April 8, 2010

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

Dear Ms. Jones,

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

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

Sincerely,

[Signature]

Jeff Teague
President/CEO
April 8, 2010

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Department of Health
Bureau of Health Licensure and Regulation
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[Signature]

Jeff Teague
President/CEO
TENNESSEE DEPARTMENT OF HEALTH
FEE RENEWAL INVOICE

AMBULATORY SURGICAL TREATMENT CENTER
Online Renewal Now Available At www.tennesseecanytime.org/hlsr

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

License No: 00000015 License Status: LICENSED
Expiration Date: 06/30/2010
Transaction No. 000002527
Telephone No. 615-345-0952

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

Facility Location Address:

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

Amount Due: $1,080.00

In making this application, I certify that the statements given in this application are true and correct and that I have complied with all renewal requirements set forth in the Tennessee Code Annotated 09-11-205, sequential and the rules and regulations of the State of Tennessee for this type of facility.

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

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

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

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

Total Amount Due: $1,080.00

3430540010000600000000000001505350000002527000010800000000000001100000
A desk review for the Plan of Correction (POC) was conducted for all previous deficiencies cited on 8/27/19. All deficiencies have been corrected and no new noncompliance was found. The facility is in compliance with all regulations surveyed.
A 001 1200-8-10 Initial

This Rule is not met as evidenced by:
Construction Type: II (111)
Stories: 1
Completed: 1950's (no drawings available)
Sprinkler: 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
During this life safety survey, this facility was
found in substantial compliance with the
requirements for participation in
Medicare/Medicaid with chapter 1200-08-10,
Standards for Ambulatory Surgical Treatment
Centers, Life Safety from Fire, and the related
National Fire Protection Association (NFPA)
standard 101-2012.

A 002 1200-8-10 No Deficiencies

During the Life Safety portion of the annual
Licensure survey conducted on 8/27/2018, no
deficiencies were cited under 1200-08-10,
Standards for Ambulatory Surgical Treatment
Centers.
<table>
<thead>
<tr>
<th>A 001. 1200-8-10 Initial</th>
<th>A 001</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Rule is not met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>An annual Licensure survey was conducted on</td>
<td></td>
</tr>
<tr>
<td>3/4/19 - 3/5/19 at Knoxville Center for</td>
<td></td>
</tr>
<tr>
<td>Reproductive Health. The facility found to not</td>
<td></td>
</tr>
<tr>
<td>be in substantial compliance with Chapter</td>
<td></td>
</tr>
<tr>
<td>1200-8-10, Standards for Ambulatory Surgery</td>
<td></td>
</tr>
<tr>
<td>Treatment Centers.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A 425: 1200-8-10-04(20)(b) Administration</th>
<th>A 425</th>
</tr>
</thead>
<tbody>
<tr>
<td>(20) Infection Control.</td>
<td></td>
</tr>
<tr>
<td>(b) The physical environment of the ambulatory</td>
<td></td>
</tr>
<tr>
<td>surgical treatment center shall be maintained in a</td>
<td></td>
</tr>
<tr>
<td>safe, clean and sanitary manner.</td>
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</tbody>
</table>

| Syringes shall be properly identified with | 3/18/19 |
| pre-printed medication labels and will include | |
| the required information. | |
| The nursing supervisor will be responsible for | |
| monitoring this practice to ensure all syringes | |
| are properly identified and prepared in accordance | |
| with the standard to ensure compliance. | |
| All staff responsible for handling and preparing | |
| the syringes have been trained and educated in the practice noted above. | |

This Rule is not met as evidenced by: Based on review of review of review of the Association of Professionals in Infection Control and Epidemiology (APIC) guidelines, observation, and interview, the facility failed to ensure pre-filled syringes were properly labeled for 8 of 8 syringes in 1 of 1 pre-procedure work areas observed.

The findings included:

Review of APIC guidelines, "Safe Injection, Infusion, and Medication Vial Practices in Healthcare," dated 2016, revealed "...draw up medication into a syringe as close to administration time as feasible. Inject with 1 hour...after drawing up the medication...label all syringes containing medication if not immediately administered. Include patient identification information, names and amounts of all
### Division of Health Care Facilities

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**POC #2**

<table>
<thead>
<tr>
<th>X1 (ID)</th>
<th>PROVIDER/SUPPLIER CLA IDENTIFICATION NUMBER</th>
<th>X2 (MULTIPLE CONSTRUCTION)</th>
<th>X3 (DATE SURVEY COMPLETED)</th>
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<tbody>
<tr>
<td>TNPL53526</td>
<td>A, BUILDING</td>
<td>B, WING</td>
<td>08/27/2019</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1547 WEST CLINCH AVENUE
KNOXVILLE, TN 37916

**X4 (ID PREFIX).Tag**

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<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A 001</td>
<td>1200-8-10 Initial</td>
<td></td>
</tr>
<tr>
<td>A 001</td>
<td>425</td>
<td></td>
</tr>
</tbody>
</table>

This Rule is not met as evidenced by:

A Licensure survey was conducted on 8/26/19 - 8/27/19 at Knoxville Center for Reproductive Health. The facility was found to not be in substantial compliance with Chapter 1200-8-10, Standards for Ambulatory Surgery Treatment Centers.

**A 425**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200-8-10-04(20)(b) Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(20) Infection Control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) The physical environment of the ambulatory surgical treatment center shall be maintained in a safe, clean and sanitary manner.</td>
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</tbody>
</table>

This Rule is not met as evidenced by:

Based on review of facility policy, review of the Centers for Disease Control and Prevention (CDC) Guidelines, review of the Association of Per-Operative Registered Nurses (AORN) Guidelines, observation, and interview, the facility failed to maintain sterile technique during 1 of 1 observations made and failed to ensure an opened multi-dose vial of medication was dated, timed, and initialed in 1 (pre-operative prep area) of 9 patient care areas observed.

The findings include:

Review of the facility policy "Medication Administration Policy" dated [redacted] revealed "...All multi-dose vial medications must be labeled with date opened and RN [Registered Nurse] initials. These medications expire 28 days after initially...

---

**Division of Health Care Facilities**

LABORATORY DIRECTOR’S UNKNOMW/SUPPLIER REPRESENTATIVE’S SIGNATURE

**STATE FORM**

Kim Demerson

**COMMENTS**

Administrative

**Americans United for Life**

SEP 20 2019
<table>
<thead>
<tr>
<th>ID</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
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</thead>
<tbody>
<tr>
<td>A 425</td>
<td>Continued From page 1</td>
</tr>
</tbody>
</table>

Review of CDC guidelines for "Injection Safety" dated 6/20/19 revealed "...If a multi-dose has been opened or accessed (e.g., [for example] needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial..."

Review of AORN "Guidelines for Perioperative Practice" dated 2016, revealed "...Items introduced to the sterile field should be opened, dispensed, and transferred by methods that maintain the sterility and integrity of the item and the sterile field. Sterile items that are not opened, dispensed, and transferred by methods that maintain sterility and integrity may contaminate the sterile field..."

Observation and interview with Surgical Assistant (SA) #1 on 8/26/19 at 1:00 PM, in treatment room #1, revealed SA #1 was setting up the procedure room for a patient procedure. Continued observation revealed a covered sterile stainless steel tray was sitting on a table. Further observation revealed SA #2 removed the cover from the stainless steel tray, which contained sterile surgical instruments and then retrieved a packaged sterile instrument from the countertop, opened the sterile package, and dropped the sterile instrument into the stainless steel tray with the other surgical instruments. Continued observation revealed the SA then touched the sterile surgical instruments that were located inside the stainless steel tray with the outside of the instrument packaging. Interview with SA #1 confirmed the SA was not aware the instrument packaging had touched the sterile surgical...
A 425: Continued From page 2

Interview with the Co-Administrator/Nurse Practitioner #1 on 8/25/19 at 1:15 PM, in the recovery room, confirmed staff were expected to maintain sterile technique when setting up for a surgical procedure.

Observation and interview with the Co-Administrator/Nurse Practitioner #1 on 8/25/19 at 1:20 PM, of a pre-operative prep area outside the procedure rooms, revealed 1 opened undated 50 milliliter multi-dose vial of 1% Lidocaine (numbing medicine). Interview with the Co-Administrator/Nurse Practitioner #1 confirmed the Lidocaine was opened and undated. Continued interview confirmed the facility failed to follow facility policy.

A 436: 1200-8-10-04 (20)(c)6. Administration

(20) Infection Control.

(c) The chief executive officer or administrator shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develops guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the committee shall include the establishment of:

6. A method of control used in relation to the sterilization of supplies and water, and a written policy addressing reprocessing of sterile supplies.

Education regarding sterile technique and sterilization procedures will be provided 9/28/19. The nursing supervisor, infection control officer will be responsible for the training.

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

The facility's goal for sustaining compliance is to strive for a culture of safety by providing continued education and training, monitoring written procedures and practices and evaluating and revising infection control policies as needed.
This Rule is not met as evidenced by:

Based on review of a manufacturer's manual, review of a facility sterilization log book, review of the facility's procedure log book, observation, and interview, the facility failed to maintain a complete sterilization log book and failed to document the reading of a biological indicator (used to demonstrate whether conditions during a steam cycle were adequate to achieve a defined level of microorganism inactivation) for 1 of 1 autoclaves (used for steam sterilization).

The findings include:

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

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

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

Observation and interview with Sterilization Technician #1 on 8/26/19 at 1:30 PM, of the sterilization log book in the Sterilization Room,
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>436</td>
<td></td>
<td>Continued From page 4</td>
<td>436</td>
<td></td>
<td>The technician states 9/30/19</td>
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<td></td>
<td></td>
<td>confirmed surgical procedures were done on</td>
<td></td>
<td></td>
<td>she provided the biological indicator log</td>
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<td></td>
<td></td>
<td>[redacted] and [redacted] Further interview confirmed</td>
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<td>but failed to provide</td>
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<td></td>
<td></td>
<td>the log book was incomplete and there was no documentation in the sterilization log book to indicate biological testing was performed.</td>
<td>436</td>
<td></td>
<td>with the &quot;Sterilization Maintenance Log&quot; This log provides documentation of mechanical and chemical indicators and is completed each procedure day. A copy of the log is attached.</td>
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<td></td>
<td>The nursing Supervisor / infection control officer will review the logs weekly to confirm procedures are being performed and results are documented as indicated. A copy of the weekly infection control monitoring sheet is attached.</td>
</tr>
</tbody>
</table>
September 20, 2019
Provider #TNPL5352G

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 MDVs 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.
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.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>TNPL53526</td>
<td>A. BUILDING: 01 - MAIN</td>
<td>03/04/2019</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
<td></td>
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</table>

**NAME OF PROVIDER OR SUPPLIER**
KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1547 WEST CLINCH AVENUE
KNOXVILLE, TN 37916

---

### A 002 1200-8-10 No Deficiencies

During the Life Safety portion of the annual Licensure survey conducted on 3/4/19, no deficiencies were cited under 1200-8-10 Ambulatory Surgical Treatment Centers.
A 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.

Each procedure day during the next 30 days the nursing supervisor shall observe the newly established practice to confirm compliance.
A desk review was conducted on 8/1/18 for all previous deficiencies cited on 6/19/18. All deficiencies have been corrected and no new compliance was found. The facility is in compliance with all regulations surveyed.
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.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 001</td>
<td>1200-8-10 Initial</td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 425</td>
<td>1200-8-10-04(20)(b) Administration</td>
<td>(20) Infection Control. (b) The physical environment of the ambulatory surgical treatment center shall be maintained in a safe, clean and sanitary manner.</td>
<td></td>
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</tbody>
</table>

This Rule is not met as evidenced by: Based on review of the Centers for Disease Control (CDC) Injection Safety guidelines, observation, and interview, the facility failed to maintain a sanitary environment in 2 of 2 procedure rooms and in 1 of 1 sterilization rooms observed. The findings included: Review of the CDC guidelines for "Injection Safety" updated on 8/16/16 revealed "Multi-dose vials should be dedicated to a single patient whenever possible. If multi-dose vials must be used for more than one patient, they should only be kept and accessed in a dedicated medication preparation area (e.g., nurses station), away from immediate patient treatment areas. This is to prevent inadvertent...
A 425  Continued From page 1

contamination of the vial through direct or indirect contact with potentially contaminated surfaces or equipment that could then lead to infections in subsequent patients. If a multi-dose vial enters an immediate patient treatment area, it should be dedicated for single-patient use only. If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated...

Observation on 6/18/18 at 11:17 AM, in Procedure Room revealed:
1. One opened 50 milliliter (ml) multi-dose vial of 1% Lidocaine (numbing medicine)
2. Two unopened 50 ml multi-dose vials of 1% Lidocaine
3. An uncovered stainless steel bowl of betadine solution (surgical scrub)

Interview with Surgery Assistant #1, on 6/18/18 at 11:25 AM, in Procedure Room confirmed the betadine solution and the Lidocaine were used on multiple patients.

Observation on 6/18/18 at 12:15 PM, in Procedure Room revealed:
1. One opened 50 ml multi-dose vial of 1% Lidocaine
2. One unopened 50 ml multi-dose vial of 1% Lidocaine
3. An uncovered stainless steel bowl of betadine solution

Interview with Surgery Assistant #2, with the Director of Nursing (DON) present, on 6/18/18 at 12:20 PM, in Procedure Room confirmed the betadine solution and the Lidocaine were used on multiple patients.

Observation and interview with Family Nurse Practitioner (FNP) #1 on 6/18/18 at 2:00 PM, in the sterilization room, revealed 1 opened undated 50 ml multi-dose vial of 1% Lidocaine. Interview
A 425 Continued from page 2

with FNP #1 confirmed the Lidocaine was opened, and undated and opened vials of medication were to be dated when opened. Further interview confirmed the multi-dose vials of Lidocaine were placed in the procedure rooms each day, remained in the procedure room throughout all surgical procedures, and were used on multiple patients. Continued interview confirmed the lidocaine solution was poured into the bowl prior to the first procedure of the day and was used on multiple patients throughout the day.

Observation and interview with the Administrator on 6/18/18 at 2:30 PM, of Procedure Room revealed eight 11 millimeter (mm) Disposable Rigid Curettes (instrument used to remove material from the uterus) with an expiration date of 5/2018. Interview with the Administrator confirmed the curettes were expired and were available for patient use.

During the monthly inspection, curettes found with an expiration for the following month shall be passed separately from the others. If not used within the month, they will be discarded. The nursing supervisor shall be responsible for monitoring the monthly inspection log to ensure compliance.
| ID | TAG | SUMMARY STATEMENT OF DEFICIENCIES
|----|-----|----------------------------------------------------------------------------------|
| A424 | 1200-8-10-04 (20)(a) Administration
   (20) Infection Control.
   (a) The ASTC must provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure expired supplies were not available for patient use in 2 of 2 procedure rooms, in 1 of 1 labs, and in 1 of 1 emergency carts observed.

The findings included:
Observation and interview with the Administrator on 11/28/17 at 3:30 PM, in Procedure Room 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 expiration date of 10/2016. Interview with the...
<table>
<thead>
<tr>
<th>A 424</th>
<th>Continued From page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Administrator confirmed the hand sanitizer was expired and the facility failed to ensure expired supplies were not available for use.</td>
</tr>
<tr>
<td></td>
<td>Observation and interview with the Advance Practice Nurse (APN) on 11/29/17 at 10:20 AM, of the Emergency Cart in the Recovery Room, revealed 6 pairs of sterile latex surgical gloves with an expiration date of 9/2017. Interview with the APN confirmed the gloves were expired and the facility failed to ensure expired supplies were not available for patient use.</td>
</tr>
<tr>
<td></td>
<td>Observation and interview with the APN on 11/29/17 at 10:50 AM, in the lab, revealed seven 4 mm purple top blood specimen tubes with an expiration date of 10/31/17. Interview with the APN confirmed the blood specimen tubes were expired and the facility failed to ensure expired supplies were not available for patient use.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A 680</th>
<th>1200-08-10-.06 (12)(a) Basic Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(12) Medical Records.</td>
</tr>
<tr>
<td></td>
<td>(a) The ASTC shall comply with the Medical Records Act of 1974, T.C.A. § 68-11-301, et seq.</td>
</tr>
</tbody>
</table>

An inquiry has been made with the Office of Vital Records to determine if the report in question was received or if we inadvertently failed to submit it. It was discussed with the surveyor that making a copy may have been overlooked or misplaced. At the request of the Office of Vital Records, a second report was prepared to compare against their records. We are awaiting their findings.
A 680
Continued From page 2
records reviewed.

The findings included:

Review of the State of Tennessee Laws, Title 68
Chapter 3, Vital Records Part 5 Deaths
(68-3-505) Reports of Abortion (termination of
pregnancy) dated 2015 and last updated on
1/7/16 revealed "... Each induced termination of
pregnancy that occurs in this state shall be
reported to the office of vital records within ten
(10) days after the procedure by the person in
charge of the institution in which the induced
termination of pregnancy was performed..."

Medical record review revealed Patient #5 was
admitted to the facility on [redacted] for an abortion.
Further review revealed the patient was
discharged home the same day. Continued
medical record review revealed a Tennessee
Department of Health, Report of Induced
Termination of Pregnancy was not in the medical
record.

Interview with the Administrator on 11/28/17 at
2:40 PM, in the employee lounge, confirmed the
facility failed to report the abortion to the State of
Tennessee as required by state law.
Division of Health Care Facilities

<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
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<tr>
<td>(X) PROVIDER/SUPPLIER/CLIA</td>
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<td>(X) DATE SURVEY COMPLETED</td>
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<tr>
<td>NUMBER: 001</td>
<td>TNL53526</td>
<td>05/09/2017</td>
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<tr>
<td>A. BUILDING:</td>
<td></td>
<td></td>
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<tr>
<td>B. WING:</td>
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NAME OF PROVIDER OR SUPPLIER

KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH

STREET ADDRESS, CITY, STATE, ZIP CODE

1647 WEST CLINCH AVENUE
KNOXVILLE, TN 37916

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<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 001</td>
<td>1200-8-10 Initial</td>
<td>During a Licensure survey completed on 5/8/17 at Knoxville Center for Reproductive Health, no health deficiencies were cited under Chapter 1200-08-10, Standards for Ambulatory Surgical Treatment Centers.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 001</td>
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</tbody>
</table>

Division of Health Care Facilities

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

TITLE

STATE FORM 865-637-1168

PRINTED: 05/10/2017 FORM APPROVED

5000 E 50TH STREET, KANSAS CITY, MO 64111-2629

1-800-392-8858

www.pks.byhhs.mo.gov
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>A824</td>
<td>1200-8-10-.08 (24) Building Standards</td>
<td>A824</td>
</tr>
</tbody>
</table>

(24) The department requires the following alarms that shall be monitored twenty-four (24) hours per day.

(a) Fire alarms;
(b) Generators (if applicable); and
(c) Medical gas alarms (if applicable).

This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to maintain the fire alarm.

The finding includes:

Observation, record review and interview with the laboratory manager on 5/8/17 at 10:00 AM revealed the main fire alarm control panel was yellow tagged by the fire alarm technician, "system has a trouble for phone lines but the phones are good. System needs replaced."

The laboratory manager was present when the deficiency was identified and acknowledged during the exit conference on 5/8/17.

As noted in the findings during the survey on 5/8/17 the fire alarm technician had determined the control panel needed to be replaced. Pending review and approval by the Dept. of Health the panel will be replaced. Quotation and description of equipment is attached.

6/22/17
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:**

TNPL53526

**Multiple Construction**

A. Building: 

B. Wing: 

**Date Survey Completed:**

11/14/2016

**Name of Provider or Supplier:**

KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH

**Street Address, City, State, Zip Code:**

1547 WEST CLINCH AVENUE

KNOXVILLE, TN 37916

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 001</td>
<td>1200-8-10</td>
<td>Initial</td>
<td>A 001</td>
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</tr>
</tbody>
</table>

During a Licensure survey conducted on November 14, 2016, at Knoxville Center for Reproductive Health, no deficiencies were cited under 1200-08-10, Standards for Ambulatory Surgical Treatment Centers.
### Division of Health Care Facilities

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREFIX</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1020</td>
<td></td>
<td><strong>1200-B.10-.10 (6)(b) Infectious and Hazardous Waste</strong></td>
</tr>
</tbody>
</table>
|           |     | (b) Pathological waste must be promptly treated, disposed of, or placed into refrigerated storage. This Rule is not met as evidenced by: Based on observation, review of a facility document, and interview, the facility failed to ensure biological waste temperatures were monitored in one of one freezers. The findings included:  
Observation during the facility tour with the facility administrator on 4/18/16 at 11:30 AM revealed a freezer located in a storage area on the first floor of the facility. Continued observation revealed the freezer contained regulated biological waste.  
Review of a facility document "...Storage Room...Freezer temperatures..." dated April 2016, revealed no documented freezer temperatures for the month of April.  
Interview with the facility administrator on 4/18/16 at 2:05 PM, in the break room, confirmed "...a temperature is to be recorded every procedure day and they failed to do so..." Continued interview confirmed procedure days in April were the 1st, 4th, 8th, 9th, and 11th. |

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

<table>
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<tr>
<th>ID PREFIX</th>
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<tbody>
<tr>
<td>A1020</td>
<td></td>
<td>5/5/16</td>
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</tbody>
</table>

The staff members that are responsible for recording freezer temperatures have been instructed to document temperatures each procedure day. A folder clearly marked and identified as the temperature log adheres to the top of the freezer for ease of use. The medical director will review and sign the log each month to ensure compliance.
**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID** | **DEFICIENCY** | **DESCRIPTION** | **DATE**
--- | --- | --- | ---
A 805 | 1200-8-10-08 (5) Building Standards | (5) No new ASTC shall be constructed, nor shall major alterations be made to an existing ASTC without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ASTC is licensed or before any alteration or expansion of a licensed ASTC can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or an engineer and in accordance with the rules of the Board of Architectural and Engineering Examiners. | 6/216

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 Director.
Division of Health Care Facilities

<table>
<thead>
<tr>
<th>(X1) PROVIDER/ SUPPLIER/CCLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>TNPLS53828</td>
<td>A. BUILDING: 01 - MAIN</td>
<td>04/19/2016</td>
</tr>
<tr>
<td>B. WING</td>
<td></td>
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</tr>
</tbody>
</table>

NAME OF PROVIDER OR SUPPLIER: KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 1547 WEST CLINCH AVENUE, KNOXVILLE, TN 37918

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
</table>
| A 805              | Continued From page 1
Officer on 4/19/2016 at 2:25 PM revealed they were not aware that submittal, review and approval were required for this change. These findings were verified by the Facility Safety Officer and acknowledged by the Administrator during the exit conference on 4/19/2016. | A 805         |                                                                                                        |                   |
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A 002</td>
<td>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.</td>
<td>A 002</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A 817 1200-8-10-.08 (17) Building Standards

(17) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension to the department demonstrating that all applicable codes have been met and the department has granted necessary approval.

(a) Before the ASTC is used, Tennessee Department of Environment and Conservation shall approve the water supply system.

(b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.

(c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to maintain hot water temperatures between 105 - 185 degrees F.

15 The findings include:
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A817</td>
<td>Continued From page 1</td>
<td>Observation and interview with the Administrator, on 10/20/2015 at 1:22 PM confirmed the hot water temperatures in 2 of 2 procedure rooms and the instrument cleaning room ranged between 130 to 134 degrees F. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 10/20/2015.</td>
<td>A817</td>
<td>1200-3-10-08 (n) Bldg. Standards (c) Maintenance was contacted to lower the water heater temperature. Upon completion, the water temperature was tested and measured 110°F.</td>
<td>10/27/15</td>
<td>Annual testing shall be performed to verify the standard range of 105°F - 115°F.</td>
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</table>
KNOXVILLE CENTER FOR REPRODUCTIVE HI

1547 WEST CLINCH AVENUE
KNOXVILLE, TN 37916

A 817 1200-8-10-.08 (17) Building Standards

(17) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension to the department demonstrating that all applicable codes have been met and the department has granted necessary approval.

(a) Before the ASTC is used, Tennessee Department of Environment and Conservation shall approve the water supply system.

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(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 - 115 degrees F.

The findings include:
**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 817</td>
<td>Continued From page 1</td>
</tr>
<tr>
<td></td>
<td>Observation and interview with the Administrator, on 10/20/2015 at 1:22 PM confirmed the hot water temperatures in 2 of 2 procedure rooms and the instrument cleaning room ranged between 130 to 134 degrees F. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on 10/20/2015.</td>
</tr>
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</table>

**Correction Plan**

- **Date:** 10/20/15
- **Description:**
  - Maintenance was contacted to lower the water heater temperature. Upon completion, the water temperature was tested and measured 110°F.
  - **Completion Date:** 10/21/15
  - Annual testing shall be performed to verify the standard range of 105°F - 115°F.
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEGAL IDENTIFYING INFORMATION)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>A001</td>
<td>1200-8-10 Initial</td>
<td>A001</td>
<td>Advance Directive Packets 4/10/12 have been created based on the request of the Physician's Orders for Scope of Treatment related to end of life issues and desires or provided information related to formulation of Advanced Directives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by: On-site completed to investigate complaint # 29091 and conduct licensure survey. Deficiencies were cited for the complaint.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A407</td>
<td>1200-8-10-04 (6) Administration</td>
<td>A407</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>(6) The ambulatory surgical treatment center shall ensure a framework for addressing issues related to care at the end of life.</td>
<td></td>
<td>Strike Directive. All patients will be asked if they have executed advance directives and if they would like to obtain information about advance directives.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>The forms shall be provided as requested. Patients previously notified should be offered the opportunity to obtain information about advance directives and if they would like to obtain information about advance directives upon admission to the facility or when care is initiated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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 or provided information related to formulation of Advanced Directives.</td>
<td></td>
<td>Daily chart review and quarterly chart audit should ensure compliance.</td>
<td></td>
</tr>
<tr>
<td>A424</td>
<td>1200-8-10-04 (20)(a) Administration</td>
<td>A424</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(20) Infection Control</td>
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<tr>
<td></td>
<td>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.</td>
<td></td>
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</tbody>
</table>
(a) The ASTC must provide a sanitary environment to avoid sources and transmission of infectious and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure infection control standards were maintained in the laboratory (lab), exam room, and surgical recovery room.

The findings included:
Observations on February 21, 2012, between 8:50 a.m. and 10:50 a.m., during the facility tour with the Administrator, revealed the following: seventeen vials of various patient’s blood stored in the lab refrigerator containing biological materials utilized for lab testing, medications and insertable birth control devices for patients, and medications for staff vaccinations; sterile forceps were stored in a drawer with paper 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 date listed.

Interview in the counselor’s office with the Administrator on February 21, 2012, at 10:50 a.m., confirmed the lab refrigerator was not to be used to store patient blood samples, medications, or insertable birth control devices intended for patient use; sterile items were to be stored only

<table>
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<tbody>
<tr>
<td>A424</td>
<td>Continued From page 1</td>
<td>To ensure infection control standards are being maintained throughout the facility, blood and biological materials shall be stored separately from all medications. Birth control devices and vaccines only sterile patient care and exam items shall be stored together and expired patient use items shall be discarded. To monitor this practice, refrigerated blood and biological contents shall be verified and documented monthly, as being stored separately and signed shall be noted on the refills and storage areas. Patient care items with an expiration date shall be included in the monthly supply order form and verified. Supplies also reviewed monthly. Staff members shall be informed of acceptable storage practices for clean or sterile patient care items.</td>
</tr>
</tbody>
</table>
A 424

Continued From page 2

with clean or sterile patient care items; and the sutures had expired and were available for patient use

C/O #29091

A 680

1200-8-10-.06 (5) Basic Services

(5) Pharmaceutical Services. The ASTC must provide drugs and biologicals in a safe and effective manner in accordance with accepted standards of practice. Such drugs and biologicals must be stored in a separate room or cabinet which shall be kept locked at all times.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure medications were secured throughout the facility; failed to ensure medications were not stored in areas with items which were not clean in the medication closet; and failed to ensure expired medications were not available for patient use.

The findings included:

Observations made during the facility tour with the Administrator on February 21, 2012, between 3:50 a.m. and 10:50 a.m., revealed the following: unsecured medications (such as birth control pills, vitamins, over the counter analgesics, and prescription antacids) observed in the unlocked medication storage closet, the lobby, the laboratory, exam rooms, storage areas, and the surgical recovery room.

Continued observation revealed the designated medication storage closet contained items such...
Continued From page 3

as an electronic piano keyboard, manuals, files, and various types of dusty office equipment.

Continued observation revealed the following expired medications: a box of birth control pills located in the exam room dated as expired April 2010, four boxes of 5 tabs each located in the medication storage closet dated as expired July 2010; and a bottle of over the counter analgesic located in the surgery recovery room dated as expired November 2011.

Interview in the counselor's office with the Administrator on February 21, 2012, at 10:50 a.m., confirmed the medications in the facility were not secured; the medications were not maintained in an area specifically designated for only medication storage, and various medications throughout the facility had expired and were available for patient use.
<table>
<thead>
<tr>
<th>ID PFX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION)</th>
<th>ID PFX</th>
<th>TAG</th>
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<tbody>
<tr>
<td>A 802</td>
<td>1200-8-10-.08 (2)</td>
<td>(2) The condition of the physical plant and the overall Ambulatory Surgical Treatment Center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure safety equipment was maintained. The findings include: Observation and interview with the lab tech at 11:00 am on February 22, 2012 confirmed the waiting room fire door to the stairwell was missing the center hinge, the label was painted over, and the door failed to close to a positive latch (NFPA 80, 15.2) Observation and interview with the lab tech at 11:40 am on February 22, 2012 confirmed the crawl space 1-1/2 hour rated fire door failed to close to a positive latch and was not self closing. (NFPA 80, 15.2) These findings were acknowledged by the administrator during the exit conference on February 22, 2012.</td>
<td>A 802</td>
<td>1200-8-10-.08(23)</td>
<td>BUILDING STANDARDS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(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.</td>
<td></td>
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</tbody>
</table>
This Rule is not met as evidenced by: based on observation and interview, the facility failed to assure dirty areas had an operable exhaust per the AIA guidelines.

The findings include:
Observation and interview with the lab tech, on February 22, 2012 p.m. at 11:00 a.m. confirmed the soiled utility room and two bathrooms adjacent to the downstairs stairwell were not provided with an operable exhaust. This finding was acknowledged by the Administrator during the exit conference on February 22, 2012.

A negative air pressure should be maintained in the soiled utility room and both restrooms located adjacent to the downstairs stairwell. Each area will have an operable exhaust installed as required.
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>This Rule is met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>The facility demonstrated compliance with the regulations reviewed for health portion of the licensure survey. The facility is in compliance with the Standards for Ambulatory Surgical Treatment Centers.</td>
<td></td>
</tr>
</tbody>
</table>
**This Rule is not met as evidenced by:**

A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 06/03/2019. During this Life Safety Survey, Planned Parenthood was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgical Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).

* All penetrations requiring Fire Stop shall be repaired in accordance with the 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 documented 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 Judgments 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.**

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<tr>
<td>A 001</td>
<td>1200-8-10 Initial</td>
<td>A 001</td>
<td>Abbreviations used: CCO=Chief of Clinical Operations, HCM=Health Center Manager</td>
<td>6/20/19</td>
</tr>
<tr>
<td></td>
<td>* 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 documented 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 Judgments requires state approval.</td>
<td></td>
<td>6/19/19</td>
<td></td>
</tr>
<tr>
<td>A 801</td>
<td>1200-8-10-08 (1) Building Standards</td>
<td>A 801</td>
<td><em>This Rule is not met as evidenced by:</em> Based on observations, the facility failed to maintain the overall environment.</td>
<td></td>
</tr>
<tr>
<td>ID TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LOOP IDENTIFYING INFORMATION)</td>
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<td>---------------</td>
</tr>
<tr>
<td>A 801</td>
<td>Continued From page 1 The findings included: 1. Document review on 08/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of a 1st quarter sprinkler inspection for 2018 and 2019, NFPA 101, 2. Document review on 08/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual fire alarm inspection for 2019. (The last date was March 2018) 3. Document review on 08/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual backflow preventer inspection for 2018. (The last inspection date was August 2017.) 4. Observations on 08/03/2019 at 3:00 PM, revealed the rated fire/smoke barrier (above the ceiling) in the mechanical room had multiple improperly sealed (sheetrock mud) or unsealed penetrations across the wall, NFPA 101, 8.3.5.1 (2012 Edition) The office manager was present when these deficiencies were identified, and were later acknowledged during the exit conference on 08/03/2019.</td>
<td>A 801</td>
<td>Quarterly sprinkler inspection performed. Deficiencies noted: 4 sidewall sprinkler heads will be replaced by COB 6/24/19. Annual fire inspection performed and passed. Inspection performed in 2018 but documentation could not be located until after exit conference. Property filed. Fire Stop vendor scheduled and work was completed on 6/19/19. CCO and HCM to perform quarterly inspections, as well as after any work is performed in affected areas.</td>
<td>6/14/19, 6/24/19, 6/19/19</td>
</tr>
<tr>
<td>(X1) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>(X3) COMPLETE DATE</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>A 803</td>
<td>Continued From page 2 made without the prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ambulatory surgical treatment center is licensed or before any alteration or expansion of a licensed ambulatory surgical treatment center can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer. This Rule is not met as evidenced by; Based on observations, the facility failed obtain written approval for alterations. The finding included: Observations on 06/03/2019 between 2:15 PM - 3:30 PM, revealed the facility had installed access control badge scanners at the stairwells and doors throughout the facility without approval from the Tennessee Department of Health. The office manager was present when this deficiency was identified on 06/03/2019. Attempt was made to contact the office manager on 06/08/2019 without success.</td>
<td>A 803</td>
<td>A punch code access system was replaced with a badge swipe access system. PPTNM did not consider the replacement system as a major alteration and there was no intent of circumventing the proper approval process. PPTNM was standardizing the Nashville ASTC facility with the same badge access system that is currently utilized at the Memphis ASTC facility. The badge swipe system improves staff and patient safety in the event of an emergency by decreasing the time it takes to exit. PPTNM sincerely apologizes and regrets the error. CCO will request guidance from TN Dept. of Health for any future projects.</td>
<td>6/11/19</td>
</tr>
<tr>
<td>A1403</td>
<td>1200-8-10-14 (1)(c) Disaster Preparedness (1) The administration of every facility shall have in effect and available for all supervisory</td>
<td>A1403</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually:

(c) Flood Procedure Plan, if applicable:

1. Staff duties;
2. Evacuation procedures;
3. Safety procedures following the flood.

This Rule is not met as evidenced by:
Based on document review, the facility failed to perform disaster drills.

The finding included:

Document review on 06/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual flood drill and training for 2019.

The office manager was present when this deficiency was identified, and was later acknowledged during the exit conference on 06/08/2019.

HCM has documented PPTNM's Flood Procedure Plan and the required drill was performed. CCO and HCM will ensure all drills are performed and properly documented in the future.

6/14/19
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1404</td>
<td>Continued From page 4</td>
<td>A1404</td>
<td>HCM has documented the Earthquake Disaster Procedures Plan and the required drill was performed. CCO and HCM will ensure all drills are performed and properly documented in the future.</td>
<td></td>
</tr>
<tr>
<td>A1404</td>
<td>1200-8-10-14 (1)(d) Disaster Preparedness</td>
<td>A1404</td>
<td>6/14/19</td>
<td></td>
</tr>
</tbody>
</table>

(1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually:

(d) Earthquake Disaster Procedures Plan:
1. Staff duties;
2. Evacuation procedures;
3. Safety procedures;
4. Emergency services.

This Rule is not met as evidenced by: Based on document review, the facility failed to perform disaster drills.

The finding included:

Document review on 08/03/2019 between 2:15 PM - 3:00 PM, revealed the facility failed to provide documentation of the annual earthquake
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1404</td>
<td>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 08/08/2019.</td>
<td>A1404-</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The office manager was present when this deficiency was identified, and was later acknowledged during the exit conference on 08/08/2019.
This Rule is met as evidenced by:
During a follow up survey on 07/15/2019 for all previous deficiencies cited on 05/03/2019, the facility was found in compliance with all regulations under 1200-08-10, Standards for Ambulatory Surgical Treatment Centers.
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.
## Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/Clinic Identification Number:</th>
<th>(X2) Multiple Construction Site:</th>
<th>(X3) Date Survey Completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TNPL53544</td>
<td>A Building: 77 - Memphis Center for Reproductive Health</td>
<td>04/10/2019</td>
</tr>
</tbody>
</table>

### Name of Provider or Supplier

**Memphis Center for Reproductive Health**

**1726 Poplar Avenue**

**Memphis, TN 38104**

### ID Prefix Tag

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Complete Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A002</td>
<td>1200-8-10 No Deficiencies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Rule is <as evidenced by:>

During the annual survey on 04/10/19, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200 -8-10, Standards for Ambulatory Surgical Treatment Centers.
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A 001) 1200-8-10</td>
<td>Initial</td>
</tr>
</tbody>
</table>

This Rule is met as evidenced by:
A Life Safety revisit survey was conducted on 07/11/2019 for all previous deficiencies cited on 06/04/2019. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.
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 Surgical 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.

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 unsupervised patch around the duct in the boiler room on the 1 hour fire rated drywall.

American United for Life
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 801</td>
<td>Continued From page 1 NFPA 101, 8.3.5.1 (2012 Ed.)</td>
<td>A 801</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These findings were verified and acknowledged by the business office manager during the survey on 6/4/19.
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 Surgical Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).

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

(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured.

This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the physical plant.

The findings included:

1. Observation on 4/16/19 at 3:22 PM, revealed the following penetrations in the fire rated assemblies:
   Elevator room - 1 hour fire rated drywall.
   a. a 1/2 inch metallic flexible conduit.
### Division of Health Care Facilities

#### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. BUILDING, 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD</td>
</tr>
<tr>
<td>B. WING</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/16/2019</td>
</tr>
</tbody>
</table>

#### NAME OF PROVIDER OR SUPPLIER

PLANNED PARENTHOOD OF TENNESSEE ANI

2430 POPLAR AVE
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
</table>
| A 801              | Continued From page 1  
  - Boiler room - 1 hour fire rated drywall  
  b. 1 inch PVC pipe.  
  c. a 3 inch PVC pipe recessed in fire rated drywall not sealed per an approved UL fire stop system.  
  d. a 1/2 inch PVC pipe.  
  e. a 1/4 inch metallic flexible conduit.  
  f. unapproved patches around duct work.  
  Third floor shell area - concrete floor.  
  g. 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.) |
| A 801              | a-g CFO will include on monthly facility inspection checklist, as well as after any maintenance occurs in reference areas.  
  In process of getting 5/20/19 quote for both fire stop and patch repairs.  
  CFO will monitor maintenance issues. |

<table>
<thead>
<tr>
<th>(X6) ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| A 818             | 1200-B-10--08 (18) Building Standards  
  (18) It shall be demonstrated through the submission of plans and specifications that in each ASTC a negative air pressure shall be maintained in the soiled utility area, toilet room, |

(See next page)
<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 818</td>
<td>Continued From page 2&lt;br&gt;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:&lt;br&gt;Observation on 4/16/19 at 3:40 PM, revealed the exhaust was not functioning in the soiled utility room.&lt;br&gt;These findings were verified and acknowledged by the facility manager during the survey on 4/16/19.</td>
<td>No deficiency per services 5/1/19&lt;br&gt;Call Air Pressure requirements are being met. C/O will inspect monthly.</td>
</tr>
</tbody>
</table>

---

**Important Note:** The text provided includes a date range of 04/16/2019, indicating the date of the survey. This document focuses on specific deficiencies and corrective actions, emphasizing the importance of maintaining proper air pressure and cleanliness standards within the facility.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A001</td>
<td>1200-8-10 Initial</td>
<td>A001</td>
</tr>
</tbody>
</table>
|     | This Rule is met as evidenced by:  
An annual licensure survey was conducted on 4/22/19. An entrance conference was held on 4/22/19 at 8:00 AM with the Clinical Manager.  
An exit conference was held on 4/22/19 at 3:30 PM with the Clinical Manager. |     |
| A002 | 1200-8-10 No Deficiencies | A002 |
|     | This Rule is met as evidenced by:  
An annual licensure survey was conducted at this facility on 4/22/19. This facility complies with all Standards reviewed for Ambulatory Surgical Treatment Center Facilities. |     |
Ms. Reed,

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

Thanks,

Rebecca Terrell
Executive Director
CHOICES
Memphis Center for Reproductive Health

1726 Poplar Ave., Memphis, TN 38104
Direct: (901) 274-3551 Fax 901-274-3551
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R. Buckminster Fuller

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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.
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 draft of the first and second floor plans with a hatched note for your review and comment. The hatch and note clearly covers the portion of the project that is not birthing center. The hatch is somewhat transparent so that some overall context is still visible to your reviewers. Is this acceptable to you? Alternatively we could go with a completely opaque gray hatch; however, it might actually obscure building system elements that pass through other parts of the building. Do you agree that the attached hatch is acceptable? If so, I will instruct a draft of the 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

---

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!

[Signature]

Rebecca Terrell
Executive Director
CHOICES
Memphis Center for Reproductive Health
1726 Poplar Ave., Memphis, TN 38104
Direct: [redacted] Fax 901-274-3551
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R. Buckminster Fuller

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---

From: Peter H. Warren
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

[Email content]

[Email content]

---

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

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

---

TN Health

Ann Rutherford Reed, RN, BSN, MBA/Director of Licensure
Division of Health Licensure and Regulation
Office of Health Care Facilities
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?

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

Mr Parisher, I just left you a voicemail. Will you be in attendance? If not, would like to get a few minutes with you separately the day after 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.

---

Health

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

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---

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

CHOICES.  
Memphis Center for Reproductive Health

1726 Poplar Ave., Memphis, TN 38104  
Direct:[REDACTED] Fax 901-274-3551  
Explore WHEREwELIVENeighbor.org | WHEREwELIVEmidSouth.org

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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?

TN Health

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Division of Health Licensure and Regulation
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ann.r.reed@tn.gov
tn.gov/health

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From: Rebecca Terrell [mailto:Rebecca_Terrell@CHOICES.org]
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
CHOICES
Memphis Center for Reproductive Health

Americans United for Life
Did you know you can support CHOICES every time you shop on Amazon?

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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ann.r.reed@tn.gov
tn.gov/health

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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

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

And is there any specific regulation regarding the two entities sharing physical space, e.g. common waiting room, etc.?
Did you know you can support CHOICES every time you shop on Amazon?

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.
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.
Did you know you can support CHOICES every time you shop on Amazon?

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

Rebecca

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

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

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

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

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

Connect with TDH on Facebook and Twitter @TNDeptoHealth!

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

1726 Poplar Ave., Memphis, TN 38104
Direct: [redacted] Fax 901-274-3551
Explore WHEREweLIVEmidfourth.org WHEREtoGIVEmidfourth.org

"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

Did you know you can support CHOICES every time you shop on Amazon?
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:
TNPL53515

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: ____________________________
B. WING: ________________________________

(X3) DATE SURVEY COMPLETED
10/15/2018

NAME OF PROVIDER OR SUPPLIER
PLANNED PARENTHOOD OF MIDDLE AND EAST

STREET ADDRESS, CITY, STATE, ZIP CODE
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)

A 002: 1200-6-10 No Deficiencies

This Rule is met as evidenced by:
A semi-annual licensure survey was conducted on 10/15/18. Planned Parenthood of Middle and East TN was in substantial compliance with licensure requirements for Ambulatory Surgery Centers. No deficiencies were cited.

(X5) COMPLETE DATE

ID PREFIX TAG

A 002

DIVISION OF HEALTH CARE FACILITIES
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A001</td>
<td>Initial</td>
<td>This Rule is not met as evidenced by: Stories: 2 Construction type: III protected No plans available Constructed: Sprinklered: Yes Census: A Life Safety Code Survey follow up was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 10/16/2018. During this Life Safety Survey, Planned Parenthood was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgical Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A801</td>
<td>1200-8-10-.08</td>
<td>(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observations, the facility failed to maintain the overall environment. The findings included:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A 801 Continued From page 1

Observation on 10/16/2018 at 9:45 AM, revealed the 1st floor and 2nd floor stairwell doors were not latching within the frame. NFPA 101, 8.3.3.1 (2012 Edition), NFPA 80, 6.1.4.2 (2010 Edition)

The manager was present when this deficiency was identified, and was later acknowledged in the exit conference on 10/16/2018.

A 801

Reports were made to the building manager, who will add checking doors to our routine assessment check list. This will be monitored and for reviewed annually by the operations committee.
<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A 001)</td>
<td></td>
<td>1200-8-10 Initial</td>
<td>(A 001)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Rule is not met as evidenced by:
- Stories: 2
- Construction type: Ill protected
- No plans available
- Constructed:
- Sprinklered: Yes
- Census:

A Life Safety revisit survey was conducted on 11/30/2018 for all previous deficiencies cited on 10/16/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.
A 002 1200-8-10 No Deficiencies

This Rule is met as evidenced by:
During the annual survey on 10/17/18, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200 -8-10, Standards for Ambulatory Surgical Treatment Centers.
<table>
<thead>
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<th>ID</th>
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<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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</thead>
<tbody>
<tr>
<td>A 002</td>
<td>1200-8-10</td>
<td>No Deficiencies</td>
<td>This Rule is met as evidenced by: This facility meets all requirements reviewed pertaining to ASTC regulations. No deficiencies were cited as a result of this licensure survey.</td>
<td>A 002</td>
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<tr>
<td>ID</td>
<td>PREVIOUSLY IDENTIFIED DEFICIENCY</td>
<td>ID</td>
<td>CURRENT PLAN OF CORRECTION</td>
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<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td>A 002</td>
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</tbody>
</table>

This Rule is met as evidenced by: During the annual survey on 04/24/2018, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-10, Standards for Ambulatory Surgical Treatment Centers.
A 002  1200-8-10 No Deficiencies

This Rule is met as evidenced by:
An annual licensure survey was conducted at this facility on 4/24/18. This facility complies with all standards for Chapter 1200-8-10, Standards for Ambulatory Surgical Treatment Center Facilities.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETE DATE</th>
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<tbody>
<tr>
<td>(A 001)</td>
<td>1200-8-10 Initial</td>
<td>(A 001)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Rule is met as evidenced by:
A Life Safety revisit survey was conducted on 11/19/2018 for all previous deficiencies cited on 10/19/2018. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.
A 001 1200-8-10 Initial

This Rule is not met as evidenced by:
Stories: 3
Construction Type: II (111)
No plans available on site
Constructed: 2010
Sprinkled: No

A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 10/15/2018. During this Life Safety Survey, Planned Parenthood of Greater Memphis was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-10 Standards for Ambulatory Surgical Treatment Centers and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).

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

(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured.

This Rule is not met as evidenced by:
Based on observations, the facility failed to maintain the physical environment.
A 801 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.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>A 002 1200-8-10 No Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 002</td>
<td></td>
<td>This Rule is met as evidenced by: This facility meets all requirements reviewed pertaining to ASTC regulations. No deficiencies were cited as a result of this licensure survey.</td>
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</tr>
<tr>
<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td>A 002</td>
</tr>
</tbody>
</table>

This Rule is met as evidenced by:
An annual licensure survey was conducted at this facility on 4/23/18. This facility complies with all standards for Chapter 1200-08-10, Standards for Ambulatory Surgical Treatment Center Facilities.
[A 801] 1200-8-10-.06 (1) Building Standards

(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured.

This Rule is not met as evidenced by:
National Fire Protection Association (NFPA) 101, 21.5.1.1 (2012 Ed.)
Utilities shall comply with the provisions of Section 9.1.

NFPA 101, 9.1.2 (2012 Ed.)
Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.

NFPA 70, 406.6 (2011 Ed.)
Receptacle Faceplates (Cover Plates). Receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface.

NFPA 99, 6.3.3.2.1 (2012 Ed.)
The physical integrity of each receptacle shall be confirmed by visual inspection.

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.
<table>
<thead>
<tr>
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</table>
| (A 801)      | Continued From page 1

NFPA 101, 7.1.10.1* (2012 Ed.)
Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

NFPA 101, 8.3.5.1*(2012 Ed.) Firestop Systems and Devices Required.
Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m²) between the exposed and the unexposed surface of the test assembly.

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

The findings included:

1. Observation during the follow-up survey on 7/3/18 at 1:15 PM, revealed a damaged receptacle cover beside the crash-cart (former area of oxygen cylinders).
DIVISION OF HEALTH CARE FACILITIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER**  
PLANNED PARENTHOOD GREATER MEMPHIS

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
2430 POPLAR AVE. MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETED DATE</th>
</tr>
</thead>
</table>
| **A 801**     | Continued From page 2  
NFPA 101, 21.5.1.1 (2012 Ed.)  
NFPA 101, 9.1.2 (2012 Ed.)  
NFPA 70, 406.6 (2011 Ed.)  
NFPA 99, 6.3.3.2.1 (2012 Ed.)  
2. Observation during the follow-up survey on 7/3/18 at 1:30 PM, revealed 3 cases of water in the path of egress at the bottom of the rear exit stairs, and a 12 pack of bottled beer on the stairs. NFPA 101, 21.2.1 (2012 Ed.)  
NFPA 101, 7.1.10.1* (2012 Ed.)  
3. Observation during the follow-up survey on 7/3/18 at 1:35 PM, revealed the following penetrations in the 1 hour fire rated drywall were not repaired per an approved ul system:  
a. bundle of cables outside the entry door on the south wall of room  
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 deficiencies were identified on 7/2/18. | **A 801** | **REMOVED AND PLACED 7/6/18 IN SPECIFIED STORAGE.**  
30, b, c - APPROPRIATE 8/13/18  
CONTRACTOR HAS BEEN SCHEDULED WEEK OF 8/13/18. |
**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>TNPL53547</td>
<td>A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD</td>
<td>R 09/11/2018</td>
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<td></td>
<td>B. WING</td>
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</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**
PLANNED PARENTHOOD GREATER MEMPHIS
2430 POPLAR AVE
MEMPHIS, TN 38104

**STREET ADDRESS, CITY, STATE, ZIP CODE**

<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 001</td>
<td>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.</td>
<td>A 001</td>
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</tr>
</tbody>
</table>

**Americans United for Life**
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 failing 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 Continued From page 1

and Devices Required.
Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly.

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

The findings included:

1. Observation on 4/24/18 at 10:28 AM, revealed (3) unsecured oxygen cylinders in the surgery suite.
   NFPA 55, 7.1.8.4 (2010 Ed.)

2. Observation on 4/24/18 at 10:28 AM, revealed required signage missing for oxygen tanks being stored and used in the surgery suite and room.  
   NFPA 55, 6.11.1 (2010 Ed.)

3. Observation on 4/24/18 at 10:42 AM, revealed blue painter's tape over the smoke detector in the biohazard room on the 1st floor.
   NFPA 72, 14.2.1.2.2 (2010 Ed.)
4. Observation on 4/24/18 at 10:20 AM, revealed the fire extinguishers thru out the building were not being signed on service tags for monthly inspections.

NFPA 10, 7.2.4.4 (2010 Ed.)

5. Observations on 4/24/18 between 10:36 AM and 10:54 AM, revealed the following penetrations in the 1 hour fire rated walls listed below.

a. boiler room on 1st floor
   (1) 1 1/2 inch copper pipe on south wall
   (1) flex conduit over door on west wall
   (1) 1 1/2 inch PVC hot water pipe on south wall

b. mechanical room 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 on 2nd floor
   (1) bundle of cables outside of entry door on south wall

d. room on 2nd floor
   (2) white cables inside entry door on the right side

NFPA 101, 8.3.5.1*(2012 Ed.)

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

a. mechanical room on 2nd floor
   (1) wall damper on the northwest wall
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

An office employee was present when the deficiencies were identified. The CFO acknowledged the deficiencies in the exit conference on 4/24/18.
<table>
<thead>
<tr>
<th>A801</th>
<th>1200-8-10-08 (1) Building Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(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.</td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the physical plant.</td>
</tr>
<tr>
<td></td>
<td>Observation on 03/21/2017 at 9:38 AM, revealed three 1.5 inch PVC sleeves in the second floor mechanical room used to run data lines, was not properly sealed between the first and second floor. 39.3.1.1 NFPA 101 (2012 Edition) 8.8.1 NFPA 101 (2012 Edition)</td>
</tr>
<tr>
<td></td>
<td>The administrator was present for this finding and acknowledged during the exit conference on 03/21/2017.</td>
</tr>
</tbody>
</table>

A801 The deficiency will be corrected by fire blocking the three 1.5 inch PVC sleeves in the second floor mechanical room used to run data lines. The deficiency will be corrected on March 27, 2017. This will be added to the quarterly facilities audit to ensure deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td></td>
<td>A 002</td>
</tr>
</tbody>
</table>

This Rule is met as evidenced by:
A licensure survey was completed 3/20/17. The facility was found to be in compliance with state regulations for Ambulatory Surgical Centers. No deficiencies were cited during the licensure survey.
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<tr>
<th>ID</th>
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<th>TAG</th>
<th>STATEMENT OF DEFICIENCY</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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</thead>
<tbody>
<tr>
<td>A 420</td>
<td>1200-8-10-04 (16)</td>
<td>Administration</td>
<td>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.</td>
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<tr>
<td>A 420</td>
<td></td>
<td></td>
<td>The Medical Services Committee of the Memphis Center for Reproductive Health (MCRH) voted on 9/19/17 to approve revisions to the SOP &quot;Credentialing of Clinicians&quot; to include language specifying that the Board of Directors would annually review &amp; approve the recommendations of the Medical Director and Medical Services Committee regarding the credentialing of clinicians at MCRH.</td>
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</table>

The findings included:

1. Review of the facility policy, "Credentialing of Clinicians" revealed, "This document defines the specific policy and procedure to be followed to credential a clinician (MD, CNM [Certified Nurse Midwife], FNP) to provide medical care or services at [Name of facility]..." The Medical Director will review the information described above and will make a recommendation to the Medical Services committee to grant or deny privileges.
2. 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.
3. The President of the Board of Directors will approve the final granting of clinical privileges.

Review of the facility policy, "Medical Services Committee policy and Procedure" revealed, "This document defines the specific policy to be..."
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**A 420** Continued From page 1

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

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

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

4. Review of CRNA #1's credential file revealed there was no documentation the governing body had granted appointment or reappointment...
A 420 Continued From page 2

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

6. During an interview in the conference area on 9/8/17 at 10:45 AM, the Executive Director verified there was no documentation by the Governing Body for appointment or reappointment of health care professionals.
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 credentialled 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.
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 to grant clinical privileges at CHOICES to the Board of Directors’ Agenda at least once a year (typically for the November meeting).

11. The Board will vote once each year to approve the MSC’s recommendations to grant clinical privileges at CHOICES to clinicians (typically at the November meeting).

12. The President of the Board of Directors will sign all forms granting clinical privileges to CHOICES on behalf of the Board.

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

I. DOCUMENTS REQUIRED FOR CHECK OFF

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

II. OBSERVATIONS REQUIRED FOR CHECK OFF

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

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

REFERENCES

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

** PROVIDER: ____________________________  **

<table>
<thead>
<tr>
<th>DOCUMENT OR OBSERVATION</th>
<th>DATE RECEIVED OR OBSERVED</th>
<th>PM INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Tennessee Medical License</td>
<td></td>
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<tr>
<td>Board Certification, if relevant to proposed services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of current local hospital privileges, if relevant to proposed services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of current Medical Malpractice Insurance</td>
<td></td>
<td></td>
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<tr>
<td>DEA number, if relevant to proposed services</td>
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<td></td>
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<tr>
<td>NPI number, if relevant to proposed services</td>
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<td></td>
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<tr>
<td>Board Certification, if relevant to proposed services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criminal background check completed – printed copy in file</td>
<td></td>
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<tr>
<td>Other documents as requested;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Counseling or patient education only:
- Two sessions of direct patient counseling
  - 1
  - 2

### Provision of direct medical care:

#### General gynecological examination including PAP smears, STD testing:
- Two exams
  - 1
  - 2

#### Transgender hormone management:
- Five patient visits
  - 1
  - 2
  - 3
  - 4
  - 5

#### Colposcopies:
- 10 procedures
  - 1
  - 2
  - 3
  - 4
## Pregnancy Terminations – Medication:
Five patient education sessions

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</tbody>
</table>

## Pregnancy Terminations – Surgical:

- **Regular (<12 weeks):** 10 procedures
- **Advanced (12 – 15 weeks):** 10 procedures

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<thead>
<tr>
<th></th>
<th>DATE OBSERVED</th>
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<tbody>
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</table>
Medical Services Committee
Standard Operating Procedure
Credentialing of Clinicians

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</table>

Other services:

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

Medical Director

President, Board of Directors

Date

Date

Rev 06-26-15
A 002 1200-8-10 No Deficiencies

This Rule is met as evidenced by:
This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment Centers during the Licensure survey conducted on 3/21/17. No deficiencies were cited.

A 002

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

STATE FORM 8150 ZOGR11
<table>
<thead>
<tr>
<th>ID</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tbody>
<tr>
<td>A 801</td>
<td>1200-8-10-08 (1) Building Standards</td>
<td>MEMPHIS CENTER FOR REPRODUCTIVE HEALTH</td>
</tr>
</tbody>
</table>

(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured.

This Rule is not met as evidenced by:

National Fire Protection Association (NFPA) 70, 210.23 (2011 Ed.)
Permissible Loads. In no case shall the load exceed, the branch-circuit ampere rating. An individual branch, circuit shall be permitted to supply any load for which it is rated. A branch circuit supplying two or more outlets or receptacles shall supply only the loads specified according to its size as specified in 210.23(A) through (D) and as summarized in 210.24 and Table 210.24.

NFPA 55, 7.1.8.4 (2010 Ed.)
Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.8.4.1 and 7.1.8.4.2.

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

The findings included:

1. Observation on 3/21/17 at 8:30 AM, revealed extension cords in the following areas:

<table>
<thead>
<tr>
<th>ID</th>
<th>CORRECTIVE ACTION SHOULD BE CROSSE-REFERENCED WITH THE APPROPRIATE DEFICIENCY</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future.</td>
</tr>
<tr>
<td></td>
<td>(NFPA) 70, 210.23 (2011 Ed)</td>
</tr>
<tr>
<td></td>
<td>Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future.</td>
</tr>
<tr>
<td></td>
<td>(NFPA) 70, 210.23 (2011 Ed)</td>
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<td></td>
<td>Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future.</td>
</tr>
<tr>
<td></td>
<td>(NFPA) 70, 210.23 (2011 Ed)</td>
</tr>
</tbody>
</table>
A 801

Continued From page 1

a. ultrasound exam room.

b. waiting room B.

c. recovery room.

d. room #2.

NFPA 70, 210.23 (2011 Ed.)

2. Observation on 3/21/17 at 8:45 AM, revealed an unsecured oxygen cylinder in the hallway by room #2.

NFPA 55, 7.1.8.4 (2010 Ed.)

The clinical manager was present when the deficiencies were identified and acknowledged the deficiencies during the exit conference on 3/21/17.

A 801

d. After the inspection on 3/23/2017, Clinic Coordinator, disabled extension cord from room #2, will be replaced with a surge protector.

Clinic Coordinator will create a monthly checklist to monitor the area to prevent any unusual recurring in the future.

(NFPA) 70,210.23 (2011 Ed.)

2. After the inspection on 3/23/2017. Clinic Coordinator ordered a oxygen cart to secure the oxygen cylinder in the hallway by room #2.

Clinic Coordinator will create a monthly checklist to monitor the oxygen cylinder to prevent any unusual recurring in the future.

(NFPA) 22,7.1.8.4 (2010 Ed.)
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.
DIVISION OF HEALTH CARE FACILITIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
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<tr>
<td>TNPL53547</td>
<td>A. BUILDING:</td>
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<td>B. WING</td>
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<tr>
<th>(X3) DATE SURVEY COMPLETED</th>
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</table>

NAME OF PROVIDER OR SUPPLIER: PLANNED PARENTHOOD GREATER MEMPHIS

STREET ADDRESS, CITY, STATE, ZIP CODE: 2430 POPULAR AVE MEMPHIS, TN 38104

(X4) ID PREFIX TAG |
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<tbody>
<tr>
<td>A 001 - 8-10 Initial</td>
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</table>

This Rule is met as evidenced by:
This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment Centers during the Licensure survey completed on 9/5/17. No deficiencies were cited.

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

STATE FORM 0109 STEW11

American's United for Life
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<th>ID PREFIX</th>
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<td>1200-8-10 No Deficiencies</td>
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</table>

This Rule is met as evidenced by:
A licensure survey was completed 10/24/16. The facility was found to be in compliance with state regulations for Ambulatory Surgical Centers. No deficiencies were cited during the licensure survey.
A801: 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:


2. Observation on 10/18/2016 at 9:43 AM, revealed 1 ceiling tile missing and 1 ceiling tile damaged in the 2nd floor communication room.

3. Observation on 10/18/2016 at 9:45 AM, revealed an extension cord in use outside of the lab. NFPA 70, 590.3 (2011 Edition)


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 Coordinator.

3. The deficiency will be corrected by replacing the extension cord outside of the 2nd floor lab with a medical grade surge protector. The deficiency will be corrected on October 30, 2016. This will be assessed as part of the quarterly facilities audit to ensure deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management 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
A 818: Continued From page 1
A 818 1200-8-10-08 (18) Building Standards

(18) It shall be demonstrated through the submission of plans and specifications that in each ASTC a negative air pressure shall be maintained in the soiled utility area, toilet room, janitor’s closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms.

This Rule is not met as evidenced by:
Based on observations, the facility failed to maintain negative air pressure where required.

The findings included:
Observation on 10/18/2016 at 9:35 AM, revealed there was no negative air pressure in the 2nd floor staff only restroom.

Maintenance staff was present when the deficiencies were identified, and acknowledged by the administrator during the exit conference on 10/18/2016.

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 (continued from page 1) be assessed as part of the quarterly facilities audit to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator.

A818: This deficiency will be corrected by fixing the exhaust fans in the 2nd floor staff only rest room. This deficiency will be corrected on November 3, 2016. This will be assessed as part of the quarterly facilities audit to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator.

A1401: The deficiency will be corrected by conducting fire drills quarterly and maintaining a detailed log of who attended drills and specifics of what was performed during each drill. Drills will include minor fires, major fires, fighting the fire, evacuation procedures, and staff functions. The deficiency will be corrected on November 11, 2016. A HR Audit will be completed monthly to ensure appropriate drills have been completed on time and contain adequate detail. This corrective action will be monitored through the risk and quality management program which is overseen by the Risk and Quality Management Coordinator.
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.

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<tr>
<td>A1401</td>
<td>71T921</td>
<td>10/18/2016</td>
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</table>
**A420** 1200-8-10-.04 (18) Administration

(16) The governing body shall provide for the appointment, reappointment, or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges.

This Rule is not met as evidenced by:

- Based on review of credentials files, the facility failed to produce proof the governing body had provided for the reappointment of a member of the medical staff and provided for the granting of clinical privileges for 1 of 3 (Physician #3) physicians practicing at the facility.

The findings included:

1. Review of the credentials file for Physician #3 revealed the privileges were expired. There was no documentation the governing body had reappointed Physician #3 and granted clinical privileges.

2. During an interview in the office on 5/2/16 at 3:05 PM, the Director of Electronic Health Records verified there was no documentation Physician #3 had been reappointed and granted clinical privileges.

The deficiency will be corrected by creating a process that requires that the board vote for the appointment, reappointment, or dismissal of all members of the medical staff and grant clinical privileges. The current form used to grant clinical privileges for all members of the medical staff that is signed by the medical director will be updated to add signature lines for the board chair and the board secretary to sign on behalf of the board after a board vote takes place. The deficiency will be corrected on May 17, 2016. The manager of human resources will ensure credentialing of providers is up to date including required board approval by maintaining the HR spreadsheet that tracks provider credentialing and completing monthly HR audits to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 801</td>
<td>1200-8-10-06 (1) Building Standards</td>
<td>A 801</td>
<td>The deficiency will be corrected by replacing the water damaged ceiling tile in the consultation room by the fire door on the 2nd floor. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of ceiling tiles for damage to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.</td>
</tr>
<tr>
<td></td>
<td>(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.</td>
<td></td>
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<td></td>
<td>This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the overall environment.</td>
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<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 818</td>
<td>1200-8-10-08 (18) Building Standards</td>
<td>A 818</td>
<td>The deficiency will be corrected by fixing the exhaust fans in the staff rest room near the surgical suite and the janitorial closet in the nurse's station to maintain negative air pressure. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of exhaust fans to ensure they are properly working and that negative air pressure is maintained to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.</td>
</tr>
<tr>
<td></td>
<td>(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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by: Based on observations and testing, the facility failed to maintain negative air pressure in toilet room.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A 818  Continued From page 1

The findings included:

Observation and testing on 5/2/16 at 9:37 AM, revealed the no negative air pressure inside the Staff Restroom near the surgical suite and the janitorial closet in the nurse's station.

This finding was verified and acknowledged by the CEO during the exit conference on 5/3/16.

A 901  1200-8-10-.09 (1) Life Safety

(1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

This Rule is not met as evidenced by:

Based on observations and document review, the facility failed to comply with the required applicable building and fire safety regulations.

These findings included:

1. Observation on 5/2/16 at 9:02 AM, revealed a space heater in the exam room by the rear exit. NFPA 101, 21.7.8 (2012 Edition)

2. Document review on 5/2/16 at 9:50 AM, revealed the facility failed to provide documentation for the required sensitivity testing of the smoke detectors. NFPA 72, 14.4.5.3.2 (2010 Edition)
A.901 Continued From page 2

3. Observation on 5/2/16 at 9:30 AM, revealed the switch cover for the light switch near the surgery suite door entering the waiting room was damaged. NFPA 70, 314.28 (2011 Edition)

4. Observation on 5/2/16 at 9:39 AM, revealed a sprinkler escutcheon plate missing in the secondary waiting room’s restroom. NFPA 13, 6.2.7 (2010 Edition)

These findings were verified and acknowledged by the CEO during the exit conference on 5/2/16.

A.901

3. The deficiency will be corrected by replacing the damaged switch cover for the light switch near the surgery suite door entering the waiting room. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of light switch covers for damage to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.

4. The deficiency will be corrected by adding an escutcheon plate to the sprinkler in the secondary waiting room’s rest room. The deficiency will be corrected on May 11, 2016. A quarterly facilities audit will be conducted by the facilities manager which will include examination of sprinklers to look for missing or damaged escutcheon plates to ensure the deficient practice does not recur. This corrective action will be monitored through the risk and quality management program which is overseen by the Director of Patient Services.
**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

TNPL63544

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH

B. WING:

**NAME OF PROVIDER OR SUPPLIER:**

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1726 POPULAR AVENUE
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENHANCE FACTORY 1</td>
<td>1200-8-10.09 (1) <strong>Life Safety</strong></td>
<td>A 801</td>
<td>a. After the inspection on 9/27/2016, Nancy Shotwell, Clinic Coordinator contacted Hilti Firestop Systems on 10/3/2016 re: unapproved fire stop around 6 conduits. On 10/6/2016 Hilti Firestop Systems was on-site to evaluate the 6 conduits. System No. F-C-2071 will be used to repair.</td>
<td>10/18/2016</td>
</tr>
<tr>
<td></td>
<td>(1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.</td>
<td></td>
<td>a. After the inspection on 9/27/2016, Nancy Shotwell, Clinic Coordinator contacted Rhodes Electric on 9/29/2016 re: 1 unsealed metallic flex conduits. On 9/30/2016 Rhodes Electric was on-site to repair and seal metallic flex conduit.</td>
<td>9/30/2016</td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by: National Fire Protection Association (NFPA) 101, 8.3.5 (2012 Ed.) The provisions of 8.3.5 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations in fire walls, fire barrier walls, and fire resistance-rated horizontal assemblies. The provisions of 8.3.5 shall not apply to approved existing materials and methods of construction used to protect existing through-penetrations and existing membrane penetrations in fire walls, fire barrier walls, or fire resistance-rated horizontal assemblies, unless otherwise required by Chapters 11 through 43. Based on the observations, the facility failed to comply with the required life safety and building code regulations.</td>
<td></td>
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<tr>
<td></td>
<td>The findings included:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Observation on 09/27/16 at 1:20 PM, revealed the following penetrations in the ceiling of the electrical/phone room above panel LB:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. unapproved fire stop around 6 conduits.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>b. 1 unsealed metallic flex conduit.</td>
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<tr>
<td></td>
<td>c. unapproved fire stop around 2 - 1/2&quot; cables.</td>
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<tr>
<td></td>
<td>National Fire Protection Association (NFPA) 101, 8.3.5 (2012 Ed)</td>
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</tr>
</tbody>
</table>

**Division of Health Care Facilities**

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE:**

[Signature]

**TITLE:**

Executive Director

**STATE-OF-**

[Signature]

**KYFN21**

**Printed:** 10/05/2016

**FORM APPROVED**

**RECEIVED:** OCT 18 2016

**SURVEY COMPLETED:** 09/27/2016
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>TNPL83544</td>
<td>A. BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

| (X5) DATE SURVEY COMPLETED: | 09/27/2016 |

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMPHIS CENTER FOR REPRODUCTIVE HEALTH</td>
<td>1726 POPLAR AVENUE MEMPHIS, TN 38104</td>
</tr>
</tbody>
</table>

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<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 901</td>
<td>Continued From page 1 8.3.5 (2012 Ed.) This finding was verified on 09/27/16 by a staff member from the facility.</td>
<td>A 901</td>
<td>(con't b.) Nancy Shotwell, Clinic Coordinator will create a monthly checklist to monitor the phone/electrical room for any unusual findings to prevent recurring in the future. (NFPA) 101, 8.3.5 (2012 Ed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>c. After the inspection on 9/27/2016. Nancy Shotwell, Clinic Coordinator contacted Hilti Firestop Systems on 10/3/2016 re: unapproved fire stop around 2-1/2&quot; cables. On 10/6/2016 Hilti Firestop Systems was on-site to evaluate the fire stop around 2-1/2&quot; cables. System No. F-C-2071 will be used to repair. Nancy Shotwell, Clinic Coordinator will create a monthly checklist to monitor the fire stop around 2-1/2&quot; cables in the phone/electrical room to prevent any unusual findings from recurring in the future. (NFPA) 101, 8.3.5 (2012 Ed)</td>
</tr>
</tbody>
</table>

**RECEIVED**

**OCT 18 2016**
A 002 1200-8-10 No Deficiencies

This Rule is not met as evidenced by:

This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment centers during the Licensure survey completed on 9/26/16. No deficiencies were cited.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td>A 002</td>
<td></td>
</tr>
</tbody>
</table>

This Rule is met as evidenced by: During the survey on 3/28/16, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-10, Standards for Ambulatory Surgical Treatment Centers.
A 002. 1200-8-10 No Deficiencies

This Rule is: met as evidenced by:
This facility complies with all requirements reviewed for Ambulatory Surgery Centers during this licensure survey conducted 3/28/16. No deficiencies were cited.
**A 901**

**1200-8-10-09 (1) Life Safety**

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.)

This Rule is not met as evidenced by:

- National Fire Protection Association (NFPA) 10, 6.1.3.3.1 (2010 Ed.) Fire extinguishers shall not be obstructed or obscured from view.
- NFPA 101, 21.2.1 (2010 Ed.) Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 21.2.2 through 21.2.11.
- NFPA 101, 7.5.1.1 (2010 Ed.) Exits shall be located, and exit access shall be arranged so that exits are readily accessible at all times.

Based on the observations, the facility failed to comply with the required life safety and building code regulations.

The findings included:

- Both deficiencies (1 & 2) were both corrected at the time of the site visit.
- Appropriate storage for #1 was identified and communicated to staff.
- Appropriate display for #2 was identified and communicated to staff.
- Both CFO and VP of Patient Services will monitor on a daily basis to ensure the deficiency does not recur.
A 901  Continued From page 1

shall be in accordance with Chapter 7, unless otherwise modified by 21.2.2 through 21.2.11. NFPA 101, 7.5.1.1 (2010 Ed.) Exits shall be located, and exit access shall be arranged, so that exits are readily accessible at all times.

The findings were verified during the survey by the business manager on 09/27/16.
<table>
<thead>
<tr>
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<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td>A 002</td>
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</table>

This Rule is not met as evidenced by:

This facility complies with all requirements for participation reviewed for Ambulatory Surgery Treatment Centers during the Licensure survey completed on 9/27/16. No deficiencies were cited.
### Statement of Deficiencies and Plan of Correction

**X(1) Provider/Supplier/CLA Identification Number:**

TNPL53547

**X(2) Multiple Construction**

A. Building: 01 - Memphis Regional Planned Parenthood
B. Wing

**X(3) Date Survey Completed:**

03/28/2016

**Name of Provider or Supplier:**

PLANNED PARENTHOOD GREATER MEMPHIS

**Street Address, City, State, Zip Code:**

2430 POPULAR AVE
MEMPHIS, TN 38104

**X(4) ID Prefix Tag:**

A 901

**Summary Statement of Deficiencies**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 901</td>
<td></td>
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(1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

This Rule is not met as evidenced by:

Based on observations, the facility failed to comply with the required building and fire safety regulations.

The findings included:

- Observation on 3/28/16 at 9:30 AM, revealed penetrations in the fire barriers in the following locations:
  - a. 4 penetrations in the ceiling of generator room.
  - b. 8 penetrations in the ceiling of 2nd floor mechanical room.

National Fire Protection Association (NFPA 101, 8.3.5 2012 Edition)

These findings were acknowledged by the administrator during the tour on 3/28/16.

**Attached Please Find Quote for All Repairs Received 4/20/16 VP of Finance Authorized, Will Be Checked Quarterly by Facility Manager VP of Finance.**
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<tr>
<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td>A 002</td>
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</table>

This Rule is met as evidenced by:
This facility complies with all state licensure requirements reviewed during this licensure survey. No deficiencies were cited.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**TNPL63547**

<table>
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<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A.001</td>
<td>(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured. This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the condition of the surgery center in a manner that the safety and well-being of the patients were assured. The findings included: Observation of the surgery center during the follow up survey on 1/26/16 revealed the elevator equipment room had multiple penetrations in fire rated walls covered with an unapproved fire stop method. (blowout patches) National Fire Protection Association (NFPA) 101, 39.3.2 (2000 edition). These findings were verified and acknowledged by the surgery center representative during the tour and exit conference on 1/26/16.</td>
<td>(A.001)</td>
<td>The wall was constructed in accordance with Tennessee Department of Health approved plans.</td>
</tr>
</tbody>
</table>

The wall was constructed in accordance with Tennessee Department of Health approved plans.
A 901 1200-8-10-.09 (1) Life Safety

(1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

This Rule is not met as evidenced by:
Based on observations the facility failed to maintain the overall environment.

The findings include:

1. Observation of the 1st floor mechanical room by staff break room on 10/7/15 at 11:33 AM, revealed three (3) penetrations in fire barrier. National Fire Protection Association (NFPA) 101: 8.3.5.1 (2012 Edition)

2. Observation on 10/7/15 at 11:34 AM, revealed escutcheon plates around the sprinkler loose in the following areas:
   a. 2nd floor stairwell (1 of 2)
   b. 2nd floor hallway by waiting room
   c. 2nd floor waiting room 2 bathroom -
   d. recovery room staff only closet
   e. 1st floor storage room across from biohazard room
   NFPA 13, 6.2.7.1 (2010 Edition)

3. Observation on 10/7/15 at 11:34 AM, revealed the fire rating tags were painted over on the following door frames:
   a. 2nd floor stairwell by elevator
   b. 2nd floor laundry room.
   NFPA 80, 4.2.2 (2010 Edition)

A 901

1. The deficiency will be corrected by having the area in question enclosed. 11/0/15
2. When building modifications are performed the contractor will ensure the changes are in compliance with Fire Safety regulations. 10/23/15
3. A service call has been placed with Life Safety and Fire Safety vendor scheduled for 10/30/15.
4. The facility has quarterly and annual fire inspections that can ensure this deficiency does not reoccur. 10/15/15

1. The deficiency will be corrected by having Life Safety and Fire Safety vendor Simplex Grinnell to come replace and or tighten escutcheon plates in each of the areas in question.
2. The facility has quarterly and annual fire inspections and escutcheon plates are checked. 10/23/15
3. The deficiency was corrected on October, 23, 2015.
4. See above answer #2

1. The deficiency will be corrected by having paint removed from fire rating tags. 11/9/15
2. The facility will notify any future contractors that fire rating tags should not be painted. 11/9/15
3. This deficiency will be corrected by November 9, 2015.
4. The facility will be sure that future contractors are aware that fire tags are not to be painted.
<table>
<thead>
<tr>
<th>ID Tag</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID Prefix Tag</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 901</td>
<td>Continued From page 1</td>
<td></td>
<td>1. The deficiency will be corrected by having service vendor West End Lock adjust smoke doors.</td>
<td>(11/9/15)</td>
</tr>
<tr>
<td></td>
<td>4. Observation on 7/10/15 at 11:41 AM, revealed the following smoke doors did not latch within the door frame: 2nd floor near consultation office and recovery room bathroom. NFPA 80, 6.1.4.2 (2010 edition)</td>
<td></td>
<td>2. Quarterly and annual fire inspections are performed and any deficiencies should be noted at inspections.</td>
<td>(11/9/15)</td>
</tr>
<tr>
<td></td>
<td>5. Observation on 7/10/15 at 11:59 AM, revealed the fire doors would not latch within the door frame in the following locations: 1st floor stairwell by elevator and 1st floor storage room across from biohazard room. NFPA 80, 7.1.4 (2010 Edition)</td>
<td></td>
<td>3. A service call is scheduled for 11-2-2015 with West End Lock.</td>
<td>(11/9/15)</td>
</tr>
<tr>
<td></td>
<td>These findings were verified and acknowledged by facility administrator during exit conference on 10/07/15.</td>
<td></td>
<td>4. See above action #2</td>
<td>(11/9/15)</td>
</tr>
<tr>
<td>A1400</td>
<td>1200-8-10-.14 Disaster Preparedness</td>
<td></td>
<td>1. This deficiency will be corrected by having documented copies of the facility disaster drills that have been conducted.</td>
<td>(11/6/15)</td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by: Based on document review the facility failed to conduct disaster drills.</td>
<td></td>
<td>2. The Center Manager along with Director of Patient Services will ensure the documentation is filed at the facility in addition to the original that is currently kept on file at the administrative office.</td>
<td>(11/6/15)</td>
</tr>
<tr>
<td></td>
<td>The finding included: During document review on 7/10/15 at 12:31 PM, revealed the facility failed to conduct the following disaster drills during 2014: a. tornado b. bomb c. earthquake</td>
<td></td>
<td>3. Fire safety log will be created to include the drills performed in 2014 as well as current drills.</td>
<td>(11/6/15)</td>
</tr>
<tr>
<td></td>
<td>This finding was verified and acknowledged by facility administrator during exit conference on 10/07/2015.</td>
<td></td>
<td>4. This corrective action will be monitored by Center Manager and Director of Patient Services each will make sure that the log kept at the facility reflects the records kept at the administrative office.</td>
<td>(11/6/15)</td>
</tr>
</tbody>
</table>
**A407** 1200-8-10-.04 (6) Administration

(6) The ambulatory surgical treatment center shall ensure a framework for addressing issues related to care at the end of life. This Rule is not met as evidenced by: Based on interview, the facility failed to ensure a framework for addressing issues related to care at the end of life.

The findings included:

1. During an interview in the office on 10/7/15 at 1:30 PM, when asked if there was a policy addressing issues related to care at the end of life, the Director of Patient Services stated, "We don't have anything like that here."

**A408** 1200-8-10-.04 (7) Administration

(7) The ambulatory surgical treatment center shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program. This Rule is not met as evidenced by: Based on interview, the facility failed to develop an effective pain management program.

The findings included:

1. During an interview in the office on 10/7/15 at 1:40 PM, when asked if the facility had a policy and procedure for managing pain, the Director of Patient Services stated, "No, we don't have anything like that."

**A420** 1200-8-10-.04 (16) Administration

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

Based on medical record review and interview, the facility failed to have an informed consent in the record for 1 of 9 (Patient #10) patients undergoing a surgical procedure and failed to document advanced directives and organ donation for 2 of 9 (Patients #3 and 5) sampled patients undergoing surgical procedures.

The findings included:

1. Medical record review for Patient #10 documented an admission date of [BLANK] with a diagnosis of Legally Induced Abortion. There was no documentation of consent for the procedure.

During an interview in the office on 10/7/15 at 10:45 AM, the Health Center Manager stated, "It has not been scanned into the electronic medical record yet. I'll have to get the hard copy of the consent." This document was never produced after multiple requests.

2. Medical record review for Patient #3 documented an admission date of [BLANK] with a diagnosis of Legally Induced Abortion. There was no documentation of an advanced directive and organ donation for Patient #3.

3. Medical record review for Patient #5 documented an admission date of [BLANK] 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.

1. The facility will conduct additional staff training to ensure proper informed consent is obtained and documented and that advance directive, and organ donation information is being documented into the Electronic Health Record. Additional staff has been designated to scanning patient records to ensure this is completed in a timely fashion.

2. Chart audit will be performed to ensure advance directive, organ donation, and informed consent are included in each chart.

3. The deficiency will be completed by Oct 23, 2015 to allow each provider to receive training.

4. Twenty surgical charts will be audited quarterly by the QRM Coordinator to ensure ongoing compliance.
Continued From page 3

A 624

1200-8-10-06 (1)(r) Basic Services

(1) Surgical Services.

(r) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

This Rule is not met as evidenced by:
Based on medical record review and interview, the facility failed to include an operative report for 2 of 9 (Patients #3 and 8) sampled patients who had undergone surgical procedures.

The findings included:

1. Medical record review for Patient #3 documented an admission date of [redacted] with a diagnosis of Legally Induced Abortion. There was no documentation of an operative report for Patient #3.

2. Medical record review for Patient #8 documented an admission date of [redacted] with a diagnosis of Legally Induced Abortion. There was no documentation of an operative report for Patient #8.

3. During an interview in the office on 10/7/15 at 10:50 AM, the Health Center Manager verified there was no documentation of operative reports for Patients #3 and #8.
A1301 Continued From page 4
A1301
1200-8-10-13(1) Pol. & Proced. for Health Care Dec. Making

(1) Pursuant to this Rule, each ambulatory surgical treatment center shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual patients. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

This Rule is not met as evidenced by:
Based on interview, the facility failed to develop policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity.

The findings included:

1. During an interview in the office on 10/7/15 at 2:10 PM, the Director of Patient Services verified there were no policies and procedures governing the designation of a health care decision-maker.

1. This deficiency will be corrected by creating an End of Life policy to address the designation of a health care decision maker for making health care decision for a patient who is incompetent or who lacks capacity and does not have a living will and/or Durable Power of Attorney for health care. Information about living wills and advance directives will be made available to patients at the facility upon request.
2. The facility will conduct additional staff training to ensure that it is documented in Electronic Health Record if the patient has an advance directive and/or living will to direct end of life care.
3. The facility will have documents available for patients October 19, 2015.
4. The End of Life Policy will be reviewed annually and updated as needed. This will be added to the RGM work plan.
**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>TNPL53544</td>
<td>A. BUILDING:</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

MEMPHIS CENTER FOR REPRODUCTIVE HEA

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1726 POPULAR AVENUE
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.454 A.454</td>
<td>1200-8-10-.04(25) Administration</td>
<td>A.454</td>
<td>CHOICES Facilities Mgr installed a “No Smoking” sign at each of the two bldg. entrances where they were missing.</td>
<td>10/12/2015</td>
</tr>
<tr>
<td></td>
<td>(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.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by:</td>
<td></td>
<td>CHOICES Facilities Mgr has added “check for No Smoking signs at each clinic entrance” to her list of semi-annual facilities inspections.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on observation and interview, the facility failed to post “No Smoking” signs at 2 of 3 (main entrance and staff entrance) entrances to the facility.</td>
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<td></td>
<td>The findings included:</td>
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<tr>
<td></td>
<td>Upon entering the facility on 10/5/15 at 9:00 AM, it was noted that there was no signs at the public entrance to indicate this was a “No Smoking” area. During a tour of the facility at 12:30 PM with the Practice Manager, it was noted there were no signs at one of the staff entrances to the facility that indicated this was a “No Smoking” area.</td>
<td></td>
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<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Accepted**

Kerry Zepf

11-9-15

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**Americans United for Life**
**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

TNPL53544

**(X2) MULTIPLE CONSTRUCTION**

A BUILDING: 77 - MEMPHIS CENTER FOR REPRODUCTIVE HEALTH

B. WING

**(X3) DATE SURVEY COMPLETED**

10/05/2015

**NAME OF PROVIDER OR SUPPLIER**

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1728 POPULAR AVENUE

MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
</table>
| A 801              | 1200-8-10-.08 (1) Building Standards 

(1) An ASTC shell 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:


3. The electrical panel did not have the breakers identified in the electrical panel. National Fire Protection Association (NFPA) 70, 408.4 (1999 edition).


5. The combination battery back-up exit and emergency light fixture over the waiting area would not illuminate when tested by the facility. |

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 801</td>
<td>1) After the inspection on 10/5/2015. Nancy Shotwell, Clinic Coordinator contacted Rhodes Electric re: the penetration around the flexible electrical conduit. Rhodes Electric will be on site to repair on 11/2/2015 Regulation 1200-8-10-8 (1) (NFPA) 101, 39.3.2.2 (2000 edition)</td>
</tr>
<tr>
<td></td>
<td>2) After the inspection on 10/5/2015. The packaged canopy was moved from in front of the electrical panel on 10/5/2015 by Rebecca Terrell, Executive Director Regulation 1200-8-10-8 (1) (NFPA) 70, 110 (26) (a) (1999 edition)</td>
</tr>
</tbody>
</table>

**Division of Health Care Facilities**

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**STATE FORM**

**TITLE**

**RECEIVED**

**OCT 26 2015**
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 801</td>
<td></td>
<td></td>
<td><strong>Continued From page 1</strong></td>
<td>A 801</td>
<td></td>
<td></td>
<td><strong>3) After the inspection on 10/5/2015</strong></td>
<td>11/2/2015</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>representative. National Fire Protection Association (NFPA) 101, 7.8, 7.9, and 7.10 (2000 edition).</td>
<td></td>
<td></td>
<td></td>
<td>Nancy Shotwell, Clinic Coordinator contacted Rhodes Electric re: electrical panel breaker need identified. Rhodes Electric will be on site to complete on 11/2/2015</td>
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<td></td>
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<td></td>
<td>7) A former restroom was being used as a storage room and did not have a self closing device to keep the door closed. (NFPA) 101, 21.3.7.6 (2000 edition).</td>
<td></td>
<td></td>
<td></td>
<td>4) After the inspection on 10/5/2015</td>
<td>10/14/2015</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>8) The facility could not provide documentation of a current sensitivity test on the smoke detectors since 7/19/11. National Fire Protection Association (NFPA) 72, 7.3.2.1 (1999 edition).</td>
<td></td>
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<td></td>
<td>William Hart (maintenance) removed the automatic hand sanitizer from over the light switch in employee break room.</td>
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<td></td>
<td>9) The facility could not provide documentation for the (30 second) monthly and (90 minute) annual testing of the exit and emergency lighting fixtures. Fire Protection Association (NFPA) 101, 7.9.3 (2000 edition).</td>
<td></td>
<td></td>
<td></td>
<td>Regulation 1200-8-10-08 (1) (CFR) 416.44</td>
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<td></td>
<td><strong>5) After the inspection on 10/5/2015</strong></td>
<td>10/12/2015</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Nancy Shotwell, Clinic Coordinator contacted Don Sills with (City Fire Extinguisher Co) re: emergency light fixture over the waiting area would not illuminate. On 10/12/2015, Don Sills replaced batteries and lights for the fixture.</td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
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<td>Regulation 1200-8-10-08 (1) (NFPA) 101, 7.8, 7.9, and 7.10 (2000 edition)</td>
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<td><strong>6) After the inspection on 10/5/2015</strong></td>
<td>10/12/2015</td>
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<tr>
<td></td>
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<td></td>
<td>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.</td>
<td></td>
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<td></td>
<td>Regulation 1200-8-10-08 (1) (NFPA) 101, 7.10 (2000 edition)</td>
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<tr>
<td>ID PREFIX TAG</td>
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<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETE DATE</td>
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</tr>
<tr>
<td>A 801</td>
<td>Continued From page 2</td>
<td>A 801</td>
<td>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 10/6/2015 to install. Regulation 1200-8-10-08 (1) (NFPA) 101, 21.3.7.6 (2000 edition)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>8) After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator e-mailed and faxed Wanda Browning, FSS1 on 10/7/2015, providing (2014 &amp; 2015) documentation on current sensitivity test on smoke detectors Regulation 1200-8-10-08 (1) (NFPA) 101, 21.3.7.6 (2000 edition)</td>
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<tr>
<td></td>
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<td></td>
<td>9) After the inspection on 10/5/2015 Nancy Shotwell, Clinic Coordinator contacted Don Sils 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)</td>
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</tbody>
</table>

These findings were verified during the tour, and acknowledged by the facility representatives during the exit conference on 10/5/15.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

<table>
<thead>
<tr>
<th>(A 601) 1200-8-10-.08 (1) Building Standards</th>
<th>(A 801)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(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.</td>
<td>[My Note: Corrective action completed on 12/11/15]</td>
</tr>
</tbody>
</table>

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:

These findings were verified and acknowledged by the surgery center representative during the tour and exit conference on 11/24/15.

Please see attached response from our architecture firm.

Service call placed for repair/replacement 1/8/16
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:

Response: Penetrations in the existing walls will be sealed to provide the necessary fire protection rating per UL standards. This work will be completed prior to January 8, 2016.

Item 2 – Observation of the soiled storage room revealed no exhaust fan had been provided for negative air pressure. National Fire Protection Association NFPA90 (1999 edition).  
Response: After further investigation, the exhaust fan motor need replacement. This work will be performed and completed prior to January 8, 2016.

Additionally, there was mention of the integrity of the rated assemblies as constructed in the existing second floor shell space. Upon inspection of the information provided by the site manager and research of rated assemblies, it is my professional opinion that the assemblies do not jeopardize the health, safety, or welfare of the occupants of the building. While a specific UL assembly is not identified, the walls are believed to be constructed in compliance with UL assembly U419. An additional layer of 5/8” Type X gypsum has been added to the top 4” of the wall. The building has received a Certificate of Occupancy by the City of Memphis and there are no outstanding Fire Department deficiencies.

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

Sincerely,

Todd C. Howard, AIA, NCARB, LEED AP  
Tennessee Architectural License #105290
A 801 1200-8-10-08 (1) Building Standards

(1) An ASTC shall construct, arrange, and maintain the condition of the physical plant and the overall ASTC environment in such a manner that the safety and well-being of the patients are assured.

This Rule is not met as evidenced by: Based on observation, the facility failed to maintain the condition of the surgery center in a manner that the safety and well-being of the patients were assured.

The findings included:

Observation of the surgery center on 10/5/15 revealed the following:

5. Observation of the facilities ceiling light fixtures in the following areas did not have bulb protection: the elevator room, the housekeeping

A 801 CORRECTIVE ACTION FOR PREVENTION AND MONITORING:

PPGMR's VP of Finance is responsible for monitoring and compliance with survey items. Item one will be monitored daily. Items 2 and 6 will require no further action. Items 3,4, and 5 have been added to PPGMR's quarterly maintenance checklist to ensure that the deficient practices are monitored/timely corrected and do not recur.

1. Wedges removed and supervisors monitor daily for compliance 10/5/15
2. Contractor hired to reinstall sanitizer 11/21/15
3. Contractor hired to seal penetrations 11/21/15
4. Replaced damaged cover 11/5/15
5. Contractor hired to install bulb protection 11/21/15
<table>
<thead>
<tr>
<th>ID</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Based on record review, the facility failed to provide documentation of a 4 year fire damper inspection.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The findings included:</td>
<td>6. Contractor stated the observation is a return unit (not an exhaust fan) and is functioning properly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>During the document review, the facility failed to provide documentation that fusible link fire dampers had been inspected. National Fire Protection Association NFPA 90 A (1999 Edition).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>These findings were verified and acknowledged by the surgery center representative during the tour and exit conference on 10/5/15.</td>
<td>Contractor performed damper inspection and provided documentation (attached), Next inspection due 11/1/2019</td>
</tr>
</tbody>
</table>

Contractor performed damper inspection and provided documentation (attached), Next inspection due 11/1/2019.
4 Year Fire Damper Inspection

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

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

Floor: First

<table>
<thead>
<tr>
<th>Damper #</th>
<th>Location</th>
<th>Type</th>
<th>Operation</th>
<th>Result</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>025</td>
<td>Storage</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
<td></td>
</tr>
<tr>
<td>026</td>
<td>Storage</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
<td></td>
</tr>
<tr>
<td>027</td>
<td>Elevator Room</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
<td></td>
</tr>
<tr>
<td>028</td>
<td>Elevator Room</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
<td></td>
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<tr>
<td>029</td>
<td>Main Entrance</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
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</table>
4 Year Fire Damper Inspection

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

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

Floor: Second

<table>
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<tr>
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<th>Type</th>
<th>Operation</th>
<th>Result</th>
<th>Action</th>
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<tbody>
<tr>
<td>001</td>
<td>Women’s Bath</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
<td></td>
</tr>
<tr>
<td>002</td>
<td>Men’s Bath</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
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</tr>
<tr>
<td>003</td>
<td>Middle Hallway</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
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<tr>
<td>004</td>
<td>Training Room</td>
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<td>005</td>
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<td>Fuse Link</td>
<td>Pass</td>
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<tr>
<td>006</td>
<td>Storage Room</td>
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<td>Fuse Link</td>
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<td>007</td>
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<td>008</td>
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<td>009</td>
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<tr>
<td>010</td>
<td>Storage Room</td>
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<td>Fuse Link</td>
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<tr>
<td>011</td>
<td>Storage Room</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
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<tr>
<td>012</td>
<td>1st Floor Feed</td>
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<td>Fuse Link</td>
<td>Pass</td>
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<tr>
<td>013</td>
<td>Hall South end</td>
<td>Fire</td>
<td>Fuse Link</td>
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<tr>
<td>014</td>
<td>Data Room</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
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<tr>
<td>015</td>
<td>Data Room</td>
<td>Fire</td>
<td>Fuse Link</td>
<td>Pass</td>
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</tr>
</tbody>
</table>
# 4 Year Fire Damper Inspection

**Site Name:** PPGMR  
**Location:** 2430 Poplar  
**Memphis, TN 38104**  
**Inspection Performed By:** Mike Morrissett 11/12/15  
**Report Prepared By:** W. David Hobbs 11/13/15  
**Next Inspection Due:** 11/01/19

**Floor: Second**

<table>
<thead>
<tr>
<th>Damper #</th>
<th>Location</th>
<th>Type</th>
<th>Operation</th>
<th>Result</th>
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<td>016</td>
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<td>Electric</td>
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<td>017</td>
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<td>Fuse Link</td>
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<tr>
<td>023</td>
<td>Air Handler</td>
<td>Fire</td>
<td>Fuse Link</td>
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<tr>
<td>024</td>
<td>Air Handler</td>
<td>Fire</td>
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**788 East Street**  
**Memphis, TN 38104**  
**(901) 775-2143 Fax (901) 948-7434**
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES. (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A614</td>
<td>1200-8-10-.06 (1)(n)</td>
<td>Basic Services, (n) Properly executed informed consent, advance directive, and organ donation forms must be in the patient's chart before surgery, except in emergencies.</td>
<td>A614</td>
<td></td>
<td>Organ donation preference will be documented in each medical record. This question has been added to the Demographics page. Completed by each patient. Organ donation will be added to our Medical Record Audit Categories.</td>
</tr>
<tr>
<td>A1101</td>
<td>1200-8-10-.11 (1)</td>
<td>Records and Reports, (1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required. This Rule is not met as evidenced by: Based on interview the facility failed to submit a Joint Annual Report (JAR) to the state.</td>
<td>A1101</td>
<td></td>
<td>The Joint Annual Report will be completed and returned to the Dept. The JAR will be added to the COP in 2014.</td>
</tr>
</tbody>
</table>

**The Joint Annual Report will be completed and returned to the Dept. The JAR will be added to the COP in 2014.**
Continued From page 1

10/20/14, the Clinical Manager confirmed the facility did not submit a JAR to the state. She further stated the facility had been told they were not required to do so.

1200-8-10-14 (2) Disaster Preparedness

(2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.

This Rule is not met as evidenced by:
Based on interview it was determined the facility failed to provide documentation of participation with the Tennessee Emergency Management Agency (TEMA).

The findings included:
During an interview in the conference room on 10/20/14 at 1:45 PM, the Clinical Manager verified the facility had not participated with TEMA.

PMET will participate with TN Emergency Management Agency, their Basic Health Care Facility Information form has been completed and submitted to TEMA. Documentation of this annual participation has been added to our RCM audits.
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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</thead>
<tbody>
<tr>
<td>A 818</td>
<td>1200-8-10-08 (18) Building Standards</td>
<td>A 818</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(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.</td>
<td></td>
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<tr>
<td></td>
<td>The finding included:</td>
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<tr>
<td></td>
<td>Observation and testing on 10/20/2014 at 11:08 AM, revealed the biohazard room on the first floor had positive pressure.</td>
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<tr>
<td></td>
<td>This finding was verified by employee #1 and acknowledged by the administrator during the exit conference on 10/20/2014.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A 901</td>
<td>1200-8-10-08 (1) Life Safety</td>
<td>A 901</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>PROVIDER'S PLAN OF CORRECTION</td>
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<td>----</td>
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</tr>
<tr>
<td>A 901</td>
<td>Continued From page 1</td>
<td>This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain life safety codes where required. The findings included: 1. Observation on 10/20/2014 at 11:08AM, revealed a fire extinguisher not secured in the 1st floor electrical closet. National Fire Protection Association (NFPA) 10, Standard for Portable Fire Extinguishers, 6.1.3.4(1), 2010 Edition. 2. Observation on 10/20/14 at 11:12 AM, revealed escutcheon plates were missing in the following rooms: 2nd floor snack storage room, soiled laundry closet, and 2nd floor storage room. NFPA 13, Standard for the Installation of Sprinkler Systems, 5.2.7.1, 2011 Edition. These findings were verified by employee #1 and acknowledge by the administrator during the exit conference on 10/20/2014.</td>
<td>The fire extinguisher in the 1st floor electrical closet has been secured. Records of this item have been added to our monthly fire extinguisher audit. Escutcheon plates will be added to the sprinklers on the 2nd floor storage room, soiled laundry closet, and 2nd floor snack closet. Records of this will be added to our monthly sprinkler audit.</td>
</tr>
</tbody>
</table>

<p>| ID | TAG | |
| A 901 | The fire extinguisher in the 1st floor electrical closet has been secured. Records of this item have been added to our monthly fire extinguisher audit. Escutcheon plates will be added to the sprinklers on the 2nd floor storage room, soiled laundry closet, and 2nd floor snack closet. Records of this will be added to our monthly sprinkler audit. | Nov 8, 2014 |</p>
<table>
<thead>
<tr>
<th>(X4) ID: A1101</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID: A1101 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY )</th>
<th>(XX) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200-8-10-.11</td>
<td>(1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure the Joint Annual Report (JAR) was filed with the department. The findings included: During an interview on 10/15/14 at 12:00 PM the Director of Clinical Services stated they were not required to file a JAR. There was no evidence the facility filed a JAR.</td>
<td>How the Deficiency will be corrected: Assign Completion of JAR to Practice Manager. How the facility will prevent the same deficiency from occurring: CHOICES: Director of Clinical Services will continue to communicate annually with the TN Department of Health Division of Policy, Planning and Health Statistics if JAR is not received annually as anticipated. Date Deficiency will be corrected 11/05/2014 On Going Monitoring Completion of JAR report will be component of Practice Manager annual evaluation.</td>
<td></td>
</tr>
</tbody>
</table>

**RECEIVED**
JAN 16 2015

"RECEIVED"

J. Matthew Ch. Director of Clinical Services 11/5/15

STATE FORM

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

11/5/15

TNPL53544

1728 POPLAR AVENUE
MEMPHIS, TN 38104

09/23/2014

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH
<table>
<thead>
<tr>
<th>ID</th>
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<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 900</td>
<td>Life Safety</td>
<td>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to conduct monthly inspections on 6 of 6 fire extinguishers. NFPA 10, 6.3.1. The findings included: Observation of the facility on 10/17/14 revealed all 6 fire extinguishers had not been inspected and recorded monthly on the extinguisher's tags since the annual fire extinguisher inspection conducted on May 2014. Based on observation, it was determined the facility failed to provide ground fault circuit interrupter receptacles serving wet areas. NFPA 70, 210-8 (b) (1). The findings included: Observation of the break room on 10/17/14 revealed the receptacles at the counter were not ground fault circuit interrupters. Based on observation, it was determined the facility failed to maintain smoke resistant assemblies in the facility. NFPA 101, 8.3.4.3.</td>
<td>A 900</td>
<td>After the inspection on 10/17/2014- A complete walk through on 10/21/2014 was performed on all fire extinguisher's. All 6 fire extinguisher's were inspected and documented by Nancy Shotwell, Clinic Coordinator. The task will be assigned monthly by Nancy Shotwell, Clinic Coordinator. Regulation 1200-8-10-09 NFPA 10, 6.3.1.</td>
<td>10/21/2014</td>
</tr>
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<td>(X4) ID PREFIX TAG</td>
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<td>(X9) COMPLETE DATE</td>
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<tr>
<td>A 900</td>
<td>Continued From page 1</td>
<td>A 900</td>
<td>After the inspection on 10/17/2014- On 10/21/2014, Christopher Lott disassembled all 5 door stops attached to the doors, assigned by Nancy Shotwell, Clinic Coordinator. All staff were informed to not secure the doors with a doorstop attachment. Regulation 1200-8-10-09 NFPA 101, 8.3.4.3</td>
<td>10/21/2014</td>
<td></td>
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<tr>
<td></td>
<td>The findings included:</td>
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<tr>
<td></td>
<td>Observation of the facility on 10/17/14 revealed 5 smoke resistant doors with kick down door stops attached and in use preventing the self closing of the doors.</td>
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<td></td>
<td>Based on record review it was determined the facility failed to provide annual testing of the fire alarm systems. NFPA 72, 7-3.2</td>
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<td></td>
<td>The findings included:</td>
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<tr>
<td></td>
<td>During the record review on 10/17/14, the facility failed to provide documentation of an annual fire alarm system test.</td>
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<td></td>
<td>These findings were verified and acknowledged by the facility director during the tour and exit conference on 10/17/14.</td>
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<tr>
<td>ID PREFIX</td>
<td>TAG</td>
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<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A614</td>
<td></td>
<td>1200-8-10-.06 (1)(n) Basic Services</td>
<td>A614</td>
<td></td>
<td>Intake form updated on 2/11/15 to capture organ donor status. This form is scanned into our EMR and becomes a permanent part of the record. Please see attached Intake form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Surgical Services.</td>
<td></td>
<td></td>
<td>The JAR was completed on 2/14/15 and will be submitted on 2/16/15.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(n) Properly executed informed consent, advance directive, and organ donation forms must be in the patient’s chart before surgery, except in emergencies.</td>
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<tr>
<td></td>
<td></td>
<td>This Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure organ donation forms were properly executed before surgery for 6 of 6 (Patients #1, 2, 3, 4, 5 and 6) sampled patients. The findings included:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1. Medical record review for Patients’ #1, 2, 3, 4, 5 or 6 revealed there was no information documented for organ donation information.</td>
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<tr>
<td></td>
<td></td>
<td>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.</td>
<td></td>
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<tr>
<td>A1101</td>
<td></td>
<td>1200-8-10-.11 (1) Records and Reports</td>
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<tr>
<td></td>
<td></td>
<td>(1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required. This Rule is not met as evidenced by: Based on interview, it was determined the facility failed to ensure the Joint Annual Report (JAR) was filed with the department.</td>
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<td>COMPLETE DATE</td>
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<tr>
<td>A1101</td>
<td>Continued From page 1</td>
<td>A1101</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The findings included:</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>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.</td>
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<td>A1405</td>
<td>1200-8-10-.14 (2) Disaster Preparedness</td>
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<tr>
<td></td>
<td>(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.</td>
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<tr>
<td></td>
<td>This Rule is not met as evidenced by:</td>
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<tr>
<td></td>
<td>Based on interview, it was determined the facility failed to provide evidence of participation with the Tennessee Emergency Management Agency (TEMA).</td>
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</tr>
<tr>
<td></td>
<td>The findings included:</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
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</tr>
</tbody>
</table>

On October 14, 2014, spoke with [redacted], Shelby County's TEMA contact. PPGMR has complied with TEMA.

This was our 1st acknowledgement of deficiencies from our visit on 10/14/14. It was received to PPGMR on [redacted].
Division of Health Care Facilities

<table>
<thead>
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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tr>
<td>TNPL53547</td>
<td>A. BUILDING: 01 - MEMPHIS REGIONAL PLANNED PARENTHOOD</td>
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<tr>
<td></td>
<td>B. WING 10/17/2014</td>
</tr>
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</table>

NAME OF PROVIDER OR SUPPLIER
PLANNED PARENTHOOD GREATER MEMPHIS
2430 POPULAR AVE
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 900</td>
<td>1200-8-10-09</td>
<td>Life Safety</td>
</tr>
</tbody>
</table>

This Rule is not met as evidenced by:
Based on observation it was determined the facility failed to conduct monthly inspections on 3 of 3 fire extinguishers. NFPA 10, 6.3.1

The findings included:

Observation of the facility on 10/17/14 revealed all 3 of the fire extinguishers had not been inspected and recorded for the month of September 2014, on the extinguisher's tags since the annual inspection on August 2014.

These findings were verified and acknowledged by the facility director during the tour and exit conference on 10/17/14.

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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<tbody>
<tr>
<td>A 900</td>
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</tbody>
</table>

Fire extinguishers were evaluated once a month. Please see emails from Health Center manager that supports monthly inspection.

RECEIVED NOV 11 2014

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Sarah Jellett, BSN, RN

VP OF PATIENT SERVICES
The findings included:

This Rule is not as clear as evidenced by:

Based on interview, was determined the facility failed to ensure the required signage was posted in accordance with these regulations.

Postings of (a) and (b) shall be on a sign no smaller than one inch high, and seventeen inches (17) in height. Authority: TCA §45-204.1, 45-204.6, 11-203, 86-1-21, 86-1-23.

(b) A statement that anyone who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in large and in a clear, visible manner, shall be on a sign in two feet high and seven inches (7) in height.

(c) A statement that anyone who may be the victim of sexual abuse or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation.

(d) A statement that anyone who may be the victim of abuse, neglect or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation!
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

(25) "No smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance.

This Rule is not met as evidenced by:
Based on interview it was determined the facility failed to ensure "no smoking" signs were posted at every entrance.

The findings included:

During an interview on 6/3/13 the Director of Patient Services stated the facility was a "no smoking" facility but failed to have signs indicating such clearly and conspicuously posted at every entrance.

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

(26) The facility shall develop a concise statement

A 453

And it check list to ensure that this deficiency does not reoccur.

PP MET will create a poster that provides the statement that every person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline. This information will be provided by a poster that is at least 8 1/2" x 11". The poster will be located near the main entrance before July 13. The required information on this poster has been added to the PP MET Annual Facility "And it check list to ensure that this deficiency does not reoccur.

PP MET will create a poster that provides the international symbol for "No Smoking." This information will be on a poster that is 8 1/2" x 11". The poster will be located...
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 455</td>
<td>Continued From page 2 of its charity care policies and shall post such statement in a place accessible to the public.</td>
<td>A 455</td>
<td>near the main entrance before 1 July 2013. The required information on this poster has been added to the PPMT Annual Facility Audit check-list to ensure this deficiency does not recur.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


This Rule is not met as evidenced by:
Based on interview it was determined the facility failed to have a posted statement regarding charity care in a place accessible to the public.

The findings included:
During an interview on 6/3/13 the Director of Patient Services stated the facility did offer charity care but did not have a sign posted of that policy/statement in a place accessible to the public.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td>A 002</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Rule is met as evidenced by:

Based on observations, testing, and records review it was determined the facility had no life safety deficiencies.
### Division of Health Care Facilities

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(x2) PROVIDER/ SUPPLIER/CJA ID</th>
<th>(x3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>TNPL63544</td>
<td>05/28/2013</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1726 POPULAR AVENUE
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>(x4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>(x6) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 420</td>
<td>1200-8-10-.04 Administration (16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges.</td>
<td>A 420</td>
<td>1) Clinical Services Coordinator contacted Medical Director to request updated verification of clinical privileges. 2) E-mail correspondence verifying current, up-to-date privileges received by CHOICES Clinical Services Coordinator. See Attachment 1 of I. 3) Director of Human Resources and Leadership 07/10/2013 will review current CHOICES policy and procedure for verifying current, updated licensure, credentialing, and/or certifications for all staff, contractors and personnel employed by or contracted to provide clinical services at CHOICES to ensure that current policy addresses systemic review of all appropriate personnel files annually. 4) CHOICES policy and procedure addressing 07/10/2013 personnel, contractors and employees of CHOICES will be amended by Leadership Team to ensure that policy addresses systemic, ongoing annual review of employee, personnel and contractor files. 5) Annual report regarding state of employee, personnel and contractor files in regards to licensure, certification and/or credentialing as appropriate and any identified deficiencies will be made and documented during Leadership Team meeting. For 2013, meeting will be scheduled to occur 09/11/2013. Meeting will be scheduled in September annually on an ongoing basis.</td>
<td>05/29/2013</td>
</tr>
<tr>
<td>A 435</td>
<td>1200-8-10-.04 (20)(c)4. Administration (20) Infection Control.</td>
<td>A 435</td>
<td>Plan of Correction 1) CHOICES current policy and procedure related 07/13/2013 to Infection Control and 1200-8-10-.04 will be scheduled to occur at meeting of CHOICES Infection Control Committee. Documentation of review of pertinent literature and findings as well as recommendations of Infection Control Committee will be documented in meeting notes of Medical Services Committee.</td>
<td>05/29/2013</td>
</tr>
</tbody>
</table>

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

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

**STATE FORM**

**TITLE**

**SIGNATURE**

**DATE**

JUL 05 2013
Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA
IDENTIFICATION NUMBER:

TNPL53544

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: __________
B. WING: __________

(X3) DATE SURVEY COMPLETED

05/29/2013

NAME OF PROVIDER OR SUPPLIER

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH

STREET ADDRESS, CITY, STATE, ZIP CODE

1726 POPULAR AVENUE
MEMPHIS, TN 38104

[X4] ID PREFIX TAG

[435] Continued From page 1

high risk areas, sources of air pollution, and routine culturing of autoclaves and sterilizers;

This Rule is not met as evidenced by:
Based on Center for Disease Control Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, and interview, it was determined the facility failed to monitor the sterilizer temperature during usage.

The findings included:

Review of the Center for Disease Control Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, page 59 documented, "...sterilizers usually are monitored using a printout (or graphically) by measuring temperature, the time at the temperature, and pressure..."

During an interview in the conference room on 5/29/13 at 3:25 PM the Clinical Services Coordinator stated there was no documentation of the temperature the autoclave digitally reads during usage.

A 435 200-8-10-04 (20)(c)(5). Administration

(20) Infection Control.

(c) The chief executive officer or administrator shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develops guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the committee shall include the establishment of:

2) CHOICES policy and procedure regarding
Infection Control specific to operation, cleaning and monitoring as well as maintenance of autoclave will be reviewed to ensure CHOICES policy and procedure meets relevant guidelines. Specific guidelines which will be utilized for review are as follows:

b) MidMark M9 Ultrasafe Steam Sterilizer Installation and Operation Manual.
d) Henry Schein Autoclave Tape Product Information (1/1-052 Rev A)
e) Henry Schein Self Seal Sterilization Seals with Internal and External Indicators (Current Lot Version)

3) All recommendations for amendments to 08/17/2013

CHOICES Policy and Procedure regarding infection control. Policy and procedure relevant to autoclave and sterilization process proposed at meeting on 07/13/2013 will be incorporated and documented as amendments to current CHOICES Infection Control policy and Procedure. Clinical Services Coordinator will be charged with incorporating any recommendations for amendments and presenting draft of updated policy and procedure at Medical Services Committee Meeting scheduled for August 2013.

Anticipate review and final approval of updated policy and procedure by both Medical Director and Infection Control Committee by 08/17/2013.

4) Annual review of CHOICES policy and procedure August 2013 related to Infection Control and specifically to Autoclave and Sterilization process will be scheduled to occur monthly by August 2014. Amendments to CHOICES policy to Infection Control or procedures will be conducted according to CHOICES policy amending Medical Policy and Procedure.
A 436 Continued From page 2

5. A log of incidents related to infectious and communicable diseases;

This Rule is not met as evidenced by:
Based on interview, it was determined the facility failed to ensure it maintained a log of incidents related to infectious and communicable diseases.

The findings included:
During an interview in the conference room on 5/29/13 at 3:35 PM the Clinical Services Coordinator stated there was no log of incidents related to infectious and communicable diseases due to the nature of the procedures performed at the facility.

A 436 PLAN OF CORRECTION

1) Documentation of CHOICES Infection Review Committee review of infection incidents (no reported incidents) was shown to inspector at time of site visit.

2) Choicies current policy and procedure related to Infection control specific to 1200-8-04(20)(c)(2) will be reviewed during Medical Service Committee Meeting by Medical Director and Infection Control Committee to ensure the policy and procedure appropriately addresses regulation specifically to log of incidents related to infectious and communicable diseases.

3) Clinical Services Coordinator will be charged with coordinating and drafting any recommended changes identified by CHOICES Infection Control Committee and updating current CHOICES Infection Control Policy and Procedure for review and approval by Medical Director, Medical Services Committee and Infection Control Committee by 08/17/2013.

4) Clinical Services Coordinator will report quarterly to Infection Control Committee during Medical Services Committee Meeting on any incidents related to infectious and communicable diseases. Documentation of report, review and findings as well as any additional recommendations by Infection Control Committee will be in CHOICES Medical Services Committee Meeting notes.

5) Annual review of CHOICES infection Control Policy and procedure as well as annual review of previous year report will be scheduled to occur annually during September Medical Services Committee Meeting.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<tbody>
<tr>
<td>A1401</td>
<td>1200-8-10-14 (1)(a) Disaster Preparedness (1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually: (a) Fire Safety Procedures Plan shall include: 1. Minor fires; 2. Major fires; 3. Fighting the fire; 4. Evacuation procedures; 5. Staff functions. This Rule is not met as evidenced by: Based on observations during the record review on 5/29/13, the facility failed to conduct fire drills in every quarter of 2012. The findings included: During the fire drill record review, the facility did not have a fire drills during the 2nd and 3rd</td>
<td>A1401</td>
<td>(1) CHOICES has scheduled staff trainings for Disaster preparedness: Fire Safety Procedure for 2013. Training will be conducted by Director of Purchasing &amp; Facilities. Staff attendance will be documented along with detailed log of agenda and topics covered. (2) Nonattendance will be managed according to CHOICES current policy on staff trainings. Individual staff not in attendance will be required to review and document review of CHOICES Fire Safety Disaster Training manual in accordance with CHOICES policy. (3) CHOICES has conducted Fire Drills on 3/21/13 and 6/4/13, and additional quarterly drills have been scheduled. These have and will be conducted by the Director of Purchasing &amp; Facilities. Unannounced drills have also been scheduled for 2013 for a total of 1 Fire drill per quarter according to requirements of regulation 1200-8-19.14(1)(a).</td>
<td>07/10/13</td>
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</tbody>
</table>

**División de Salud de las Instituciones de Cuidado con Salud **

**Firma del Laboratorio Directores o Representantes del Proveedor/Suministrador**

**Fecha de Recepción**

**Firma**

**Fecha**

**Titulo**

**Fecha**

**Fecha**

**Fecha**

**Fecha**
<table>
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<tr>
<th>ID</th>
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<tbody>
<tr>
<td>A1401</td>
<td>Continued From page 1 quarters of the year 2012.</td>
<td></td>
</tr>
<tr>
<td>A1404</td>
<td>1200-8-10-14 (1)(d) Disaster Preparedness</td>
<td></td>
</tr>
</tbody>
</table>

(1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually:

(d) Earthquake Disaster Procedures Plan:

1. Staff duties;
2. Evacuation procedures;
3. Safety procedures;
4. Emergency services.

This Rule is not met as evidenced by:
Based on observations on 5/28/13, it was determined the facility failed to conduct disaster drills during 2012.

The findings included:
During the record review on 5/28/13, the facility...
**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
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</thead>
<tbody>
<tr>
<td>A1404</td>
<td>Continued From page 2</td>
<td>failed to conduct an earthquake drill during the 2012 year.</td>
<td>A1404</td>
<td>(4)</td>
<td>Continued</td>
<td>training by reviewing and documenting review of CHOICES Earthquake Safety Disaster Preparedness Training Manual according to CHOICES policy. Any amendments or deficiencies identified by the Director of Purchasing and Facilities or during Leadership Team's review of CHOICES Disaster Preparedness policies will be reflected in Leadership Team meeting notes and will be amended and/or a plan of correction implemented immediately &amp; reviewed annually.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1405</td>
<td>1200-8-10-14 (2)</td>
<td>Disaster Preparedness</td>
<td>A1405</td>
<td>(1)</td>
<td>Contacted Shelby County Chairman of TN Emergency Preparedness by telephone, requested information re/ Regulation 1200-8-10-14(2)</td>
<td>05/29/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1405</td>
<td>(2)</td>
<td></td>
<td>A1405</td>
<td>(2)</td>
<td>Contacted Director of TN Emergency Management by telephone, requested information re/ Regulation 1200-8-10-14(2)</td>
<td>07/02/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1405</td>
<td>(3)</td>
<td></td>
<td>A1405</td>
<td>(3)</td>
<td>Received and completed Basic Health Care Facility Survey form and submitted to Director of TN Emergency Management (See attachment 1, 1 of 1 pages)</td>
<td>07/02/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1405</td>
<td>(4)</td>
<td></td>
<td>A1405</td>
<td>(4)</td>
<td>Reviewed information and report regarding Regulation 1200-8-10-14(2) and follow up steps. Scheduled review with Leadership Team along with draft of policy to address regulation. Review will be documented in Leadership Team mgmt notes.</td>
<td>07/10/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1405</td>
<td>(5)</td>
<td></td>
<td>A1405</td>
<td>(5)</td>
<td>Scheduled annual review of Disaster Preparedness Policies and Procedures to be conducted on ongoing basis by Leadership Team. Any amendments or deficiencies identified by the Director of Purchasing and Facilities or during Leadership Team's review of CHOICES Disaster Preparedness policies will be reflected in Leadership Team meeting notes and will be amended and/or a plan of correction implemented immediately &amp; reviewed annually.</td>
<td>07/10/13</td>
<td></td>
<td></td>
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</tbody>
</table>

**This Rule is not met as evidenced by:**

Based on observations on 5/29/13, it was determined the facility failed to participate in a local county emergency plan on an annual basis.

The findings included:

During the record review on 5/28/13, the facility did not have documentation showing participation in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis.

The finding was acknowledged by the Assistant Administrator at the exit interview on 5/29/13.
A 420 1200-8-10-04 (16) Administration

(16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges.

This Rule is met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure clinical privileges were granted for the Medical Director.

The findings included:

Review of the Medical Director's employee record revealed no documentation of current clinical privileges.

During an interview on 5/28/13 at 2:25 PM the Vice President of Patient Services verified there was no documentation of the current clinical privileges for the Medical Director.

A 624 1200-8-10-06 (1)(p).3. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

3. Atropine 0.1 mg/ml

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have atropine on the crash cart.

Americans United for Life

AUG 15 2013
Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:

TNPL53547

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: __________________________
B. WING: __________________________

(X3) DATE SURVEY COMPLETED
05/28/2013

NAME OF PROVIDER OR SUPPLIER
PLANNED PARENTHOOD GREATER MEMPHIS

STREET ADDRESS, CITY, STATE, ZIP CODE
2430 POPULAR AVE
MEMPHIS, TN 38104

(X4) ID
PREFIX TAG

(X5) COMPLETE DATE

A 624 Continued From page 1
The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no atropine available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner (NP) verified there was no atropine available for emergency use. The NP stated, "...on back order..."

A 626 1200-8-10-06 (1)(p)(5). Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

5. calcium chloride 10%; 10ml amp

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have calcium chloride available on the crash cart.

The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no calcium chloride available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no calcium chloride available for emergency use.

PREMAR will develop a protocol specifying the required emergency cart drugs and why we exclude calcium chloride. This protocol will be reviewed and approved by the Medical Director and the CEO by September 15, 2013. This protocol will be reviewed and updated annually by the Medical Director.
Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER:

TNPL53547

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: __________
B. WING: __________

(X3) DATE SURVEY COMPLETED

05/28/2013

NAME OF PROVIDER OR SUPPLIER
PLANNED PARENTHOOD GREATER MEMPHIS

STREET ADDRESS, CITY, STATE, ZIP CODE
2430 POPULAR AVE
MEMPHIS, TN 38104

(X4) ID
PREFIX TAG

A 628

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

A 628

ID PREFIX TAG

(1) Surgical Services.

(1) (p) A crash cart must be available and include at
a minimum the following medication and supplies:

7. dilantin (phenotoin)

This Rule is not met as evidenced by:
Based on observation and interview, it was
determined the facility failed to have dilantin
available on the crash cart.

The findings included:

1. Observations of the crash cart contents
5/28/13 at 1:40 PM revealed there was no dilantin
available.

2. During an interview in the recovery room area
on 5/28/13 at 1:55 PM the Nurse Practitioner
verified there was no dilantin available for
emergency use.

A 629

1200-8-10-.06 (1)(p)8. Basic Services

1. Surgical Services.

(1) (p) A crash cart must be available and include at
a minimum the following medication and supplies:

8. dopamine

This Rule is not met as evidenced by:
Based on observation and interview, it was
determined the facility failed to have dopamine
available on the crash cart.

PPGRME will develop a protocol
specifying the required emergency
cart drugs and why we exclude
dilantin. This protocol will be
reviewed and approved by the Medical
Director and CEO by September 15,
2013. This protocol will be reviewed
and updated annually by the Medical
Director.

PPGRME will develop a protocol specifying
the required emergency cart drugs and why we exclude
dopamine. This protocol will be reviewed and approved
by the Medical Director and CEO by
September 15, 2013. This protocol will be reviewed
and updated annually by the Medical Director.
A 629. Continued From page 3

The findings included:

1. Observations of the crash cart contents on 5/28/13 at 1:40 PM revealed there was no dopamine available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no dopamine available for emergency use.

A 630 1200-8-10-.06 (1)(p)9. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

9. heparin

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have heparin available on the crash cart.

The findings included:

1. Observations of the crash cart contents on 5/28/13 at 1:40 PM revealed there was no heparin available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no heparin available for emergency use.

PPGMR will develop a protocol specifying the required emergency cart drugs and why we excluded heparin. This protocol will be reviewed and approved by the Medical Director and filed by 9/15/13. This protocol will be reviewed and updated annually by the Medical Director.
A 631  Continued From page 4
A 631 1200-8-10-.06 (1) (p) 10. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

10. inderal (propranolol)

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have inderal available on the crash cart.

The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no inderal available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no inderal available for emergency use.

A 632 1200-8-10-.06 (1) (p) 11. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

11. Isuprel

PPGMC will develop a protocol specifying the required emergency cart drugs and why Inderal was excluded. This protocol will be reviewed and approved by the Medical Director and CEO by 9/15/13. This protocol will be reviewed and updated annually by the Medical Director.
A 632: Continued From page 5

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have isuprel available on the crash cart.

The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no isuprel available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no isuprel available for emergency use.

A 633 1200-8-10-.06 (1)(p)12. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

12. Ipanoxin (digoxin)

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have Ipanoxin 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 Ipanoxin available.

The protocol will develop a protocol specifying the required emergency cart drugs and why we excluded Digoxin. This protocol will be reviewed and approved by the Medical Director and CED by 9/1/13. This protocol will be reviewed and/or updated annually by the Medical Director.
A 633  Continued From page 6
available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no lasix available for emergency use.

A 634  1200-8-10-.06 (1)(p)13. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

13. lasix (furosemide)

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have lasix available on the crash cart.

The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no lasix available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no lasix available for emergency use.

A 635  1200-8-10-.06 (1)(p)14. Basic Services

1. Surgical Services.

(p) A crash cart must be available and include at
A 635: Continued From page 7

14. xylocaene (lidocaine)

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have xylocaene 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 xylocaene 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 xylocaene available for emergency use.

A 636: 1200-8-10-.06 (1)(p) 15. Basic Services

1. Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

15. magnesium sulfate 50%

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have magnesium sulfate available on the crash cart.

The findings included:

A 635: and CEO by 9/15/13. The Medical Director will review and for update annually.

PPGMR. will develop a protocol specifying the required crash cart drugs and why we excluded Magnesium Sulfate. This protocol will be reviewed and approved by the Medical Director and CEO. This protocol will be reviewed and for updated annually by the Medical Director. The protocol will be completed by 9/15/13.
A 636  Continued From page 8

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no magnesium sulfate available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no magnesium sulfate available for emergency use.

---

A 638  1200-8-10-.06 (1)(p)17. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

17. progestin (procamidina)

This Rule is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to have progestin 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 progestin 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 progestin available for emergency use.
A 639    Continued From page 9

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

18. sodium bicarbonate 50 mEq/50ml

This Rule is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to have sodium bicarbonate available on the crash cart.

The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no sodium bicarbonate available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no sodium bicarbonate available for emergency use.

A 640 1200-8-10-.06 (1)(p)19. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

19. solu-medrol (methylprednisolone)

This Rule is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to have solu-medrol...
A 640. Continued From page 10
available on the crash cart.

The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no solu-medrol available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no solu-medrol available for emergency use.

A 641. 1200-8-10-.06 (1)(p)20. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

20. verapamil hydrochloride

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have verapamil hydrochloride available on the crash cart.

The findings included:

1. Observations of the crash cart contents 5/28/13 at 1:40 PM revealed there was no verapamil hydrochloride available.

2. During an interview in the recovery room area on 5/28/13 at 1:55 PM the Nurse Practitioner verified there was no verapamil hydrochloride available for emergency use.

PPLene will develop a protocol specifying the required crash cart drugs and will exclude verapamil hydrochloride. The protocol will be reviewed and/or uploaded annually by the Medical Director.
<table>
<thead>
<tr>
<th>A 002</th>
<th>1200-8-10 No Deficiencies</th>
<th>A 002</th>
</tr>
</thead>
</table>

This Rule is not met as evidenced by:
During the annual survey on 5/28/13, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-10.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| A 614 | 1200-8-10-.06 (1)(n) Basic Services | (1) Surgical Services.  
(n) Properly executed informed consent, advance directive, and organ donation forms must be in the patient’s chart before surgery, except in emergencies.  
This Rule is not met as evidenced by:  
Based on medical record review and interview, it was determined the facility failed to execute advance directive and organ donation forms for 6 of 6 (Patient #1, 2, 3, 4, 5, and 6) sampled patients.  
The findings included:  
1. Medical record review for Patients #1, 2, 3, 4, 5, and 6 did not document if the patients had advance directives or if they were organ donors.  
2. During an interview in the Vice President of Patient Services office on 11/8/11 at 3:00 PM, the Nurse Practitioner stated the clinic did not ask about advance directives or organ donation due to the age of the patients served. | A 614 | PPNET will develop and advance directive and organ donation form. This form will be reviewed with each surgical pt. and maintained in her chart.  
This form will be implemented by Jan 1, 2012. It will also become part of our quarterly chart audit. |
| A 626 | 1200-8-10-.08 (1)(p)5. Basic Services | (1) Surgical Services.  
(p) A crash cart must be available and include at a minimum the following medication and supplies:  
5. calcium chloride 10%; 10ml amp | A 626 | PPNET will develop protocol specifying the required emergency cart drugs and why we include Calcium Chloride 10%. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This |
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 626</td>
<td>continued from page 1 determined the facility failed to have calcium chloride available on the crash cart.</td>
<td>protocol will be reviewed and updated annually by the Medical Director.</td>
<td></td>
</tr>
<tr>
<td>A 627</td>
<td>1200-3-10-06 (1)(p)6. Basic Services</td>
<td>PPMET will develop a protocol specifying the required emergency cart drugs and why we exclude dextrose 50%</td>
<td></td>
</tr>
<tr>
<td>(1) Surgical Services.</td>
<td>This protocol will be reviewed and approved by the Medical Director and the CEO by Dec 2012. This protocol will be reviewed and updated annually by the Medical Director.</td>
<td></td>
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<tr>
<td>(p) A crash cart must be available and include at a minimum the following medication and supplies:</td>
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<tr>
<td>8. Dextrose, 50%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>The findings included:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
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<tr>
<td>2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no dextrose 50% available for emergency use.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>ID PREFIX TAG</td>
<td>STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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<tr>
<td>A 628</td>
<td>1200-8-10-.06 (1)(p)7. Basic Services&lt;br&gt;&lt;br&gt;(1) Surgical Services.&lt;br&gt;&lt;br&gt;(p) A crash cart must be available and include at a minimum the following medication and supplies:&lt;br&gt;&lt;br&gt;7. Dilantin (Phentoin)&lt;br&gt;&lt;br&gt;This Rule is not met as evidenced by:&lt;br&gt;&lt;br&gt;Based on observation and interview, it was determined the facility failed to have Dilantin available on the crash cart.&lt;br&gt;&lt;br&gt;The findings included:&lt;br&gt;&lt;br&gt;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.&lt;br&gt;&lt;br&gt;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.&lt;br&gt;&lt;br&gt;A 629</td>
<td>1200-8-10-.06 (1)(p)8. Basic Services&lt;br&gt;&lt;br&gt;(1) Surgical Services.&lt;br&gt;&lt;br&gt;(p) A crash cart must be available and include at a minimum the following medication and supplies:&lt;br&gt;&lt;br&gt;8. Dopamine&lt;br&gt;&lt;br&gt;This Rule is not met as evidenced by:&lt;br&gt;&lt;br&gt;Based on observation and interview, it was determined the facility failed to have dopamine available on the crash cart.&lt;br&gt;&lt;br&gt;PNNET will develop a protocol specifying the required emergency cart drugs and why we exclude Dilantin. This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.</td>
<td>11/08/2011</td>
</tr>
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</table>
**A 629** Continued From page 3

The findings included:

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no dopamine available.

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no dopamine available for emergency use.

**A 630** 1200-8-10-.06 (1)(p)9. Basic Services

1. Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

9. heparin

This Rule is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to have heparin available on the crash cart.

The findings included:

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no heparin available.

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no heparin available for emergency use.
<table>
<thead>
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<tbody>
<tr>
<td>A 631</td>
<td><strong>Continued From page 4</strong> 1200-8-10-.06 (1)(p)10. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 10. inderal (propranolol) <strong>This Rule is not met as evidenced by:</strong> Based on observation and interview, it was determined the facility failed to have inderal on the crash cart. <strong>The findings included:</strong> 1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no inderal available. 2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no inderal available for emergency use.</td>
<td>A 631</td>
<td><strong>PPMNET will develop a protocol specifying the required emergency cart drugs and why we include inderal.</strong> This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually by the Medical Director.</td>
</tr>
<tr>
<td>A 631</td>
<td>1200-8-10-.06 (1)(p)11. Basic Services (1) Surgical Services. (p) A crash cart must be available and include at a minimum the following medication and supplies: 11. isuprel</td>
<td>A 632</td>
<td><strong>PPMNET will develop a protocol specifying the required emergency cart drugs and why we exclude isuprel.</strong> This protocol will be reviewed by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually.</td>
</tr>
</tbody>
</table>
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Planned Parenthood of Middle and East

**Address:** 412 D. B. Todd Boulevard, Nashville, TN 37203

<table>
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<th>Prefix Tag</th>
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<tbody>
<tr>
<td>A 632</td>
<td>Continued From page 5</td>
<td>A 632</td>
<td></td>
</tr>
</tbody>
</table>

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.

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<th>Prefix Tag</th>
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<th>Prefix Tag</th>
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<tr>
<td>A 633</td>
<td>1200-8-10-06 (1)(p)12. Basic Services</td>
<td>A 633</td>
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</table>

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

12. Iannoix (digoxin)

This Rule is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to have Iannoix available on the crash cart.

The findings included:

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed...
A 633  Continued From page 6  
there was no lanoxin available.  

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no lanoxin available for emergency use.

A 634  
1200-8-10-.06 (1)(p)13. Basic Services  

(1) Surgical Services.  

(p) A crash cart must be available and include at a minimum the following medication and supplies:  

13. lasix (furosemide)

This Rule is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to have lasix available on the crash cart.  

The findings included:  

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no lasix available.  

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no lasix available for emergency use.

A 636  
1200-8-10-.06 (1)(p)15. Basic Services  

1. Surgical Services.  

(p) A crash cart must be available and include at
Continued From page 7

a minimum the following medication and supplies:

15. magnesium sulfate 50%

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have magnesium sulfate 50% available on the crash cart.

The findings included:

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no magnesium sulfate 50% available.

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no magnesium sulfate 50% available for emergency use.

A 636

1200-8-10-06 (1)(p)17. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

17. pronestyl (procainamide)

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have pronestyl available on the crash cart.

The findings included:

A 636
A 638  Continued from page 8

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no pronestyl available.

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no pronestyl available for emergency use.

A 639  1200-8-10-06 (1)(p)18. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

18. sodium bicarbonate 50 mEq/50ml

This Rule is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to have sodium bicarbonate 50 mEq/50ml on the crash cart.

The findings included:

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no sodium bicarbonate 50 mEq/50ml available.

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no sodium bicarbonate 50 mEq/50ml available for emergency use.

PPM/T will develop a protocol specifying the required emergency cart drugs and why we should store sodium bicarbonate 50 mEq/50ml.

This protocol will be reviewed and approved by the Medical Director and the CEO by Jan 1, 2012. This protocol will be reviewed and updated annually.
Continued From page 9
1200-8-10-06 (1)(p)20. Basic Services

(1) Surgical Services.

(p) A crash cart must be available and include at a minimum the following medication and supplies:

20. verapamil hydrochloride

This Rule is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to have verapamil hydrochloride available on the crash cart.

The findings included:

1. Observations of the crash cart contents in the recovery area on 11/8/11 at 2:40 PM revealed there was no verapamil hydrochloride available.

2. During an interview in the recovery room area on 11/8/11 at 2:45 PM the Nurse Practitioner verified there was no verapamil hydrochloride available for emergency use.

A 672
1200-8-10-06 (3)(c) Basic Services

(3) Medical Staff.

(c) Clinical privileges shall be granted based on the practitioners’ qualifications and the services provided by the facility, and shall be reviewed and/or revised at least every two (2) years.

This Rule is not met as evidenced by:

PPMNET will develop a protocol specifying the required emergency cart drugs and why we exclude verapamil hydrochloride.

This protocol will be reviewed and approved by the Medical Director and the CEO by Jul 2012. This protocol will be reviewed and updated annually by the Medical Director.
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>A 672</td>
<td>Continued From page 10</td>
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<tr>
<td></td>
<td>Based on review of physician information and interview, it was determined the facility failed to maintain current privilege information for 4 of 5 (Physician #2, 3, 4, and 5) physicians on staff. The findings included:</td>
</tr>
<tr>
<td></td>
<td>1. Review of a one page document that listed credentialling information documented Physician #2 had no current Drug Enforcement Agency (DEA) number, no current privileges, and no current background check.</td>
</tr>
<tr>
<td></td>
<td>2. Review of a one page document that listed credentialling information documented Physician #3 had no current DEA number and no current background check.</td>
</tr>
<tr>
<td></td>
<td>3. Review of a one page document that listed credentialling information documented Physician #4 had no current DEA number and no current background check.</td>
</tr>
<tr>
<td></td>
<td>4. Review of a one page document that listed credentialling information documented Physician #5 had no current DEA number, no current privileges, and no current background check.</td>
</tr>
<tr>
<td></td>
<td>5. During an Interview in the Vice President of Patient Services (VPPS) office on 11/8/11 at 3:30 PM, the VPPS stated they have a company hired that credentials the physicians. The clinic verifies the Medical Director's DEA number is current because medications are ordered under his number. He stated the clinic only began doing background checks during the past year.</td>
</tr>
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<tr>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>A 672</td>
<td>review and audit all employee files to ensure proper documentation is maintained and updated. Annual HR audits will be conducted. Copies of DEA licenses will be in each physician file by Jan 1, 2012. Copies of the Medical Director review for each physician will be completed by Jan 1, 2012. Background checks for each physician shall be completed by Jan 1, 2012.</td>
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</table>

A1101 1200-8-10-11 (1) Records and Reports (1) The Joint Annual Report of Ambulatory
<table>
<thead>
<tr>
<th>ID</th>
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| A1101 | Continued From page 11 | A1101 | PPMET that per her supervisor, Lonelle Matthews, abortion providers did not need to complete the report according to TCA internal guidelines and to protect the confidentiality of abortion providers.

Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required.

This Rule is not met as evidenced by:

Based on interview, it was determined the facility failed to ensure the Joint Annual Report (JAR) of Ambulatory Surgical Treatment Centers was filed with the department for the 2010 year.

The findings included:

- The facility was unable to provide a copy of the JAR for the 2010 year.

During an interview in the Vice President of Patient Service's office on 11/8/11 at 3:10 PM, he stated he would have to call the corporate office to see if the JAR was submitted for the 2010 year.

RECEIVED

JAN 8, 2012
<table>
<thead>
<tr>
<th>A 802</th>
<th>1200-8-10-.08 (2) Building Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(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.</td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>Based on observations, it was determined the facility failed to maintain the overall Ambulatory Surgical Treatment Center environment.</td>
</tr>
<tr>
<td></td>
<td>The findings include:</td>
</tr>
<tr>
<td></td>
<td>On 11/9/11 at 9:35 AM, observation within the Director's office revealed there was a 3&quot; by 4&quot; cut-out penetration within the sheetrock wall.</td>
</tr>
<tr>
<td></td>
<td>2. On 11/9/11 at 10:00 AM, observation within the supply storage revealed a penetration within the left-side wall.</td>
</tr>
<tr>
<td></td>
<td>These findings were acknowledged and verified by the Assistant Director during the exit interview on 11/9/11.</td>
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<table>
<thead>
<tr>
<th>A 901</th>
<th>1200-8-10-.09 (1) Life Safety</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.</td>
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<td></td>
<td>This Rule is not met as evidenced by:</td>
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|       | Based on observations, it was determined the
<table>
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<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
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<tbody>
<tr>
<td>A 901</td>
<td>Continued From page 1 facility failed to maintain the electrical system.</td>
<td>A 901</td>
<td></td>
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<tr>
<td></td>
<td>The findings include:</td>
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<tr>
<td></td>
<td>On 11/9/11 at 9:45 AM, observation within consulting room revealed an electric outlet behind the entry door without a cover plate.</td>
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<tr>
<td></td>
<td>This finding was acknowledged and verified by the Assistant Director during the exit interview on 11/9/11.</td>
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<tr>
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<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</td>
<td>(X5) COMPLETE DATE</td>
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<tr>
<td>A 002</td>
<td>1200-8-10 No Deficiencies</td>
<td>A 002</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Rule is met as evidenced by: This facility complies with all requirements reviewed for Ambulatory Surgical Treatment Centers surveyed during the annual licensure survey conducted 3/1/2010. No deficiencies were cited.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A 801</td>
<td>1200-8-10-.08 (1) Building Standards</td>
<td>A 801</td>
<td>1) Spoke with building manager, Dave Disney, and this has been corrected on 3/9/10.</td>
<td>3/9/10</td>
</tr>
<tr>
<td></td>
<td>(1) The Ambulatory Surgical Treatment Center must be constructed, arranged, and maintained to ensure the safety of the patient.</td>
<td></td>
<td>2) The exam room emergency light was repaired by Mid South Emergency Lights on 3/9/10.</td>
<td>3/9/10</td>
</tr>
<tr>
<td></td>
<td>This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the Ambulatory Surgical Treatment Center in a manner that would ensure the safety of the patients.</td>
<td></td>
<td>3) I have attached the e-mail from the building manager, Dave Disney, in regards to the generator. We do not have a tentative completion date. To assure that the deficient practices does not recur, we will continue to notify building management in a timely fashion and we will continue to do our routine clinic inspections which includes visual inspections of the sited observations.</td>
<td>3/9/10</td>
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<td></td>
<td>The findings included: observations during the facility tour on 3-4-10 beginning at 9:00 AM, the following deficiencies were found:</td>
<td></td>
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<tr>
<td></td>
<td>1. The exit light was inoperative in the Administration hall rear.</td>
<td></td>
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<tr>
<td></td>
<td>2. The emergency light in exam room [ ] was broken.</td>
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<tr>
<td></td>
<td>3. The emergency generator testing reports are not on site for review.</td>
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</tr>
</tbody>
</table>

(Handwritten notes: Acceptable by Shelley 3/9/10)