA 101, 21.2.1 (2010 Ed.) Every aisle. passageway, corridor, exit discharge, exit location, and access shall be in accordance with PATIENT SERVICES WILL Chapter 7, unless otherwise modified by 21.2.2 through 21,2,11. MODITOR ON A DAILY NFPA 101, 7.5.1.1 (2010 Ed.) Exits shall be located, and exit access shall be arranged, so BASIS TO ENSURF that exits are readily accessible at all times. THE DEFICIENCY DOES Based on the observations, the facility failed to NOT RECUR. 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

Division of Health Care Facilities

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

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** TNPL53547 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 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) A 901 Continued From page 1 A 901 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. Division of Health Care Facilities

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Division of Health Care Facilities

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	SURVEY LETED
		TNPL53547	B. WING		09	27/2016
	OVIDER OR SUPPLIER	FR MEMPHIS REGIC 2430 POR	DDRESS, CITY, STATE PLAR AVE 5, TN 38104	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
A 002	1200-8-10 No Deficie	ncies	A 002			
	This Rule is not met	as evidenced by:				
	participation reviewed Treatment Centers du	with all requirements for I for Ambulatory Surgery Iring the Licensure survey S. No deficiencies were cited.				
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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B.-WING _ TNPL53547 03/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION iD (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) A 901 1200-8-10-.09 (1) Life Safety A 901 Any ambulatory surgical treatment center (1) 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 administrator during the tour on 3/28/16.

Division of Health Care Faulties
LABORATORY DIRECTOR'S OR PROVIDER/SUBFLIER REPRESENTATIVE'S SIGNATURE

TITLE

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Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ B. WING 03/24/2016 TNPL53547 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 002 A 002 1200-8-10 No Deficiencies met as evidenced by: This Rule is This facility complies with all state licensure requirements reviewed during this licensure survey. No deficiencies were cited.

Division of Health Care Facilities

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

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Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 10/05/2015 TNPL53547 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 002 A 002 1200-8-10 No Deficiencies met as evidenced by: This Rule is This facility complies with all State licensure requirements reviewed during the annual licensure survey. Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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	of Health Care Fac	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI	E CONSTRUCTION	(X3) DATE	SUBVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING; 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD		COMPLETED	
		TNPL53547	B WING			6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	***********	
PLANNE	D PARENTHOOD GR	EATER MEMPHIS	LAR AVE			
		MEMPHIS	S, TN 38104	The second secon		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETE DATE
{A 801j	1200-8-1008 (1) E	Building Standards	{A 801}			
	maintain the condit the overall ASTC e	construct, arrange, and ition of the physical plant and nvironment in such a manner well-being of the patients are	e X			
	Based on observati maintain the condit	et as evidenced by: ion, the facility falled to lon of the surgery center in a fety and well-being of the red.	59	The wall was constructed is accordance u	a	1/27
	The findings include	ed:		Tennessee		16
	follow up survey on equipment room ha	surgery center during the 1/26/16 revealed the elevator ad multiple penetrations in fire I with an unapproved fire stop atches)		Department of Health appro plans.	red	
	National Fire Protect 39.3.2 (2000 edition	ction Association (NFPA) 101, n).		,		
		e verified and acknowledged er representative during the rence on 1/26/16.				-CC
			i i			Sy
1000000	-00 K-2 F2 000				_An	eric
ORATOR	alth Care Facilities	DER/SUPPLIER-REPRESENTATIVE'S SIG	NATURE	TITLE		(XB) DATE

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PRINTED: 10/21/2015 FORM APPROVED

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION OF 0 2 2015 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: 10/07/2015 B. WING TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION (X8) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG A 901 11/9/15 A 901, 1200-8-10-,09 (1) Life Safety The deficiency will be corrected by having the area in question enclosed. When building modifications are performed the Any ambulatory surgical treatment center contractor will ensure the changes are in compliance which complies with the required applicable with Fire Safety-regulations. building and fire safety regulations at the time the 3. A service call has been placed with Life Safety board adopts new codes or regulations will, so and Fire Safety vendor scheduled for 10/30/15. The facility has quarterly and annual fire long as such compliance is maintained (either inspections that can ensure this deficiency does 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) 1. The deficiency will be corrected by having Life Safety and Fire Safety vendor Simplex Grinnell to come 2. Observation on 10/7/15 at 11:34 AM, revealed replace and or tighten escutcheon plates in each 10/23/15 escutcheon plates around the sprinkler loose in of the areas in question. 2. The facility has quarterly and annual fire the following areas: inspections and escutcheon plates are checked. a. 2nd floor stairwell (1 of 2) 3. The deficiency was corrected on October, 23,2015. b. 2nd floor hallway by waiting room 4. See above answer #2 c. 2nd floor waiting room 2 bathroom . d. recovery room staff only closet e. 1st floor storage room across from biohazard 1. The deficiency will be corrected by having room paint removed from fire rating tags. 11/9/15 NFPA 13, 6.2.7.1 (2010 Edition) 2. The facility will notify any future contractors that fire rating tags should not be painted. 3. Observation on 10/7/15 at 11:34 AM, revealed 3. This deficiency will be corrected by the fire rating tags were painted over on the November 9, 2015. The facility will be sure that future contractor; following door frames: are aware that fire tags are not to be painted a. 2nd floor stairwell by elevator b. 2nd floor laundry room. NFPA 80, 4.2.2 (2010 Edition) Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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END21

Division	of Health Care Fac	lities			(X3) DATE SURVEY
STATEMEN	T OF DEFICIENCIES	(X1): PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:	02 - STATE BUILDING	
	2	TNPL53515	B. WING		10/07/2015
		L	DECC CITY S	STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		TODD BOUL		1
PLANNE	D PARENTHOOD OF	MIDDLE AND EA: NASHVILI	LE, TN 3720	3	ON (X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
A 901	Continued From pa	age 1	A 901	1	
7.001	4. Observation on the following smok door frame: 2nd florecovery room battedition) 5. Observation on the fire doors woul frame in the following elevator and 1st from biohazard room Edition) These findings well	7/10/15 at 11:41 AM, revealed e doors did not latch within the for near consultation office and arcom. NFPA 80, 6.1.4.2 (2010) 7/10/15 at 11:59 AM, revealed d not latch within the door ing locations: 1st floor stairwell the floor storage room across om. NFPA 80, 7.1.4 (2010) The verified and acknowledged rator during exit conference on		1. The deficiency will be corrected is service vendor West End Lock to a doors. 2. Quarterly and annual fire inspect performed and any deficiencies shout at inspections. 3. A service call is scheduled for 11 with West End Lock. 4. See above action #2	ions are : buld be noted
A1400	1200-8-1014 Disa	aster Preparedness	A1400	Ģ.	
	Based on document conduct disaster d The finding included During document revealed the facility disaster drills during a tornado b. bomb c. earthquake This finding was well as the conduction of the conduction	ed: review on 7/10/15 at 12:31 PM, y failed to conduct the following		1. This deficiency will be correct documented copies of the facility disaster drills that have been a comment of Patient Services will ensure is filed at the facility in addition that is currently kept on file at toffice. 3. Fire safety log will be create the drills performed in 2014 as drills. 4. This corrective action will be by Center Manager and Direct Services each will make sure the facility reflects the records administrative office.	ty conducted. 11/6/15 with Director the documentation to the original he administrative d to include well as current emonitored or of Patient hat the log ke pt a
Division of I	Health Care Facilities		****	LEND21 RECEIVED	If continuation sheet 2 of 2
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NOV 02 2015 for Life

STATEMENT OF DEFICIENCES		1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ñ	TNPL53515	B, WING		10/07/	2015	
AME OF PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, ST TODD BOULE LE, TN 37203	EVARD			
X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(SHOULD BE	(X5) COMPLETE DATE	
shall ensure a fram related to care at the This Rule is not mediated on interview framework for additional at the end of life. The findings included the same and y surgical treatment center lework for addressing issues the end of life. The et as evidenced by: If the facility failed to ensure a ressing issues related to care ed: The et as evidenced by: If the facility failed to ensure a ressing issues related to care ed: The et as evidence on 10/7/15 at the et as a policy related to care at the end of Patient Services stated, "We	A 407	The deficient practice will be considered a written policy to PPMET Star Procedures relating to End of I.2. When PPMET annual review Operating Procedures is performent of Life policy and procedured and updated as needed. 3. The policy and procedure recare will be added to PPMET Stand Procedures by Oct. 30,2015 4. This practice will be monitor of facilities Standard Operating	indard Operating Life Care. w of Standard rmed a review of the ures will be reviewed egarding End of Life dard Operating	10/30/15		
shall provide a propatients. There sheffective pain man. This Rule is not mean an effective pain mean effective pain effective pain mean effective pain mean effective pain effective pain mean effective pain effective	y surgical treatment center cess that assesses pain in all all be an appropriate and agement program. et as evidenced by: y, the facility failed to develop an agement program. led: view in the office on 10/7/15 at ked if the facility had a policy		1. The deficient practice has been further review of facilities Meethat outline Pain Management 2. The facility will continue to creview and ensure all staff are updates and revisions to the gwill be conducted by October 3. This is currently in practice pain management are in the Practice Protocols which where February 2015. 4. The facility will conduct staft to ensure all staff is aware of updates have been addressed.	for patients. for patients. conduct annual protoc. familiar with any uidelines. Staff trainin 23,2015. as the guidelines for facilities Medical re implemented ff meeting annually any revisions and or	ol	
and procedure for Patient Services s anything like that." A 420 1200-8-1004 (16)	managing pain, the Director of tated, "No, we don't have	A 420		Am	SS erica	

Division	of Health Care Faci	lities	a:		(X3) DATE	CLIDVEY
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPL	
		TNPL53515	B. WING		10/0	7/2015
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
	D PARENTHOOD OF	SEIDDI E AND EA!	TODD BOUL			4
PLANNEI			_E, TN 3720	PROVIDER'S PLAN OF CORRECTION	ON T	(X5)
(X4) ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETE DATE
A 420	Continued From pa	ge 1	A 420			
7420	members of the me professions and pro privileges.	edical, dental, and other health ovide for the granting of clinical		The facility has been in direct contact Physician #2 to obtain verification of priv while current credentialing warehouse provider information. The Manager of HR will ensure crede providers is up to date by maintaining ar detailed spreadsheet that tracks credent	ntialing of d monitoring ialing due	10/30/15
	failed to produce pr provided for the rea the medical staff ar	credentials files, the facility roof the governing body had appointment of a member of a provided for the granting of or 1 of 4 (Physician #2)		dates including licensing and privileging. 3. The practice of the monitoring and tracredentialing has begun August 20, 2014. A monthly audit will be completed by of HR to determine that credentialing is each provider. Credentialing paperwork to providers two months in advance and will be filed no later than thirty days prior date.	cking 5. he Manager current for will be given paperwork	
	The findings include	ed:				
	revealed the privile	redentials file for Physician #2 ges were expired. There was the governing body had ian #2 and granted clinical			:	
	2:30 PM, the Direct	iew in the office on 10/7/15 at tor of Patient Services verified mentation Physician #2 had and granted clinical privileges.		Et .		
A 614	1200-8-1006 (1)(r	n) Basic Services	A 614	(9		
* £	(1) Surgical Service	es.				
	advance directive,	ited informed consent, if available, and organ available, must be in the patient gery, except in emergencies.		8		65
	8			#	-	500
	This Rule is not m	et as evidenced by:			Am	erica r

Division of Health Care Facilities STATE FORM

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Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: 10/07/2015 B. WING TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY A 614 Continued From page 2 A 614 1. The facility will conduct additional staff training to ensure proper informed consent is Based on medical record review and interview, 10/23/15 obtained and documented and that advance the facility failed to have an informed consent in directive, and organ donation information is being the record for 1 of 9 (Patient #10) patients documented into the Electronic Health Record. undergoing a surgical procedure and failed to Additional staff has been designated to scanning patient records to ensure this is completed in a document advanced directives and organ timely fashion. donation for 2 of 9 (Patients #3 and 5) sampled 2. Chart audit will be performed to ensure patients undergoing surgical procedures. advance directive, organ donation, and informed consent are included in each chart. 3. The deficiency will be completed by The findings included: Oct 23,2015 to allow each provider to receive Medical record review for Patient #10 4. Twenty surgical charts will be audited quarterly by the RQM Coordinator to ensure ongoing documented an admission date of with a compliance. 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. Medical record review for Patient #3 documented an admission date of diagnosis of Legally Induced Abortion. There was no documentation of an advanced directive and organ donation for Patlent #3. Medical record review for Patient #5 documented an admission date of 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.

Division of Health Care Facilities STATE FORM





Division	of Health Care Fac	ilities	-0.01.14	(VO) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: C			ETED		
AND PLAN	OF SURFICION			d. Boilding.		ľ	
		TNPL53515		B. WING		10/0	7/2015
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	PROVIDER OR SUPPLIER			TODD BOUL			
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(X4) ID PREFIX TAG	JEACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
A 624	Continued From pa	 age 3		A 624			
				A 624	1. The deficiency will be com	ected by performing	
A 624	1200-8-1006 (1)(1) basic services			additional provider training o	n completion of	
	(1) Surgical Servic	ces.			The Center Manager will r Surgical charts at the end of	eview 100% of	11-17-15
	(r) An operative re	eport describing tech	niques.		ensure operative report has	been completed.	
	findings, and tissue	es removed or altered	d must be		This process will be imple Nov.17,2015 to correct defic	iency.	
	written or dictated i	immediately following	surgery		Ongoing compliance will be quarterly audit of twenty surger	ne monitored by a	
	and signed by the	surgeon.			RQM Coordinator.		
							l.
	F:					0	
1							
	This Rule is not m	et as evidenced by:					
	Based on medical	record review and int include an operative	report for				
	2 of 9 (Patients #3	and 8) sampled patie	ents who				C.
	had undergone sui	rgical procedures.					
	The findings includ	led:					
	1. Medical record	review for Patient #3	743				
	documented an ad	mission date of	with a There was				
	no documentation	of an operative repor	t for		*		
	Patient #3.	5762			i i		
	2 Medical record	review for Patient #8	i				
	documented an ad	Imission date of	with a				
	diagnosis of Legal	ly Induced Abortion. of an operative repo	There was				1
1	Patient #8.	or an operative repo	, , , , , ,	1	1		9
	, = "		(OFFIRE =1		ž-		
	3. During an inter	view in the office on a lith Center Manager	verified				
	there was no docu	imentation of operation	ve reports				R'S
	for Patients #3 and	d #8.				'	HODY
	*						
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Division of Health Care Facilities STATE FORM

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PRINTED: 11/05/2015 FORM APPROVED

Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A BUILDING: AND PLAN OF CORRECTION 10/07/2015 B. WING TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A1301 Continued From page 4 A1301 A1301 1200-8-10-.13(1) Pol. & Proced. for Health Care A1301 This deficiency will be corrected by creating 10-19-15 Dec. Making 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 (1) Pursuant to this Rule, each ambulatory incompetent or who lacks capacity and does not surgical treatment center shall maintain and have a living will and/or Durable Power of Attorney establish policies and procedures governing the for health care. Information about Living Wills and designation of a health care decision-maker for advance directives will be made available to making health care decisions for a patient who is patients at the facility upon request. 2. The facility will conduct additional staff training incompetent or who lacks capacity, including but to ensure that it is documented in Electronic not limited to allowing the withholding of CPR Health Record if the patient has an advance measures from individual patients. An adult or directive and/or living will to direct end of life care. 3. The facility will have documents available for emancipated minor may give an individual patients October 19,2015. instruction. The instruction may be oral or 4. The End of Life Policy will be reviewed annually written. The instruction may be limited to take and updated as needed. This will be added to the effect only if a specified condition arises. RQM work plan. 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: 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.

Division of Health Care Facilities

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: B. WING. TNPL53544 10/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1726 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 454 1200-8-10-.04(25) Administration A 454 (25)"No smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in **CHOICES Facilities Mgr** 10/12/2015 a red circle with a red bar across it, shall be clearly and conspicuously posted at every installed a "No Smoking" sign entrance. at each of the two bldg. entrances where they were This Rule is not met as evidenced by: Based on observation and interview, the facility missing. failed to post "No Smoking" signs at 2 of 3 (main entrance and staff entrance) entrances to the facility. **CHOICES Facilities Mgr** has added "check for No The findings included: Smoking signs at each clinic Upon entering the facility on 10/5/15 at 9:00 AM. entrance" to it was noted that there was no signs at the public her list of semi-annual entrance to indicate this was a "No Smoking" facilities inspections. 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. accepted Kouthy I Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Executive K

Division of Health Care Facilities

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 77 - MEMPHIS CENTER FOR COMPLETED REPRODUCTIVE HEALTH B. WING TNPL53544 10/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1726 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A 801 1200-8-10-.08 (1) Building Standards A 801 (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: 11/2/2015 1) After the inspection on 10/5/2015. 1. A penetration in the electrical room around a Nancy Shotwell, Clinic Coordinator flexible electrical conduit. National Fire contacted Rhodes Electric re: the Protection Association (NFPA) 101, 39.3.2.2 penetration around the flexible (2000 edition). electrical conduit. Rhodes Electric 2. A packaged canopy was stored in front of the will be on site to repair on 11/2/2015 electrical panel, obstructing the door. National Regulation 1200-8-10-8 (1) (NFPA) 101, 39.3.2.2 (2000 edition) Fire Protection Association (NFPA) 70, 110 (26) (a) (1999 edition). 3. The electrical panel did not have the breakers After the inspection on 10/5/2015. identified in the electrical panel. National Fire 10/5/2015 The packaged canopy was moved from Protection Association (NFPA) 70, 408.4 (1999) in front of the electrical panel on edition). 10/5/2015 by Rebecca Terrell, Executive 4. An automatic hand sanitizer had been installed Director over the light switch in the employee break room. Regulation 1200-8-10-8 (1) Code of Federal Regulations (CFR) 416.44 (NFPA) 70, 110 (26) (a) (1999 edition) 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 Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

STATE FORM

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH TNPL53544 B. WING 10/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1726 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ΙD PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 3) After the inspection on 10/5/2015 A 801 11/2/2015 Continued From page 1 A 801 Nancy Shotwell, Clinic Coordinator contacted Rhodes Electric re: electrical representative. National Fire Protection panel breaker need identified, Rhodes Association (NFPA) 101, 7.8, 7.9, and 7.10 (2000) Electric will be on site to complete on edition). 11/2/2015 6. The battery back-up exit light by by the phone Regulation 1200-8-10-08 (1) room would not illuminate when tested by the (NFPA)70, 408.4 (1999 edition) facility representative. National Fire Protection Association (NFPA) 101, 7.10 (2000 edition). 10/14/2015 A former restroom was being used as a 4) After the inspection on 10/5/2015 William Hart (maintenance) removed storage room and did not have a self closing the automatic hand sanitizer from over device to keep the door closed. (NFPA) 101. the light switch in employee break 21.3.7.6 (2000 edition). room. 8. The facility could not provide documentation of Regulation 1200-8-10-08 (1) a current sensitivity test on the smoke detectors (CFR) 416,44 since 7/19/11. National Fire Protection Association (NFPA) 72, 7.3.2.1 (1999 edition). 9. The facility could not provide documentation 10/12/2015 5)After the inspection on 10/5/2015 for the (30 second) monthly and (90 minute) Nancy Shotwell, Clinic Coordinator annual testing of the exit and emergency lighting contacted Don Sills with (City Fire fixtures. Fire Protection Association (NFPA) 101, Extinguisher Co) re: emergency light 7.9.3 (2000 edition). fixture over the waiting area would not illuminate, On 10/12/2015, Don Sitis 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)

Division of Health Care Facilities

STATE FORM

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FIWL21

for Life

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MEMPHIS CENTER FOR REPRODUCTIVE HEA

1726 POPLAR AVENUE

	MEMPH!	S, 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	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)	10/26/201
			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)	10/7/2015
	These findings were verified during the tour, and acknowledged by the facility representatives during the exit conference on 10/5/15.		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)	10/12/201
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Division of Health Care Facilities

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD B. WING TNPL63547 11/24/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE **PLANNED PARENTHOOD GREATER MEMPHIS** MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) (A 801) 1200-8-10-.08 (1) Building Standards {A 801} (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 Please see attached response from our 1/8/16 revealed multiple penetrations in 3 of 4 walls. architecture firm. National Fire Protection Association (NFPA) 101. 39.3.2 (2000 edition). Service call placed for repair/ 2. Observation of the soiled storage room 1/8/16 revealed no exhaust fan had been provided for replacement 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. Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

EN0322

STATE FORM

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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.

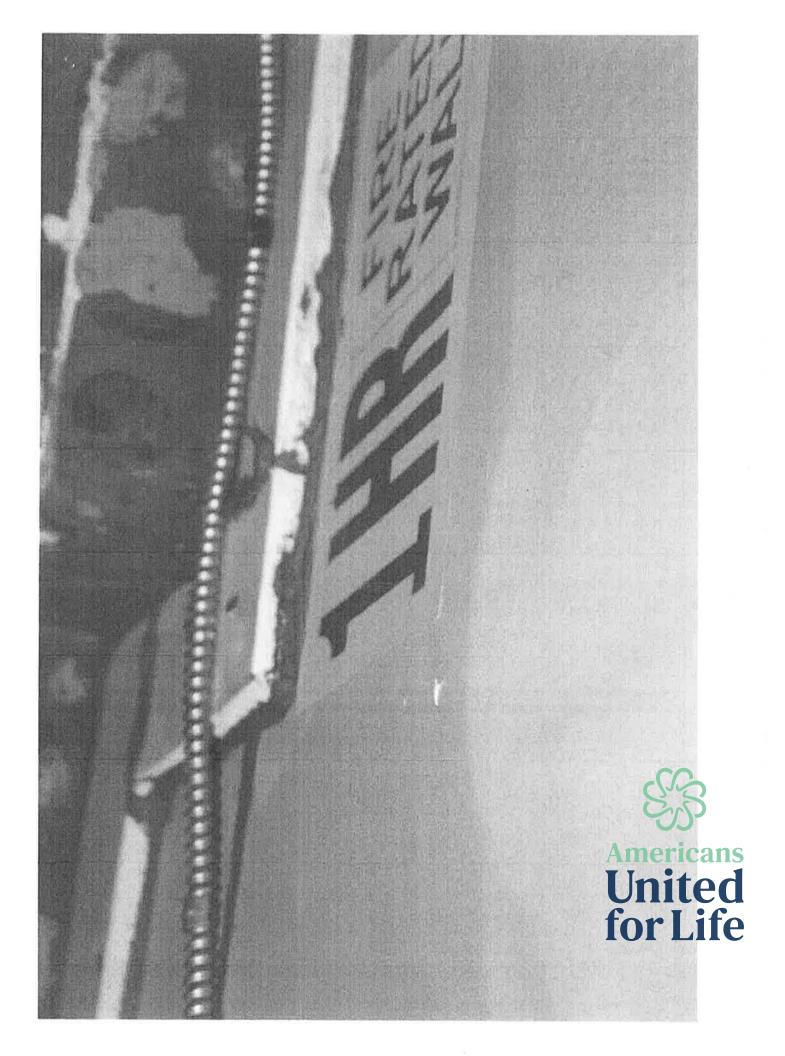
Additionally, there was mention of the integrity of the rated assemblies as constructed in the existing second floor shell space. Upon inspection of the information provided by the site manager and research of rated assemblies, it is my professional opinion that the assemblies do not jeopardize the health, 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.

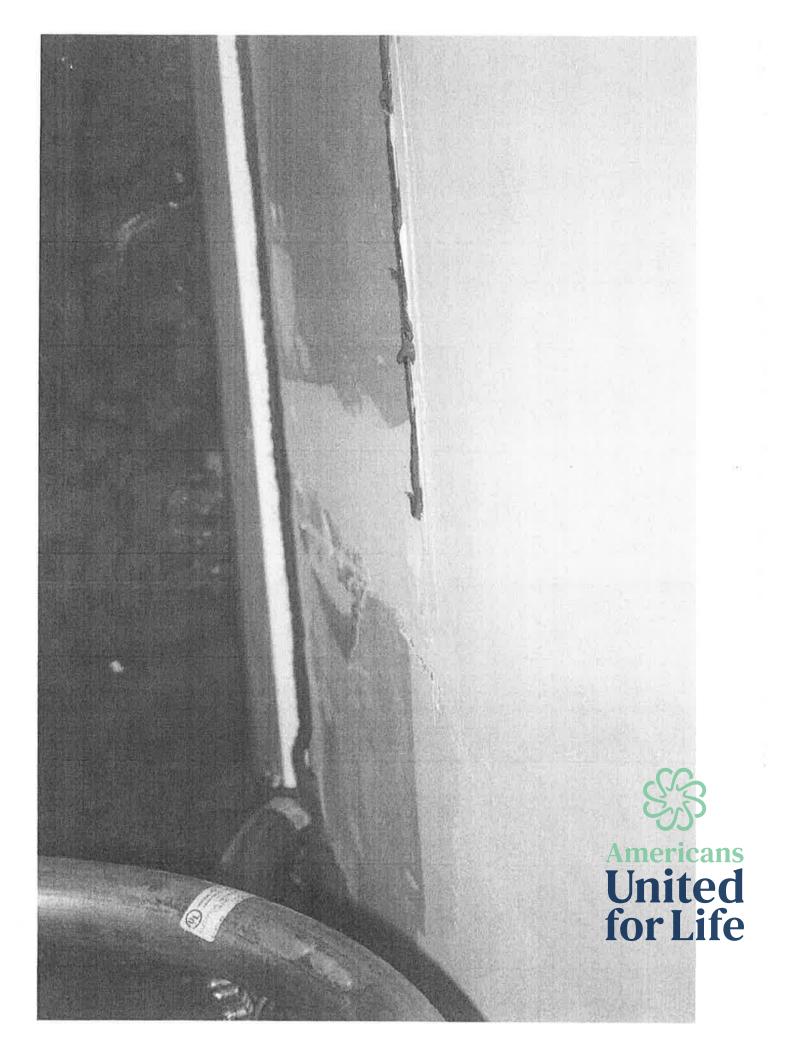
Should you have any further questions regarding this firm's observations, please do not hesitate to contact me at 903-337-8522.

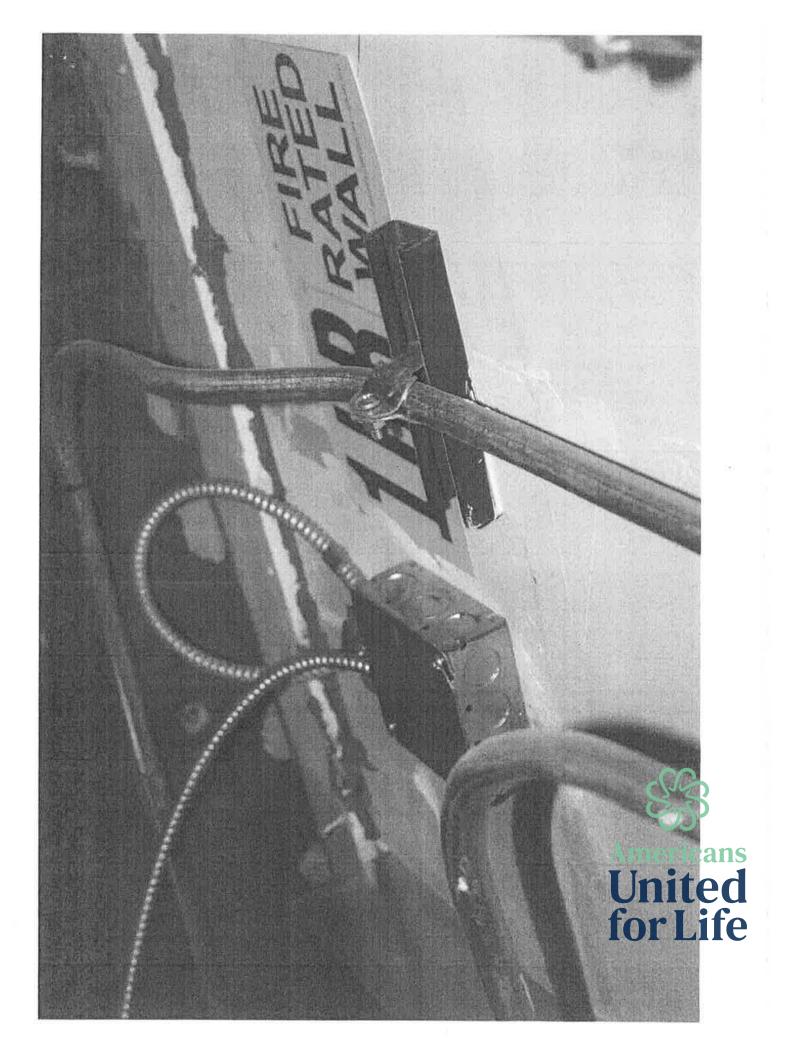




Todd C. Howard, AIA, NCARB, LEED AP Tennessee Architectural License #105290







Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING. TNPL53547 10/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) CORRECTIVE ACCTION FOR A 801 1200-8-10-.08 (1) Building Standards PREVENTION AND MONITORING: (1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and PPGMR's VP of Finance is responsible the overall ASTC environment in such a manner for monitoring and compliance with that the safety and well-being of the patients are survey items. Item one will be assured. monitored daily. Items 2 and 6 will require no further action. Items 3,4, and 5 have been added to PPGMR's This Rule is not met as evidenced by: Based on observation, the facility failed to quarterly maintenance checklist to maintain the condition of the surgery center in a ensure that the deficient practices are manner that the safety and well-being of the monitored/timely corrected and do patients were assured. not recur. The findings included: Observation of the surgery center on 10/5/15 revealed the following: Storage room doors, and doors in the paths of Wedges removed and supervisors 10/5/15 1. egress were obstructed with rubber wedges. monitor daily for compliance National Fire Protection Association (NFPA) 101, 21.2.2.3, (2000 edition). An automatic hand sanitizer had been installed 11/21/15 2. Contractor hired to reinstall sanitizer over the light switch in the employee break room. Code of Federal Regulations (CFR) §416.44 (f). 3. Observation of the elevator equipment room 3. Contractor hired to seal penetrations 11/21/15 revealed multiple penetrations in 3 of 4 walls. National Fire Protection Association (NFPA) 101, 39.3.2 (2000 edition). Observation of the corridor electrical 4. Replaced damaged cover receptacles revealed a damaged cover located by the elevator room door. National Fire Protection Association (NFPA) 70 B, 16-6.2 (1998 edition). Observation of the facilities ceiling light 5. Contractor hired to install bulb 11/21/15 fixtures in the following areas did not have bulb protection protection: the elevator room, the housekeeping Division of Figalth Care Facilities

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PRINTED: 10/09/2015 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED **PARENTHOOD** B. WING TNPL53547 10/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 801 Continued From page 1 A 801 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 6. Contractor stated the observation is a 10/26/15 revealed the exhaust fan was not functioning. return unit (not an exhaust fan) and is National Fire Protection Association NFPA 90 A functioning properly (1999 Edition). Based on record review, the facility failed to provide documentation of a 4 year fire damper inspection. The findings included: 11/12/15 Contractor performed damper During the document review, the facility falled to provide documentation that fusible link fire inspection and provided dampers had been inspected. documentation (attached), Next National Fire Protection Association NFPA 90 A inspection due 11/1/2019 (1999 Edition). These findings were verified and acknowledged by the surgery center representative during the tour and exit conference on 10/5/15.

Division of Health Care Facilities

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4 Year Fire Damper Inspection

Site Name: PPGMR

Inspection Performed By: Mike Morrissett 11/12/15

Location: 2430 Poplar

Report Prepared By: W. David Hobbs 11/13/15

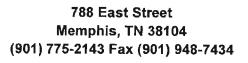
Memphis,TN 38104

Next Inspection Due: 11/01/19

Floor: First

Page: 1 of 3

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	







4 Year Fire Damper Inspection

Site Name: PPGMR

Inspection Performed By: Mike Morrissett 11/12/15

Location: 2430 Poplar

Report Prepared By: W. David Hobbs 11/13/15

Memphis, TN 38104

Next Inspection Due: 11/01/19

Floor: Second

Page: 2 of 3

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	1 st 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	
					CC

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





4 Year Fire Damper Inspection

Site Name: PPGMR =

Inspection Performed By: Mike Morrissett 11/12/15

Location: 2430 Poplar

Report Prepared By: W. David Hobbs 11/13/15

Memphis,TN 38104

Next Inspection Due: 11/01/19

Floor: Second

Page: 3 of 3

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	
,					

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



Division of Health Care Facilities STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

TNPL53515

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** A. BUILDING: _ B. WING 10/20/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PLANNED PARENTHOOD OF MIDDLE AND EAS

412 D. B. TODD BOULEVARD

W 1 1 -		LE, TN 372		
(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	1200-8-1006 (1)(n) Basic Services	A 614		
	(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.	\$	Organ donation preference will be documented in each	6Nov!
	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.	1/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	medial record. This guestin his been added to the Demographic page Campleted by each patent.	
	The findings included:	Đ	Completed by each patent.	
	Medical record review for Patients #1 through 6 revealed no documentation of organ donation preference in the medical records.	,	Organ denation will be	
	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.		Moord Andit Categories.	
A1101	1200-8-1011 (1) Records and Reports	A1101	0 . 1 . 6 . 4	
	(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		the Joint Annual Regart will be completed and peturned to the Dop't. The JAR will be added to	12 Dec
1	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.		JAR will be added to the CORECENTED Plan	R
	The findings included:	-	DEC 1 1 2014	777
	During an interview in the Managers officeon		Ame	rica

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

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED TNPL53515 B. WING 10/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A1101 Continued From page 1 A1101 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. A1405 1200-8-10-.14 (2) Disaster Preparedness A1405 PPMET will participate (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.

Division of Health Care Facilities

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PRINTED: 10/22/2014 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 02 - STATE BUILDING TNPL53515 B. WING 10/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA: NASHVILLE, TN 37203 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 818 1200-8-10-.08 (18) Building Standards A 818 (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. the bishagard room on the 1st floor will have 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 901 1200-8-10-.09 (1) Life Safety A 901 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

Division of Health Care Facilities LABORATORY DIRECTOR'S

considered to be in compliance with the requirements of the new codes or regulations.

OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

long as such compliance is maintained (either with or without waivers of specific provisions), be

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 02 - STATE BUILDING TNPL53515 10/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA! NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) A 901 Continued From page 1 A 901 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 fire extinguisher in the 1st floor electrical closet (x+23, has been secured. Review 2014 of this item has been added to our monthly birextinguisher audit. 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. Escatcheon plates will be added to the sprinklers on NW 8.

the 2nd flr storage roum,
sociled Laundry closet, and
2nd flow snack closet, fleview
of this will be added to
our monthly sprinkler
andit 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. Division of Health Care Facilities

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 10/15/2014 TNPL53544 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **FURNISHED** 1726 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) A1101 A1101 1200-8-10-.11 (1) Records and Reports How the Deficiency will be corrected: Assign Completion of (1) The Joint Annual Report of Ambulatory JAR to Practice Manager. 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. Now the facility will prevent the same deficiency from occuring: This Rule is not met as evidenced by: CHOICES Director of Clinical Services will continue to Based on interview, it was determined the facility communicate annually with the TN Department of Health Division of Policy, Planning and Health Statistics if JAR is not received annually as anticipated. failed to ensure the Joint Annual Report (JAR) was filed with the department. Date Deficiency will be corrected The findings included: 11/05/2014 During an interview on 10/15/14 at 12:00 PM the On Going Monitoring Director of Clinical Services stated they were not Completion of JAR report will be component required to file a JAR. There was no evidence of Practice Manager annual evaluation. the facility filed a JAR. JAN 1 6 2015 Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH TNPL53544 10/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1726 POPLAR AVENUE** MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A 900 1200-8-10-.09 Life Safety A 900 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 After the inspection on 10/17/2014- A The findings included: complete walk through on 10/21/2014 10/21/2014 was performed on all fire extinguisher's. All 6 fire extinguisher's were inspected Observation of the facility on 10/17/14 revealed and documented by Nancy Shotwell, all 6 fire extinguishers had not been inspected Clinic Coordinator. The task will be and recorded monthly on the extinguisher's tags assigned monthly by Nancy Shotwell. since the annual fire extinguisher inspection Clinic Coordinatorconducted on May 2014. Regulation 1200-8-10-09 NFPA 10, 6.3.1 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) After the inspection on 10/17/2014- G&R Services installed ground fault circuit 10/24/2014 The findings included: interrupters in the break room area on 10/24/2014. The installment is a Observation of the break room on 10/17/14 permanent change/fix for the facility. revealed the receptacles at the counter were not All maintenance will be monitored by ground fault circuit interrupters. Nancy Shotwell, Clinic Coordinator Regulation 1200-8-10-09 NFPA 70, 210-8 (b) (1) Based on observation, it was determined the facility failed to maintain smoke resistant NFPA 101, 8.3.4.3 continued on page 2 of assemblies in the facility. NFPA 101, 8.3.4.3 Division of Health Care Facilities

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

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH TNPL53544 10/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1726 POPLAR AVENUE** MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) A 900 Continued From page 1 A 900 After the inspection on 10/17/2014- On The findings included: 10/21/2014 10/21/2014, Christopher Lott disassembled all 5 door stops attached to the doors, Observation of the facility on 10/17/14 revealed 5 assigned by Nancy Shotwell, Clinic smoke resistant doors with kick down doorstops Coordinator. All staff were informed to not attached and in use preventing the self closing of secure the doors with a doorstop the doors. attachment. Regulation 1200-8-10-09 NFPA 101, 8.3.4.3 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 After the inspection on 10/17/2014-10/29/2014 failed to provide documentation of an annual fire Nancy Shotwell, Clinic Coordinator alarm system test. 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. These findings were verified and acknowledged Nancy Shotwell, Clinic Coordinator will by the facility director during the tour and exit properly file report in life safety binder as conference on 10/17/14. assigned. Regulation 1200-8-10-09 NFPA 72, 7-3.2 RECEIVED

Division of Health Care Facilities

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Executive Director



PRINTED: 11/04/2014 **FORM APPROVED** Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING TNPL53547 10/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) A 614 1200-8-10-.06 (1)(n) Basic Services A 614 Intake form updated on 2/1/15 to capture organ donor status. This form (1) Surgical Services. (n) Properly executed informed consent. advance directive, and organ donation forms must be in the patient's chart before surgery. is scanned into our EMR except in emergencies. and becomes a permanent This Rule is not met as evidenced by: part of their record. Based on record review and interview, it was determined the facility failed to ensure organ Please see attached donation forms were properly executed before surgery for 6 of 6 (Patients #1, 2, 3, 4,5 and 6) Intake form. sampled patients. Mary 3-13 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. The JAR was completed on A1101 1200-8-10-.11 (1) Records and Reports A1101 2/6/15 and will be submitted (1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the on 216/15. department. The forms are furnished and mailed

Division of Health Care Facilities

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

This Rule is not met as evidenced by:

to each ASTC by the department each year and the forms must be completed and returned to the

Based on interview, it was determined the facility failed to ensure the Joint Annual Report (JAR)

department as required.

was filed with the department.



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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING TNPL53547 10/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A1101 Continued From page 1 A1101 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. A1405 1200-8-10-.14 (2) Disaster Preparedness A1405 On October 14, 2014, spoke county's TEMA contact. PPGMR has complied (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 with TEMA. 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: This was our 1st acknowledgement of deficiencies from our visit on 10/14/14. It was received to PPGMR on 2/16/15. 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.

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD TNPL53547 10/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) A 900 1200-8-10-.09 Life Safety A 900 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: Fire extinguishers were evaluated once a month please see 11/0/14 emails from Iteath Center 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. RECEIVED MOV 1 0 2019

Division of Health Care Facilities

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

		1	LE CONSTRUCTION	(X3) DATE SURVEY
		A. BUILDING	·	COMPLETED
	L 53 515	B. WING		06/03/2013
NAME OF PROVIDER OR SUPPLIER	STREET AD	DORESS, CITY,	STATE, ZIP CODE	1 00/00/2010
PLANNED PARENTHOOD OF MIDDLE AN	JD EA 412 D. B.	TODD BOU LE, TN 372	LEVARD	
(X4) ID SUMMARY STATEMENT OF D	DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON I we
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A 453 1200-8-1004 (24) Administra	tion	A 453	-	
(24) All health care facilities lice T.C.A. §§ 68-11-201, et seq. s following in the main public entail (a) Contact information includ toll-free number of the division services, and the number for the services.	hall post the trance: ing statewide of adult protective	0/2/2	Planned Parentle of Middle + East	
attorney 's office; (b) A statement that a person who may be the victim of abuse exploitation may seek assistan complaint with the division conneglect and exploitation; and	e, neglect, or ce or file a cerning abuse,	The President	Services, and the no	ech ve um ber through
(c) A statement that any personage, who may be the victim of a may call the nationwide domes hotline, with that number printe for immediate assistance and proceeding no smaller than eight and one-width and eleven inches (11") in	domestic violence tic violence d in boldface type, posted on a sign half inches (8½") in	T.	for the land districts If is. In addition, a Statement that a per advanced age may be within g abuse, keg explostation may see k assistance of file a comp Concerning abuse, regles	son of the b lect, or
Postings of (a) and (b) shall be smaller than eleven inches (11" seventeen inches (17") in heigh) in width and		assistance of file a comp Concerning above, neglec	t, or
Authority: T.C.A. §§4-5-202, 4-68-11-202, 68-11-204, 68-11-206, and 71-6-121.	5-204, 68-11-201, 06, 68-11-209,		explortation This cirpo will be provided in a that is at least 11"x1. The poster will be locate that the main entra	poster
This Rule is not met as evidence Based on interview it was determined to ensure the required signification in accordance with these regular. The findings included:	mined the facility nage was posted		before you on this p who heer added to t	05/2
vision of Health Care Facilities	2001		PPINET Annual A	diericans
	EPRESENTATIVE'S SIGNA	ATURE 7	resident RED	
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PRINTED: 06/12/2013 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING: COMPLETED TNPL53515 B. WING 06/03/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A 453 Continued From page 1 A 453 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 454 1200-8-10-.04(25) Administration A 454 (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. racce before 1July 13. 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: deficiency does not During an interview on 6/3/13 the Director of Patient Services stated the facility was a "no

Division of Health Care Facilities

at every entrance.

A 455 1200-8-10-.04(26) Administration

smoking" facility but falled to have signs

indicating such clearly and conspicuously posted

(26) The facility shall develop a concise statement

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The poster will be Localina

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: TNPL53515 B. WING 06/03/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) A 455 Continued From page 2 year the mark entrance A 455 before I July 2013. The required information on this poster has been added to the PPMET 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. Annual Facility Andit 68-11-268, and 71-6-121. check-list to ensure this deficiery does not recur. poster that provides the charity Care Policy by poster will provides the poster will provide and provides the poster will 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 be located near the main Patient Services stated the facility did offer charity entrance befor 1 goly 13. The required information on this poster has been care but did not have a sign posted of that policy/statement in a place accessible to the public, added to the PRIMET Annual Facily Andit check-list to ensure that this deficiency does not recur.

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		TNPL53515		B. WING		06/0	5/2013	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	•		
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	This Rule is ne Based on observatireview it was determined to the safety deficiencies.	et as evidenced by: ons, testing, and rec nined the facility had	ords I no life	A 002				
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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ... (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING TNPL53544 05/29/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1726 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 420 1200-8-10-.04 (16) Administration A 420 05/29/2013 1) Clinical Services Coordinator contacted Medical Director to request updated verification of clinical (16) The governing body shall provide for the privileges. appointment, reappointment or dismissal of members of the medical, dental, and other health 2) E-mail correspondence verifying current, professions and provide for the granting of clinical up-to-date privileges received by CHOICES Clinical privileges. Services Coordinator from Methodist Staff Services Coordinator. See Attachment I of 3) Director of Human Resources and Leadership 07/10/2013 This Rule is not met as evidenced by: will review current CHOICES policy and Procedure Based on record review and Interview, it was determined the facility failed to ensure clinical for verifying current, updated licensure, credentialing, privileges were granted for the Medical Director. and/or certifications for all staff, contractors and personnel employed by or contracted to provide clinical The findings included: services at CHOICES to ensure that current policy Review of the Medical Director's employee record addresses systemic review of all appropriate personnel revealed no documentation of current clinical files annually. privileges. 4) CHOICES policy and procedure addressing | 07/10/2013 personnel, contractors and employees of CHOICES will be During an interview on 5/29/13 at 1:50 PM the amended by Leadership Team to ensure that policy addresse Clinical Services Coordinator verified there was no documentation of the current clinical privileges systemic, ongoing annual review of employee, personnel and for the Medical Director. contractor files. 5) Annual report regarding state of employee, personnel and A 435 1200-8-10-.04 (20)(c)4. Administration A 435 contractor files in regards to licensure, certification and/or credentialing as appropriate and any identified deficiencies will (20) Infection Control. be made and documented during Leadership Team meeting. 2013, meeting will be scheduled to occur 09/11/2013. Meeting (c) The chief executive officer or administrator shall assure that an infection control committee will be scheduled in September annually on an ongoing basis including members of the medical staff, nursing staff and administrative staff develops guidelines A435 Illan of Correction and techniques for the prevention, surveillance, 1) CHOICES current policy and procedure related 07/13/201 control and reporting of facility infections. Duties to Infection Control and 1200-8-10-.04 will be of the committee shall include the establishment scheduled to occur at meeting of CHOICES infection Control Committee. Documentation of review of 4. Written procedures concerning food handling, pertinent literature and findings as well as recommendation. laundry practices, disposal of environmental and of Infection Control Committee will be documented in meeting patient wastes, traffic control and visiting rules in notes of Medical Services Committee Division of Health Care Facilities

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING TNPL53544 05/29/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1726 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY A 435 07/13/2013 A 435 Continued From page 1 2) CHOICES policy and procedure regarding Infection Control specific to operation, cleaning and monitoring high risk areas, sources of air pollution, and routine culturing of autoclaves and sterilizers; 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 This Rule Is not met as evidenced by: review are as follows: Based on Center for Disease Control Guideline a) Center for Disease Control Guideline for Disinfection and for Disinfection and Sterilization in Healthcare Facilities, 2008, and interview, it was determined Sterilization in Healthcare Facilities, 2008 the facility failed to monitor the sterilizer b) MidMark M9 Ultraclave Steam Sterilizer Installation and temperature during usage. Operation Manual. c) National Abortion Federation Clinical Policies Committee: The findings included: Infection Prevention Policy Guidelines (2013/Rev. September Review of the Center for Disease Control Guideline for Disinfection and Sterilization in d) Henry Schein AutoClave Tape product Information (LP-0\$) Healthcare Facilities, 2008, page 59 documented, Rev A) "...sterilizers usually are monitored using a e) Henry Schein Self Seal Sterilization Pouch with Internal arts printout (or graphically) by measuring External Indicators Product Information (Current Lot Version temperature, the time at the temperature, and pressure..." 3) All recommendations for amendments to 08/17/2013 CHOICES Policy and Procedure regarding infection control Tolicy During an interview in the conference room on and procedure relevant to autoclave and sterilization process 5/29/13 at 3:25 PM the Clinical Services proposed at meeting on 07/13/2013 will be incorporated and Coordinator stated there was no documentation documented as amendments to current CHOICES Infection Control of the temperature the autoclave digitally reads during usage. policy and Procedure. Clinical Services Coordinator will be charged with incorporating any recommendations for amendal ents A 436 A 436 1200-8-10-.04 (20)(c)5. Administration and presenting draft of updated policy and procedure at Medical Services Committee Meeting scheduled for August 2013. (20) Infection Control. Anticipate review and final approval of updated policy and (c) The chief executive officer or administrator procedure by both Medical Director and Infection Control shall assure that an infection control committee Committee by 08/17/2013. including members of the medical staff, nursing 4) Annual review of CHOICES policy and procedure August 1013 staff and administrative staff develops guidelines related to Infection Control and specifically to Autocrave and and techniques for the prevention, surveillance, Sterilization process will be scheduled to occur initially by Aligust control and reporting of facility infections. Duties of the committee shall include the establishment on-going. Amendments to CHOICES policy to Infection Control of: or procedures will be conducted according to CHCICES policy on

Division of Health Care Facilities

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amending Medical Policy and Procedures

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED
		TNPL53544		B. WING		05/29/2013
NAME OF P	ROVIDER OR SUPPLIER	1	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
MEMPHI	S CENTER FOR REP	RODUCTIVE HEA		LAR AVENI 5, TN 3B104	JE	
(X4) ID PREF/X TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT. (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
A 436	The findings included buring an interview 5/29/13 at 3:35 PM Coordinator stated related to infections	s related to infectious ases; et as evidenced by: , it was determined to a log of in and communicable and communicable are the Clinical Services.	the facility icidents diseases. com on s incidents diseases	A 436 PL	AN OF CORRECTION 1) Documentation of CHOICES In review of infection incidents (no reto inspector at time of site visit. 2) CHOICES current policy and prelated to Infection control specific will be reviewed during Medical Simulation of the policy and procedure appropriately to log of incidents related to infection control of the policy and procedure appropriately to log of incidents related to infection diseases. 3) Clinical Services Coordinator we coordinating and drafting any recomby CHOCIES Infection Control Committee Infection Control Policy and approval by Medical Director, and Infection Control Committee 4) Clinical Services Coordinator we Infection Control Committee during Communicable diseases. Document findings as well as any additional and Control Committee Weeting notes. 5) Annual review of CHOICES in procedure as well as annual review be scheduled to occur annually during Services Committee Meeting.	ocedure 07/13/2013 to 1200-8-1004(20)(c) ervice Committee Meeting by introl Committee to ensure the addresses regulation specific ions and communicable iill be charged with immended changes identified immittee and updating current y and Procedure for review Medical Services Committee by 08/17/2013. iill report quarterly to log Medical Services into related to infectious of intation of report, review and recommendations by Infection DICES Medical Services fection Control Policy and of previous year report will

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Division of Health Care Facilities (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES D(2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING TNPL53544 05/29/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1726 POPLAR AVENUE **MEMPHIS CENTER FOR REPRODUCTIVE HEA** MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XB) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY 07/10/13 CHOICES has scheduled staff trainings for A1401 A1401 1200-8-10-.14 (1)(a) Disaster Preparedness Disaster preparedness: Fire Safety Procedure for 2013, Training will be conducted The administration of every facility shall have by Director of Purchasing & Facilities. in effect and available for all supervisory Staff attendance will be documented along with personnel and staff, written copies of the detailed log of agenda and topics covered. following required disaster plans for the protection of all persons in the event of fire and (2) Nonattendance will be managed according to 07/10/13 other emergencies for evacuation to areas of CHOICES current policy on staff trainings. refuge and/or evacuation from the building. A Individual staff not in attendance will be detailed log with staff signatures of training required to review and document review of received shall be maintained. All employees shall **CHOICES Fire Safety Disaster Training** be trained annually as required in the following manual in accordance with CHOICES policy. plans and shall be kept informed with respect to (3) CHOICES has conducted Fire Drills on 3/21/13 07/10/13 their duties under the plans. Acopy of the plans and 6/4/13, and additional quarterly drills and the specific emergency numbers related to have been scheduled. These have and will be that type of disaster shall be readily available at conducted by the Director of Purchasing & all times. Each of the following plans shall be Facilities, Unannounced drills have also been exercised annually: scheduled for 2013 for a total of 1 Fire drill per quarter according to requirements of (a) Fire Safety Procedures Plan shall include: regulation 1200-8-10.14(1)(a). 07/10/13 Minor fires: (4) CHOICES has scheduled a review to revise our policies and procedures related to Disaster Major fires; Preparedness for 2013. This review and revision will be conducted by the Leadership 3. Fighting the fire; Team. The Director of of Purchasing and Facilities will report to the Leadership Team all dates for Evacuation procedures; trainings, drills and any deficiencies for the year. Non-compliance by any employee 5. Staff functions. will be managed according to CHOICES Employee Review policy and will be reflected in staff annual reviews per CHOICES policy, Any This Rule is not met as evidenced by: amendments or deficiencies identified by Based on observations during the record review the Director of Purchasing and Facilities or during on 5/29/13, the facility failed to conduct fire drills Leadership Team's review of CHOICES policies in every quarter of 2012. will be reflected in Leadership Team meeting notes and will be amended and/or a plan of The findings included: correction implemented and reviewed annually During the fire drill record review, the facility did not have a fire drills during the 2nd and 3rd Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDENCEUPPLIER REPRESENTATIVE'S SIGNATURE

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Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CC2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION. IDENTIFICATION NUMBER: A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING TNPL53544 05/29/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1728 POPLAR AVENUE** MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX TAG (705) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE FAG DEFICIENCY) A1401 A1401 Continued From page 1 quarters of the year 2012. A1404 A1404 A1404 1200-8-10-.14 (1)(d) Disaster Preparedness (1) CHOICES has scheduled a staff training for 07/10/13 Disaster Preparedness: Earthquake Safety (1) The administration of every facility shall have Procedure for 2013. Training will be conducted in effect and available for all supervisory by the Director of Purchasing and Facilities. Staff personnel and staff, written copies of the attendance will be documented with staff following required disaster plans for the signatures along with a detailed log of training protection of all persons in the event of fire and agenda and topics. other emergencies for evacuation to areas of refuge and/or evacuation from the building. A (2) Earthquake Safety Training detailed log with staff signatures of training 07/10/13 attendance is mandatory. received shall be maintained. All employees shall Nonattendance will be managed be trained annually as required in the following according to CHOICES policy on staff plans and shall be kept informed with respect to training. Individual staff not in their duties under the plans. A copy of the plans attendance will be required to update and the specific emergency numbers related to training by reviewing and documenting that type of disaster shall be readily available at review of CHOICES Earthquake Safety all times. Each of the following plans shall be Disaster Preparedness Training Manual exercised annually: according to CHOICES policy. (d) Earthquake Disaster Procedures Plan: 07/10/13 (3) Earthquake drills have been scheduled for 2013 and training will be conducted by the Director of 1. Staff duties; Purchasing and Facilities. Evacuation procedures; 07/10/13 (4) A review of CHOICES policy and 3. Safety procedures; procedures related to Disaster Preparedness has been scheduled to Emergency services. be conducted by the Leadership Team. Director of Purchasing and Facilities will report to Leadership This Rule is not met as evidenced by: Team the dates and attendance of all Based on observations on 5/29/13, it was required training and safety drills determined the facility failed to conduct disaster as well as staff attendance at each drills during 2012. session. Nonattendance will be managed according to CHOICES policy on staff The findings included: training. Individual staff not in attendance will be required to update During the record review on 5/29/13, the facility



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Division of Health Care Facilities (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/BUPPLIER/CLIA COMPLETED DENTIFICATION NUMBER A BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH B. WING 05/29/2013 TNPL53544 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1728 POPLAR AVENUE MEMPHIS CENTER FOR REPRODUCTIVE HEA MEMPHIS, TN 38104 PROVIDER'S PLAN OF CORRECTION (05) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL Préfix CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY A1404 (4) Continued A1404 A1404 Continued From page 2 training by reviewing and documenting review of failed to conduct a earthquake drill during the CHOICES Earthquake Safety Disaster Preparedness 2012 year. Training Manual according to CHOICES policy. Any amendments or deficiencies identified by the Director The finding was acknowledged by the Assistant of Purchasing and Facilities or during Leadership Team's Administrator at the exit interview. review of CHOICES Disaster Preparedness policies will be reflected in Leadership Team meeting notes and A1405 A1405 1200-8-10-.14 (2) Disaster Preparedness will be amended and/or a plan of correction implemented immediately & reviewed annually. (2) All facilities shall participate in the Tennessee Emergency Management Agency local/county A1405 emergency plan on an annual basis. Participation (1) Contacted Shelby County Chairman of TN 05/29/13 Includes filling out and submitting a questionnaire Emergency Preparedness by telephone, requested on a form to be provided by the Tennessee information re/ Regulation 1200-8-10-14(2) Emergency Management Agency. Documentation (2) Contacted Director of TN Emergency Management 07/02/13 of participation must be maintained and shall be by telephone, requested information re/ Regulation made available to survey staff as proof of 1200-8-10-14(2) participation. (3) Received and completed Basic Health Care Facility 07/02/13 Survey form and submitted to Director of TN Emergency Management (See attachment 1, 1 of This Rule is not met as evidenced by: pages) Based on observations on 5/29/13, it was (4) Reviewed information and report regarding 07/10/13 determined the facility failed to participate in a Regulation 1200-8-10-14(2) and follow up steps. local county emergency plan on a annual basis. Scheduled review with Leadership Team along with draft of policy to address regulation. Review The findings included: will be documented in Leadership Team mtg notes (5) Scheduled annual review of Disaster Preparedness 07/10/13 During the record review on 5/29/13, the facility Policies and Procedures to be conducted on ongoing did not have documentation showing participation basis by Leadership Team. Any amendments in the Tennessee Emergency Management or deficiencies identified by the Director of Purchasing and Agency local/county emergency plan on an Facilities or during Leadership Team's review of CHOICES annual basis. Disaster Preparedness policies will be reflected in Leadership Team meeting notes and will be The finding was acknowledge by the Assistant amended and/or a plan of correction Administrator at the exit interview on 5/29/13. implemented immediately & reviewed annually.

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	n of Health Care Faci	lities				FORM APPROV
STATEME AND PLAN	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		TNPL53547		B. WING		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD		STATE, ZIP CODE	05/28/2013
PLANNE	ED PARENTHOOD GRI	EATER MEMPHIS	2430 PO	PLAR AVE 5, TN 38104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FIRE	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE COMPLE
A 420	1200-8-1004 (16)	Administration	3	A 420		
	(16) The governing appointment, reappointment, reappointment of the median professions and professions and provideges.	ointment or dismissa dical, dental, and oth	l of er health :	2	بعقائيت	
:	This Rule is not met Based on record rev determined the facili privileges were grant	iew and interview, it ty failed to ensure cli	inical -	ay of	2012 None	a a
E	The findings included	d:				31 ×
•	Review of the Medica revealed no docume privileges.	al Director's employe ntation of current clir	e record nical			
,	During an interview of Vice President of Pat was no documentation privileges for the Med	ient Services verified on of the current clini	d there		Please see a Hached Orivileges for Dr. N	, a copy of clinic 1. stack.
A 624'	1200-8-1006 (1)(p)3	Basic Services		A 624		
•	(1) Surgical Services	5.	3		Atropines was en b	ack order throug
* ((p) A crash cart mus a minimum the follow	t be available and in ing medication and :	clude at supplies:		Atropinu was en b the rendor, but is	now in steck.
3	3. atropine 0.1 mg/n	nl	-	ľ	The vendor is serve 0.1 mg/ml and it s OPGME no later	hould be at
				i P	PGMR NO later	than 8/15/13/1
E C	This Rule is not met a Based on observation determined the facility the crash cart.	and interview, it wa	s ine on	0	our crash carti	SS
on of Hee	IIIh Cara Engillian	- 4 .0-				America
	olth Care Facilities July DIRECTOR'S OR PROVIDER	oh telliott	つ		TITLE	Inte
TOTA ONT D	SILEO LOLLO OK LYCONDEK	SUPPLIER REPRESENTA	TIVE'S SIGNA	TURE	VP Patient Services	0 12/12

Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED TNPL53547 B. WING 05/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 1D PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 624 Continued From page 1 E A 624 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..." 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 A 626 1200-8-10-.06 (1)(p)5. Basic Services A 626 Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: calcium chloride 10%; 10ml amp the CEO by September 15, 2013. This protocol will be reviewed and updated annually by the Medical 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. Director. 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.

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DIVISIO	n of Health Care Faci					FORW APPROVEL
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIA IDENTIFICATION NU	ER/CLIA JMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		TNPL53547		B. WING_	· · · · · · · · · · · · · · · · · · ·	05/28/2013
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	03/20/2013
PLANNE	D PARENTHOOD GR			PLAR AVE 5, TN 3810	4	
(X4) ID PREFIX TAG	. (EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D 8E COMPLETE
	Continued From page	_	!	A 628	PPame will develop a	protocol
71 020	1200-8-1006 (1)(p) (1) Surgical Service			A 628	specifying the required cart drugs and why we dilantin. This protocol reviewed and approved Director and CEO by \$2013. This protocol will	emergenou
	(p) A crash cart mu	st be available and i	nclude at		dilantin This protocol	v KCTUDE
ř	a minimum the follow	wing medication and	supplies:		reviewed and approved	by the Medic
	7. dilantin (phentoi	n)	1		Director and CEO by	September 15,
82	This Rule is not me Based on observation	on and interview, it w	as		2013. This protocol will and updated annually	by the Medica
ñ.	determined the facili available on the cras	ty failed to have dilai	ntin		Director.	U
(*	The findings included	d:	15			
	 Observations of to 5/28/13 at 1:40 PM re available. 	he crash cart conten evealed there was n	its o dilantin			
93	During an intervie 5/28/13 at 1:55 P verified there was no emergency use.	M the Nurse Practiti	oner			
A 629	1200-8-1006 (1)(p)8	8. Basic Services	3	A 629	PPGMR MILL develope of the required emergence and why we exclude do protocot will be reviewed	otocol specify
: ((1) Surgical Services	3. .	14		and whenve exclude de	pamine . The
	(p) A crash cart mus a minimum the follow				protocet will be reviewed by the Medical Director	and approved + CEO, by
क्ष	8. dopamine				9/15/13. This protocol mi	11 be reviewe
: £	This Rule is not met Based on observation determined the facility available on the crash	n and interview, it wa y failed to have dopa			by the Medical Director 9/15/13. This pro-tocol mi and upclated annually Medical Director.	merican

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STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MULTI	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		TNPL53547		B. WING		05/20/2042
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS CITY	, STATE, ZIP CODE	05/28/2013
PLANNE	D PARENTHOOD GR	EATER MEMPHIS	2430 POF	PLAR AVE 5, TN 3810		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETE
A 629	Continued From pa	ge 3		A 629		300 St 51 St 51
	The findings include	ed:			i	
	1. Observations of 5/28/13 at 1:40 PM dopamine available.	the crash cart conter revealed there was r	nts :	:		
	2. During an intervious 5/28/13 at 1:55 liverified there was no emergency use.	ew in the recovery ro PM the Nurse Practit o dopamine available	ioner			
A 630	1200-8-1006 (1)(p)	9. Basic Services	i	A 630	PRGMR will developa	protocol
:	(1) Surgical Service) S.			specifying the required	emergency
34	(p) A crash cart mu a minimum the follow	st be available and ir wing medication and	nclude at ** supplies:		PPGMR. Will develope specifying the required cart drugs and why reparis This protocol	will be review
	9. heparin		,, e		and approved by the	Ti - ourter
1	This Rule is not me Based on observation determined the facility available on the cras	on and interview, it want ty failed to have hep			mill be reviewed and annually by the Mea	t updated licai Director
	The findings include	d:			ê	
	 Observations of t 5/28/13 at 1:40 PM r heparin available. 					
:	 During an intervie on 5/28/13 at 1:55 F verified there was no emergency use. 	PM the Nurse Practiti	oner		¥	
			- 3		A	merican

Division of He	alth Care Fac	ilities				FORM APPROVED
STATEMENT OF D AND PLAN OF COR	EFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		TNPL53547		B. WING_		05/28/2013
NAME OF PROVIDE	R OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE	1 00/20/2013
PLANNED PAR		EATER MEMPHIS	MEMPHIS	PLAR AVE 5, TN 3810	4	
(X4) ID PREFIX (E TAG RE	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
A 631 . Contil	nued From pag	ge 4		A 631	PPGMR will develop a p	MMMAL SOROLLIN
A 631 1200-	8-1006 (1)(p)10. Basic Services	-	A 631	the required covergency	And drugge
(1) S	urgical Service	es.	×		and why Inderal was ex	cluded. This
≐ (p). A ±a mini	crash cart mu mum the follo	st be available and ir wing medication and	clude at supplies:		protocol will be reviewed by the Medical Director	ed and approved
10. in	deral (propran	dolol)	:		by alializ This cornto	AA WILL ho
(# (#)			g.		reviewed and updated	annually
Based detern availat	on observation		as ral		reviewed and updated by the Medical Direct	
≗1. Ob:	servations of to 3 at 1:40 PM re	he crash cart content evealed there was no	s inderal			
on 5/2 verified	8/13 at 1:55 P	w in the recovery roo M the Nurse Practitic inderal available for	om area :			
A 632 1200-8	-1006 (1)(p)	11. Basic Services		A 632	PREMIR WILL develop a +	arotocol
(1) Su	rgical Services	3.			specifying the required	emergency
(p) A c a minin	crash cart mus	t be available and ind ring medication and s	clude at supplies:		specifying the required cart drugs and why w Isuprel. This protocol will ard approved by the Measure of This protocol will	11 be reviewed
11. isu	prel				4CEO. This protocol will	be reviewed
*			((2.)		and updated annually	9 09 770

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Medical Director. Protocol description of the Pignant of the Pigna

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING TNPL53547 05/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 632: Continued From page 5 A 632 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: 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. PPGMR mil clevelopa protocol specifying the required emergency cout drugs and why we excluded Digoxin. This protocol will be review A 633 1200-8-10-.06 (1)(p)12. Basic Services A 633 Surgical Services. (p) A crash cart must be available and include at protocol will be reviewed by the Medical Director a minimum the following medication and supplies: 12. lanoxin (digoxin) annually by the Medical Director. 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: Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no lanoxin

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Division of Health Care Fac	ilities				FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU	ER/CLIA JMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
	TNPL53547		B. WING_		05/00/0040
NAME OF PROVIDER OR SUPPLIER	1.50	STREET AC	DRESS, CITY	STATE, ZIP CODE	05/28/2013
PLANNED PARENTHOOD GR	EATER MEMPHIS		PLAR AVE S, TN 3810	4	i
PRÉFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
A 633 Continued From pa	ge 6	W.1	A 633		
available.				1	Ť
on 5/28/13 at 1:55	iew in the recovery ro PM the Nurse Practi o lanoxin available fo	tioner	e e e e e e e e e e e e e e e e e e e		i i i i i i i i i i i i i i i i i i i
A 634 1200-8-1006 (1)(p)13. Basic Services	3	A 634	PRGMR WILL develop a pr	otocol specitying
(1) Surgical Service	es.			the required emergencyt	art drugs
(p) A crash cart mu		neluda at		and why we excluded L	asix This
a minimum the follo	wing medication and	supplies:	165	protocol will be reviewed	and approva
13. lasix (furosemid	le)			by the Medical Director	HCEO by
				9/15/13, Mis prolow, 1	ly buthe
This Rule is not me Based on observation determined the facility available on the crass	on and interview, it w ity failed to have lasi	as (PPGMR will develop a protocol will be reviewed by the Medical Director and for updated annual Medical Director	
The findings include	d:				
1. Observations of to 5/28/13 at 1:40 PM in available.	the crash cart contenter revealed there was n			U	
2. During an intervie on 5/28/13 at 1:55 F verified there was no emergency use.	PM the Nurse Practiti				
A 635 1200-8-1006 (1)(p)	14. Basic Services		A 635	PPGMR will develop a prot the required crash cart dr excluded iidocaino. This pr reviewed and approved by t	ocol specitying
1. Surgical Service	es.			the required crash curt and	otocol will be
(p) A crash cart mus	st be available and in	clude at		reviewed and approved by	no Medical

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING TNPL53547 05/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) and CEO by 9/15/13. The Medical Director will review and for update A 635 Continued From page 7 A 635 a minimum the following medication and supplies: annually 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. PPGMR. WILL develop a protocol specificing
the required crash cart drugs and
why we excluded Magnesium Sulfate
This protocol will be reviewed and
approved by the Medical Director +
CED. This protocol will be reviewed
and for updated annually by the
Medical Director. A 636 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 The protocol will be complete determined the facility failed to have magnesium sulfate available on the crash cart. 9/15/13. The findings included:

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: TNPL53547 B. WING. 05/28/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2430 POPLAR AVE PLANNED PARENTHOOD GREATER MEMPHIS MEMPHIS, TN 38104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) A 636 Continued From page 8 A 636 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. EPENME will develop a protocol specifying the required crash cart drugs and why we excluded Pronestyl. The protocol will be reviewed and approved by the CED a Medical Director by 9/15/13. This protocol will be reviewed and lor updated annually by the Medical Director. A 638° 1200-8-10-,06 (1)(p)17. Basic Services A 638 Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 17. pronestyl (procainalmide) This Rule is not met as evidenced by: Director. Based on observation and interview, it was determined the facility failed to have pronestyl available on the crash cart. The findings included: 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 639 1200-8-10-.06 (1)(p)18. Basic Services A 639

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		TNPL53547		B. WING_		05/28/2013
NAME OF D	ROVIDER OR SUPPLIER	1111 233347	STREET AD		STATE, ZIP CODE	U3/20/2013
	D PARENTHOOD GR	EATER MEMPHIS	2430 POP			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
A 639	Continued From pa	ge 9		A 639		3 S S
	(1) Surgical Service	es.				55 E
35.	(p) A crash cart mu a minimum the follo				a in a andronale is in	the emergency
# **	18. sodium bicarbo	nate 50 mEq/50ml	;		Sodium Bicarbonate is in crash card currently @	PPGMR.
!	This Rule is not me Based on observation determined the facilo bicarbonate availab	on and interview, it w lity failed to have so				le le
	The findings include	ed:				
: : : : : : : : : : : : : : : : : : :	1. Observations of 5/28/13 at 1:40 PM bicarbonate availab	revealed there was r				
	2. During an intervi on 5/28/13 at 1:55 verified there was n	PM the Nurse Practit	tioner			
	available for emerge		:			
A 640	1200-8-1006 (1)(p)19. Basic Services		A 640	ppenne will developa pri	Hocol specifying
	(1) Surgical Service	es.			We exalled Solu-med	rol. The
	(p) A crash cart mu a minimum the follo	wing medication and			ppenne will develope pre- the required crash cart dr we excluded solu-med protocol mill be reviewed a by the CEO. This protoc reviewed and for upclas by the Medical Director	and approved
	19. solu-medrol (me	ethylprednisolone)			reviewed and for upclas	rea arenawy
	ereta Data ta da	**************************************		e .	by the Medical Director	· 8,5
	This Rule is not me Based on observational the facilities				Δ	merican

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•	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		TNPL53547		B. WING	A - 1111	05/28/2013
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	
PLANNE	D PARENTHOOD GR	EATER MEMPHIS		PLAR AVE 5, TN 38104		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE COMPLETE
A 640	Continued From pa	age 10		A 640		
	available on the cra	ash cart.		6 5		8
	The findings include	ed:				
		f the crash cart conte i revealed there was ole.		¥:		
	on 5/28/13 at 1:55	riew in the recovery report the Nurse Pract no solu-medrol availa	itioner	27 27 28 28 28 28		la an I smai Suisan
A 641	1200-8-1006 (1)(p	o)20. Basic Services		A 641	PPGMR Will develop a pro	Inigs and who
	(1) Surgical Service	ces.			we excluded Verapamil	Hydrochloride.
	(p) A crash cart magain a minimum the follow	ust be available and owing medication an	include at d supplies:		PPGMR will develop a pro the required crash eart a we excluded verapamil The protocol will be revie updated annually by	the Medical
	20. verapamil hydr	ochloride			Director.	
				# *		ä
	Based on observat determined the fac	et as evidenced by: tion and interview, it v tility failed to have ve lable on the crash ca	rapamil			
	The findings includ	led:				
		f the crash cart conte I revealed there was Ioride available.		e a	*	SS
	on 5/28/13 at 1:55	view in the recovery in the Nurse Prac	titioner	740 34		500
	available for emerg	no verapamil hydroc gency use.	moriae			<u>Americans</u>
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Division of Health Care Facilities STATE FORM

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United for Life

PRINTED: 05/31/2013 **FORM APPROVED**

Division of Health Care Facilities									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED				
	TNPL53547	TNPL53547			05/28/2013				
NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	**************************************				
PLANNED PARENTHOOD GR	2430 POPLAR AVE MEMPHIS, TN 38104								
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLII AND PLAN OF CORRECTION IDENTIFICATION NL			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - MEMPHIS REGIONAL PLANNED PARENTHOOD		(X3) DATE SURVEY COMPLETED			
TNPL53547			B. WING			05/28/2013		
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE, ZIP CODE				
PLANNED	PARENTHOOD GREAT	ER MEMPHIS REGI(2430 POPL MEMPHIS,					
(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		
	was found to be in co Safety Code requirem	as evidenced by: rvey on 5/28/13, this fa mpliance with the Life nents of the Tennessee , Board for Licensing F	e	A 002	6			
						Ame	rican	
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Division of Health Care Facilities RECEIVED (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING MAN 0 6 2012 B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) A 614 1200-8-10-.06 (1)(n) Basic Services 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: 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. PPMET will develop a protocod A 626 1200-8-10-.06 (1)(p)5. Basic Services A 626 specifying the required omergency cart drup and why we exclude Calcium (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 will be reviewed and approve by the Medical Director and This Rule is not met as evidenced by: Based on observation and interview, it was Division of Health Care Es LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5)PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY protocol will be reviewed A 626 Continued From page 1 A 626 determined the facility failed to have calcium chloride available on the crash cart. The findings included: 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 627 A 627 1200-8-10-.06 (1)(p)6. Basic Services PPMET will develop a protocol Openfying the required Divergency Cost drugs and why we exclude (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: This protocol will be reviewed dextrose, 50% and approved by the Medical Director and the CEO by Jeal, This Rule is not met as evidenced by: 2012. This protocol will be Based on observation and interview, it was terioused and up dated annually by the Medical Director. 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. 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.

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED (DENTIFICATION NUMBER: A. BUILDING B. WING TNPL53515 11/08/2011 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) PPMET will develop a protocol A 628 1200-8-10-.06 (1)(p)7. Basic Services A 628 (1) Surgical Services. (p) A crash cart must be available and include at this protocol will be reviewed a minimum the following medication and supplies: and approved by the Medical Drector and the OEO by Jen 1, 2012 This protocal will be reviewed and updated 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 annually by the Hedical 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. PPMET vi U develop a protuct A 629 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: This protocol will be revioued and approved by the medical Director and the CEO by Jan 2012. This protocol will be dopamine This Rule is not met as evidenced by: Based on observation and interview, it was

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determined the facility failed to have dopamine

available on the crash cart.

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) pledied Director. A 629 Continued From page 3 A 629 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. PPMET will develop a protocol A 630 1200-8-10-.06 (1)(p)9. Basic Services A 630 Aprilying the required over your cont drugs and wby we exclude heparin-Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: This protocol will be reviewed and approved by the Medical Director and the CEO by Gent, 2012. This protocol will be reviewed and updated animally by the Medical Director. 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.

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) A 631 Continued From page 4 A 631 PPMET will develop a protocol A 631 1200-8-10-.06 (1)(p)10. Basic Services A 631 specifying the regimed everyone cost drugs and why we spelled Surgical Services. (p) A crash cart must be available and include at This protocol will be reviewed and approved by the medical Director and the CEO by gel, a minimum the following medication and supplies: 10. inderal (proprandolol) 2012 This protocol will be reviewed and updated an molly by the medical Director, 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: 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. PPMIET will develop a protocol specifying the required amorgang cont drug and why we exclude is uprel. A 632 A 632 1200-8-10-.06 (1)(p)11. Basic Services Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: This protocol will be revocally by the Medical Director and the

Division of Health Care Facilities

11. isuprel

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER; COMPLETED A. BUILDING B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 632 Continued From page 5 A 632 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. PPMET will develop a protocol A 633 1200-8-10-.06 (1)(p)12, Basic Services A 633 specifying the required amorgany Cost draws conductive endade Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: This protect will be reviewed and updated approved by the medical Director and QEO by Gen 1, 2012. This protocol will be reviewed and updated and updated armostly by the Medical 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 Director. available on the crash cart. The findings included: 1. Observations of the crash cart contents in the

Division of Health Care Facilities

recovery area on 11/8/11 at 2:40 PM revealed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

TNPL53515

NAME OF PROVIDER OR SUPPLIER

PLANNED PARENTHOOD OF MIDDLE AND EA

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

412 D. B. TODD BOULEVARD

NASHVILLE, TN 37203

PLANNE	D PARENTHOOD OF MIDDLE AND EA	•	TODD BOU LE, TN 3720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA	=ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETE DATE
A 633	Continued From page 6 there was no lanoxin available. 2. During an interview in the recovery ro on 11/8/11 at 2:45 PM the Nurse Practitic verified there was no lanoxin available for emergency use.	oner	A 633		
A 634	1200-8-1006 (1)(p)13. Basic Services (1) Surgical Services. (p) A crash cart must be available and ir a minimum the following medication and 13. lasix (furosemide) This Rule is not met as evidenced by: Based on observation and interview, it we determined the facility failed to have lasis available on the crash cart.	supplies: as	A 634	specifying the required somergency cost draps and why we exclude lasix. This protect will be reviewed approved by the Medial Director and the CEO by feel, 2012. This protocol will be reviewed and excluded armiably by the Medial Director.	
A 636	The findings included: 1. Observations of the crash cart content recovery area on 11/8/11 at 2:40 PM revet there was no lasix available. 2. During an interview in the recovery roon 11/8/11 at 2:45 PM the Nurse Practition verified there was no lasix available for emergency use. 1200-8-1006 (1)(p)15. Basic Services	ealed om area	A 636	PPMET will develop a protect	
	 Surgical Services. A crash cart must be available and in 	iclude at		specifying the required amorgency of Oast drup and why we exclude American	car

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) magnesium sulfate 50%. A 636 Continued From page 7 A 636 This protocol will be reviewed and approved by the nutral Director and the CEO by Jewl, 2017. This protocod will be a minimum the following medication and supplies: 15. magnesium sulfate 50% seviewed and appealed annually by the needical 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. 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. PPMET will develop a protocol A 638 1200-8-10-.06 (1)(p)17. Basic Services A 638 specifying the required omer gency cert drugs and why we exclude pronestyl. (1) Surgical Services. (p) A crash cart must be available and include at This protect will be reviewed and a minimum the following medication and supplies: approved by the Iredial Director and the CEO by Jen 1, 2012 17. pronestyl (procainalmide) This protocol will be reviewed and updated annually has the intedical Director-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.

Division of Health Care Facilities

The findings included:

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	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		TNPL53515		B. WING	Average 1	11/0	8/2011
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY,	STATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
A 638	Continued From pa	ge 8		A 638			
	recovery area on 11 there was no prones 2. During an intervion 11/8/11 at 2:45 F	the crash cart conte 1/8/11 at 2:40 PM re- styl available. ew in the recovery re PM the Nurse Practit o pronestyl available	vealed com area ioner				
A 639	1200-8-1006 (1)(p (1) Surgical Service	•	2	A 639	PPMET will devalope	nor gener	
	(p) A crash cart mu	ist be available and i wing medication and			OPMET will developed Appecifying the reguired of Cent drap and why we sodium bicar bounds 50 Jhis protocol will be to cend approved by the I Director and the CEO I ZOLZ. This protocol will reviewed and appeared of appeared	e sechide o meg/som/ viewed nedical on Jen/	e.
	determined the facil	et as evidenced by: on and interview, it w lity failed to have soo q/50ml on the crash	tium		2012. This protocol wi reviewed and applicated	ll be enoughly	
	The findings include	ed:					
	recovery area on 11	the crash cart conte 1/8/11 at 2:40 PM rev n bicarbonate 50 mB	/ealed				
	on 11/8/11 at 2:45 F verified there was n	ew in the recovery re PM the Nurse Practit o sodium bicarbonat for emergency use.	ioner te 50			S	S
	nolth Cara Excilition	a fragisti				Ame	rican

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) A 641 Continued From page 9 A 641 PPMET will develop a protocol A 641 1200-8-10-.06 (1)(p)20. Basic Services A 641 specifying the regured emergeny cent drugs and why we exclude varapamil hydrochloride (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 20. verapamil hydrochloride This protocol will be reviewed and approved by the Medical Director and the CEO by gent 2012. This protocol will be 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. reviewed and updated annually by the Medical 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. PPMET will document the A 672 A 672 1200-8-10-.06 (3)(c) Basic Services Anual Reviews Congleted by (3) Medical Staff. the medical Director. These (c) Clinical privileges shall be granted based on reviews will be maintained the in each physicians personal fle.
PPINET will be a themen the practitioners ' qualifications and the services provided by the facility, and shall be reviewed

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and/or revised at least every two (2) years.

This Rule is not met as evidenced by:

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SL COMPLE	
		TNPL53515		B. WING_		11/08	3/2011
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STATE, ZIP CODE				
			TODD BOULEVARD LE, TN 37203				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEMENTY)	ULD BE	(X5) COMPLETE DATE
A 672	interview, it was def maintain current pri (Physician #2, 3, 4, The findings include 1. Review of a one credentialling inform #2 had no current E (DEA) number, no current background 2. Review of a one credentialling inform #3 had no current E background check. 3. Review of a one credentialling inform #4 had no current E background check. 4. Review of a one credentialling inform #5 had no current E privileges, and no current E privileges.	physician information termined the facility for vilege information for and 5) physicians or ed: page document that nation documented Forug Enforcement Agourrent privileges, and termined privileges.	ailed to r 4 of 5 r 4 of 5 r staff. c listed Physician pency rent current c listed Physician current clisted Chysician current clisted Chysician current current current current clisted current current clisted clisted current clisted clisted current clisted clisted current clisted clisted current clisted		review, and audit all employer files to answer proper documents to the proper declar will be considered by audit of the box Jun 1, 2012. It he died Director for each physicians of Completed by Jon 1, Beckground check lack physician At be completed by Jon 1,	is Annual bucked. Lucked. Copies review 11/be 2012.	
A1101	1200-8-1011 (1) F			A1101	In 2008. Janie D with TDH, informed	lbort,	(N)
Stateles of C	(1) The Joint Annua	al Report of Ambulate	ory		with TDH, informed	AIIIE	ICall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TNPL53515 11/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A1101 Continued From page 11 A1101 Surgical Treatment Centers shall be filed with the rvisor, Loselle Mothers 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 RECEIVED JAN 0 6 2012

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** 02 - STATE BUILDING A. BUILDING 8. WING 11/09/2011 TNPL53515 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 412 D. B. TODD BOULEVARD PLANNED PARENTHOOD OF MIDDLE AND EA NASHVILLE, TN 37203 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) A 802 1200-8-10-.08 (2) Building Standards A 802 PPMET has corrected
the penetration within
the lift side wall of the
supply room. The (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 addition, the Assit Dir. Director's office revealed there was a 3" by 4" cut-out penetration within the sheetrock wall. or her designer, will 2. On 11/9/11 at 10:00 AM, observation within the monitorand document supply storage revealed a penetration within the somes with the brilling left-side wall. These findings were acknowledged and verified by the Assistant Director during the exit interview on 11/9/11. A 901 A 901 1200-8-10-.09 (1) Life Safety PPMET has corrected 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

Division of Health Care Facilities

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

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

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with the building

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 02 - STATE BUILDING B. WING

(X3) DATE SURVEY COMPLETED

11/09/2011

TNPL53515

STREET ADDRESS, CITY, STATE, ZIP CODE

412 D. B. TODD BOULEVARD

PLANNED PARENTHOOD OF MIDDLE AND EA	NASH
	14001

PLANNE			E, TN 3720		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION	ILL ON)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
A 901	Continued From page 1	1	A 901		
	facility failed to maintain the electrical system	em.	м		
	The findings include:			97	
	On 11/9/11 at 9:45 AM, observation within consulting room revealed an electric out behind the entry door without a cover plate	utlet			
	This finding was acknowledged and verifie the Assistant Director during the exit interv 11/9/11.	ed by riew on			
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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU	ER/CLIA JMBER:	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED
		TNPL53547		B. WING		_	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		03/0	1/2010
	D PARENTHOOD GR		1407 UNIO MEMPHIS		3RD FLOOR		
(X4) ID PREFIX TAG	CAUH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	P-1 44 A	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLE DATE
A 002	1200-8-10 No Defic	iencies		A 002		·/	
	This Rule is me This facility complies reviewed for Ambula Centers surveyed du survey conducted 3/ cited.	s with all requirement atory Surgical Treatn uring the appual lices	nent				
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on of Harlin	Care Sa III					Ame	icai
	Care Facilities	SUPPLIER REPRESENTAT	IN/FIG GIGNATI	ipr	TITLE	Uni	te
FORM		OLL NEI REGENTA	6899	JRE XOTP		If on thurstion	Lif

03/04/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MERTALE ®NETRUCTION A. BUILDING

01 - MEMPHIS REGIONAL PLA

(X3) DATE SURVEY COMPLETED

TNPL53547

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

PLANNE	ED PARENTHOOD GREATER MEMPHIS	1407 UNI MEMPHIS	ON AVENUE S, TN 38104	E 3RD FLOOR	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	PT II I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	1200-8-1008 (1) Building Standards (1) The Ambulatory Surgical Treatment of must be constructed, arranged, and mainto ensure the safety of the patient. This Rule is not met as evidenced by: Based on observations, it was determine facility failed to maintain the Ambulatory Treatment Center in a manner that would the safety of the patients. The findings included: Observations during the facility tour on 3-beginning at 9:00 AM, the following deficitiver found: 1. The exit light was inoperative in the Administration hall rear. 2. The emergency light in exam room for the emergency generator testing report on site for review.	ntained of the Surgical densure 4-10 encies	2.) 3.)	Spoke with building management Dave Disney, and this has been corrected on 3/9/10 The exam room emerger light was repaired by Mid South Emergency Lights on 3/9/10. I have attached the e-mail from the building manager, Dave Disney, in regards to the generator. We do not have a tenative completion clate. To assure that the deficient practice does not recur, we will continue to notify building management in a time as his mand we will continue to do our routine clinic inspections which includes is a line observations of the lited observations.	3)9/10

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