

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/16/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 EAST 3900 SOUTH, SUITE 203 SALT LAKE CITY, UT 84107</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	<p>Initial Comments</p> <p>On 4/16/19, a scheduled recertification survey was conducted. The facility was surveyed according to R432-600 Rules for Abortion Clinics. No deficiencies were identified.</p>	G 000		
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Bureau of Licensing and Certification  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Apple*

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/17/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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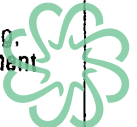
G 000	Initial Comments  A scheduled re-licensure survey was completed 04/17/14. The facility was surveyed against the R432-600 rules for abortion clinics. A deficiency was cited.	G 000	1. Each employee will have a signed job description in their employee file.	
G 240	R432-600-8(6)(c) Administrator  (6) Responsibilities shall include at least the following: (c) Develop clear and complete job descriptions for each position;  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the administrator did not develop clear and complete job descriptions for each position, for 3 of 4 sampled employees. Employee Identifiers: 2, 3, and 4.  Findings Include:  On 04/17/14, a review of employee records was completed and revealed 3 employees records did not include job descriptions as follows:  1.) Employee 2's date of hire was 01/24/14, no job description was present in her record. 2.) Employee 3's date of hire was 08/14/13, no job description was present in her record. 3.) Employee 4's date of hire was 10/17/13, no job description was present in her record.  On 04/17/14 at 1:00 P.M., an interview was initiated with the clinic administrator, who acknowledged Employees 2, 3, and 4 did not have job descriptions. No further documentation was provided.	G 240	2. Zandy Nicolosi (administrator) will be responsible for the correction.  3. The correction was completed on 5/2/14	

*5-13-14  
POL  
Acceptable  
Complete date  
5-2-14*

Utah Department of Health

MAY 13 2014

Bureau of Health Facility Licensing,  
Certification and Resident Assessment



**Americans  
United  
for Life**

Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Zandy Nicolosi*

TITLE

*Administrator*

(X6) DATE

*5/13/14*

Utah Department of Health, Health Facility Licensing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/04/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 EAST 3900 SOUTH, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G 000	Initial Comments  A scheduled relicensure survey was conducted on 4/4/18. The facility was surveyed against the R432-600 rules for abortion clinics. No deficiencies were cited.	G 000		
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for Life**

Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE

*Administrator*

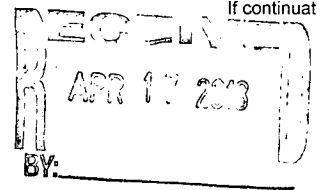
(X6) DATE

STATE FORM

6899

5JKK11

If continuation sheet 1 of 1



*[Handwritten mark]*

*AW*  
Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/17/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G 000	Initial Comments  An unannounced semi-annual survey was conducted on 9/17/13. The facility was surveyed against the R432-600 rules for abortion clinics. The facility met the minimum standards set forth in those rules. No deficiencies were cited.	G 000		
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Utah Department of Health

OCT 03 2013

Bureau of Health Facility Licensing,  
Certification and Resident Assessment



Americans  
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for Life

Your Agency Name *Wasatch Womens Center*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Judy N...*

TITLE

*Administrative*

(X6) DATE

Utah Department of Health, Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/02/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 EAST 3900 SOUTH, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G 000	<p>Initial Comments</p> <p>On 10/2/17, an unscheduled relicensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiencies were cited.</p>	G 000		
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**RECEIVED**

OCT 26, 2017

Utah Department of Health  
Health Facility Licensing  
and Certification



Americans  
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for Life**

Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*R*

Utah Department of Health, Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/25/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 EAST 3900 SOUTH, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G 000	<p>Initial Comments</p> <p>On 04/25/17, a scheduled re-licensure survey was conducted. The facility was surveyed according to R 432-600 rules for abortion clinics. No deficiencies were cited.</p>	G 000		
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MAY 11 2017

Utah Department of Health  
Health Facility Licensing and Certification

**Americans United for Life**

Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE (X6) DATE

Administrator **for Life**

*[Handwritten Mark]*

*Adole*

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/15/2012</b>
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G 000	<p>Initial Comments</p> <p>A re-certification survey was completed 11/15/12. The facility was surveyed against the R432-600 rules for abortion clinics. No deficiencies were cited.</p>	G 000	<p>Utah Department of Health</p> <p><b>DEC 05 2012</b></p> <p>Bureau of Health Facility Licensing, Certification and Resident Assessment</p>	
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Your Agency Name *Wasatch Women's Center*

*[Signature]*  
LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*Administrator*



Utah Department of Health, Licensing and Certification

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G 000 Initial Comments  
  
On 10/2/19, an unscheduled re-licensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. Regulatory non-compliance was identified. Deficiencies were cited.

G 065 R432-600-6(3)(d) Organization  
  
(3) Responsibilities shall include at least the following:  
(d) Appoint, in writing, a qualified medical director to be responsible for clinical services;  
  
This STANDARD is not met as evidenced by:  
**THIS IS A CLASS II DEFICIENCY:**  
  
Based on record review and interview, it was determined the licensee did not appoint, in writing, a qualified medical director to be responsible for clinical services.  
  
Findings include:  
  
On 10/2/19 at 12:10 PM, the written appointment for the agency medical director was requested from the agency Administrator. No written appointment was provided.  
  
At 12:20 PM, the agency Administrator was interviewed and acknowledged the licensee did not appoint, in writing, a qualified medical director to be responsible for clinical services.

G 610 R432-600-12(2)(a) Contracts  
  
(2) The contract shall include:  
(a) The effective and expiration dates;

G 000  
POC Accepted  
10/22/19

G 065  
Correction date 10/14/19  
Korimes

G 610

Dr. Tilly was appointed Medical Director in 2012. Her agreement was misplaced and has signed a new one on 10/14/19. Zandy Nicolosi has made the correction. Checking agreements and job description in employee files has been added to the quality assurance check list.

10/14/19

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OCT 21 2019

Utah Department of Health  
Health Facility Licensing  
and Certification



**Americans  
United  
for Life**

Bureau of Licensing and Certification  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE  
*Administrator*

(X6) DATE

*P*



Utah Department of Health, Licensing and Certification

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G 610	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY:</b></p> <p>Based on record review and interview, it was determined 1 of 2 sampled contracts did not include an expiration date.</p> <p>Findings include:</p> <p>On 10/2/19 at 12:10 PM, the agency contracts were requested and reviewed.</p> <p>A laboratory contract, effective March 2018, was reviewed. There was no expiration date located on the contract.</p> <p>At 12:20 PM, the agency Administrator was interviewed and acknowledged the laboratory contract did not include an expiration date.</p>	G 610	<p>On 10/2/19 Zandy Nicolas received current contracts from our lab and steri-cycle with exp dates. Checking contracts for outside services will also be added to the quality assurance checklist</p>	10/2/19

Utah Department of Health, Licensing and Certification

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{G 000}	<p>Initial Comments</p> <p>A follow-up was completed on October 22, 2019, for all deficiencies previously cited on October 2, 2019. All cited deficiencies have been corrected as of October 14, 2019, and no new non-compliance was found.</p>	{G 000}		
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Bureau of Licensing and Certification  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE



(X8) DATE

*Adelle*

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S 715 E, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G 000 Initial Comments

An initial licensure survey was conducted on 5/09/12. The facility was surveyed against the R432-600 rules for abortion clinics. Deficiencies were cited.

G 435 R432-600-10(5)(a)(i-iii) Health Surveillance

(a) The licensee shall ensure that all employees are skin tested for tuberculosis within two weeks of:

- (i) initial hiring;
- (ii) suspected exposure to a person with active tuberculosis; and
- (iii) development of symptoms of tuberculosis.

This STANDARD is not met as evidenced by:  
THIS IS A CLASS II DEFICIENCY:

Based on record review and interview it was determined that the facility had not ensured that all employees were skin tested for tuberculosis (TB) within two weeks of initial hire.

Findings include:

On 5/09/12 a review of six employee files was completed. None of the employee files contained documentation for TB testing being completed within two weeks of hire.

At 11:30 AM, an interview was initiated with the Administrator of the facility. The Administrator stated that she had not yet obtain TB testing on any of her employees.

G 975 R432-600-15(6)(a) Emergency and Disaster

(a) The evacuation plan shall identify evacuation

*6/18/12*  
*Accountable*  
*Complete date*  
*6/15/12*

Each employee completed a TB test in our office on 6/4. The results were read by Mary Bishop RN. The copy of the TB test can be found in the employee files. Both Physicians had previous test & brought copies of results and are filed. (see form)

*6/4/12*

Utah Department of Health

JUN 27 2012

Bureau of Health Facility Licensing, Certification and Resident Assessment



**Americans United for Life**

Your Agency Name *Wasatch Women's Center*

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

TITLE  
*Administrator*

(X6) DATE

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2012</b>
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G 975 Continued From page 1

routes, location of fire alarm boxes, fire extinguishers, and emergency telephone numbers of the local fire department and shall be posted throughout the facility.

This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY.

Based on a facility walk through with the assistant administrator, the facility did not meet the requirements of this statute.

Findings include:

The facility did not have evacuation routes located on the corridor walls that would give the whereabouts of fire extinguishers, exit doors and fire alarm boxes.

G 975

In the process of completing. Will be done and posted by 6/15. Will fax/send soon as its completed.

6/15/12

G1335 R432-600-19(5)(b) Pharmacy Service

(b) Contents of the emergency drug supply shall be listed on the outside of the container.

This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY

Based on observation and interview with the clinic owner/office manager, it was determined that contents of the emergency drug supply was not listed on the outside of the container.

Findings include:

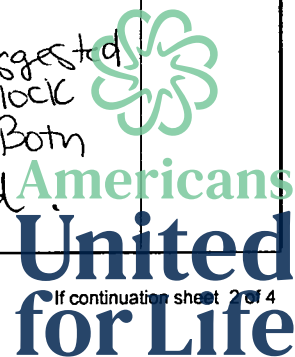
On 5/09/12, the clinic owner/office manager identified the emergency drug supply to the surveyor. It was noted the emergency drug supply was kept in a drawer at the clinic.

There was no documentation on the outside of

G1335

The emergency drug list is now located on the outside of the cupboard instead of the container. The supplies that were in the drawer are now in the container. So no list is needed on the drawer. The nurse also suggested we add a hepmn lock and new needles. Both have been added.

6/11/12



Utah Department of Health

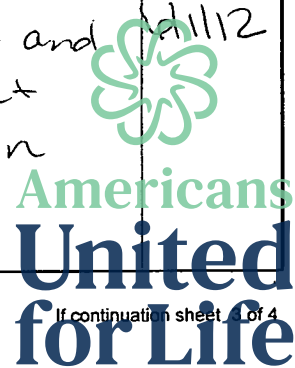
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2012</b>
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G1335	Continued From page 2 the drawer of contents of the emergency drug supply.	G1335		
G1340	<p>R432-600-19(5)(c) Pharmacy Service</p> <p>(c) The use and regular inventory of the contents shall be documented by nursing staff.</p> <p>This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY</b></p> <p>Based on observation and interview with the clinic owner/office manager, it was determined that regular inventory of the emergency drug supply was not being done.</p> <p>Findings include:</p> <p>On 5/09/12, the clinic owner/office manager identified the emergency drug supply to the surveyor.</p> <p>On 5/09/12, on interview with the owner/office manager, she said that regular inventory of the contents had not been done.</p>	G1340	<p>The regular controlled drug inventory is now being logged. The log is located inside the lock box. (See form).</p> <p>The emergency inventory log sheet is located in the drug container. If something is used it will be logged &amp; reordered. (See form)</p>	6/1/12
G1650	<p>R432-600-22(6)(e) Medical Records</p> <p>(6) Each patient's medical record shall include the following: (e) Discharge summary which contains a brief narrative of conditions and diagnoses of the patient and final disposition;</p> <p>This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY.</b></p> <p>Based on a review of patient records with the administrator, the facility did not meet the</p>	G1650	<p>WWC has added a discharge summary to the bottom of the operative report and will be filled out by the physician (See form)</p>	6/1/12

Your Agency Name  
STATE FORM

6899 KS9U11



Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/09/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S 715 E, SUITE 203 SALT LAKE CITY, UT 84107</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G1650	Continued From page 3 requirements of this statute.  Findings include:  In 4 of 4 patient records reviewed of past services received longer than 30 days, there was no discharge summary in their medical record which contains a brief narrative of conditions and diagnoses of the patient and final disposition.	G1650		

Your Agency Name  
STATE FORM

6899 KS9U11



If continuation sheet 1 of 4

Utah Department of Health, Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/09/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 EAST 3900 SOUTH, SUITE 203 SALT LAKE CITY, UT 84107</b>
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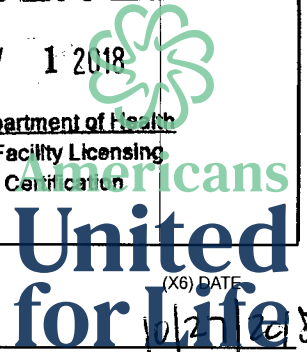
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	<p>Initial Comments</p> <p>On 10/9/18, an unscheduled relicensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiency was cited.</p>	G 000		
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**RECEIVED**

NOV 1 2018

Utah Department of Health  
Health Facility Licensing  
and Certification



Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE

*Administrator*

(X6) DATE

*10/27/18*

*R*



*Adele*

Utah Department of Health

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ <b>JUN 18 2013</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000

Initial Comments

A scheduled relicensure survey was conducted on 5/21/13. The facility was surveyed against the R432-600 rules for abortion clinics. Deficiencies were cited.

G 000

1. The Staff Notes form has been changed to comply with R432-600-22(3)

G1615

R432-600-22(3) Medical Records

(3) All entries shall be permanent and capable of being photocopied. Entries must be authenticated including date, name or identified initials, and title of the person making the entry.

G1615

The new form now includes Patients first and last name. Date and time. And a space for staff signature.  
See form -

This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY

Based on record review and interview it was determined that all entries were not authenticated including date, name or identified initials, and title of the person making the entry.

Findings Included:

On 05/21/13, a review of patient records revealed a staff note for Patient 1 dated 04/25/13 which did not include patient's last name and the first entry written was not signed or dated. The second entry on Patient 1's staff note did not include a name to identify the initials and a date. Additionally, Patient 2's record review showed a staff note with an entry that did not include a signature or date identifying who made the entry, and when the entry was made.

On 05/21/13, an interview was initiated with the administrator, who acknowledged the entries did not include the name or date of staff making the entry.

*5-19-13  
POC  
Acceptable  
Complete  
date  
7-1-13  
[Signature]*

- 2. Office Administrator (Zandy Nicolosi)
- 3. Effective 7/1/13



**Americans  
United  
for Life**

Your Agency Name  
*Wasatch Womens Center Zandy Nicolosi*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE *Administrator* (X6) DATE *6/13/13*



Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G1640	Continued From page 1	G1640	<p>1. The pre-op report form has been changed to comply with R432-600-22(6)(c). The new form has a line for the physician signature approving any pre-op medications. See attached form</p> <p>2. Office Administrator (Zandy Nicolosi)</p> <p>3. Effective 7/1/13</p>	
G1640	<p>R432-600-22(6)(c) Medical Records</p> <p>(6) Each patient's medical record shall include the following: (c) Signed and dated physician orders for drugs and treatments;</p> <p>This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY</b></p> <p>Based on record review and interview, it was determined that 5 of 10 patient medical records sampled did not include the following: (c) Signed and dated physician orders for drugs and treatments. Resident Identifiers: 2, 4, 7, 9, and 10.</p> <p>Findings Included:</p> <p>On 05/21/13, a review of patient records revealed a "Pre-Op Report" which listed the pre-op medications: Ibuprofen 800 mg/1600 mg PO, Lortab 7.5/500 mg PO, Xanax .5/1mg PO, and Misoprostol 400 mcg buccal/vaginal given to patients prior to the procedure. For 5 of the 10 patient records sampled, it was noted on their "Pre-Op Report" that either Lortab, Xanax, or Misoprostol was administered before the procedure, but did not include a signature and date by the physician.</p> <p>On 05/21/13, the administrator acknowledged that the physician was not signing the "Pre-Op Report" and stated she would ensure the physician starts signing the form, when medications are administered prior to the procedure.</p>	G1640		

Your Agency Name **Wasatch Women's Center**  
STATE FORM

6899 OWL811



Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  UT000523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/28/2015
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NAME OF PROVIDER OR SUPPLIER  WASATCH WOMEN'S CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 000	Initial Comments  On 4-28-2015 an announced relicensure survey was conducted at this facility. The facility was found not to be in compliance with Abortion Clinic Rules R 432-600. The following demonstrate non compliance.	G 000		
G1935	<p>R432-600-25(7) Maintenance Services</p> <p>(7) Electrical systems including appliances, cords, equipment, call lights, and switches shall be maintained to guarantee safe functioning and compliance with the National Electrical Code.</p> <p>This STANDARD is not met as evidenced by: Electrical systems including cords shall be in compliance with the National Electric Code.</p> <p>Findings include:</p> <p>During the tour of the facility a residential style extension cord was observed to be suppling power to some electronics in the waiting room. In accordance with NFPA 70 National Electric Code 400.8 flexible cords shall not be used as a substitute for fixed wiring.</p>	G1935	<p>5-18-15 PDC Accepted Cynthia date 4-29-15</p> <p>The extension cord was replaced with a Surge Protector on 4/29/15 by Zandy Nicolosi</p> <p>Zandy has added in the maintenance log book to check for extension cords monthly.</p>	

Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Zandy Nicolosi</i>	WASATCH WOMEN'S CENTER	TITLE Administrator	(X6) DATE 5/13/15
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MAY 13 2015



Utah Department of Health

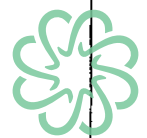
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  UT000523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  10/05/2015
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NAME OF PROVIDER OR SUPPLIER  WASATCH WOMEN'S CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	Initial Comments  On 10/05/15 a relicensure survey was conducted. The facility was surveyed according to R 432- 600 rules for Abortion clinics. Deficiencies were cited.	G 000		
G 012	R432-600-4(2)(b) Licensure  (2) An abortion clinic may be licensed as a Type I facility if the facility: (b) does not perform abortions, as defined in section 76-7-301, after the first trimester of pregnancy.  This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY:  Based on record review and interview, it was determined the Type I facility performed abortions, after the first trimester of pregnancy, for 1 of 10 sampled clients. Client Identifier: 4.  Findings Include:  On 10/05/15 a review of Client 4's facility record was conducted and revealed Client 4 was a 28 year old female, who had a surgical abortion on 09/21/15. The "Medical History" stated the EGA (Estimated Gestational Age) by Ultrasound was 14.1 weeks, which is the second trimester of pregnancy.  On 10/05/15 at 2:30 PM, an interview was initiated with the clinic administrator, who acknowledged that in a Type I facility, women are eligible for abortions within the first trimester.	G 012	Effective Immediately - Zandy held a staff meeting on 10/7/15 with all employees and physicians regarding rule 76-7-301. Everyone is now aware of the rule. They all understand that no patient over 13.6 by ultrasound is to be seen at our clinic for <u>any</u> reason.	
G 985	R432-600-15(6)(c) Emergency and Disaster  (c) Fire drills and documentation shall be in	G 985		

11-13-15  
 Acceptable  
 Zandy



**Americans  
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for Life**

Your Agency Name	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Zandy Nelson</i>	TITLE Administrator	Utah Department of Health	(X6) DATE
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Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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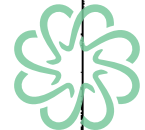
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G 985	<p>Continued From page 1</p> <p>accordance with R710-4, State of Utah Fire Protection Board. The actual evacuation of patients during a drill is optional.</p> <p>This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY:</b></p> <p>Based on record review and interview, it was determined fire drills and documentation were not in accordance with R710-4, State of Utah Fire Protection Board.</p> <p>Findings Include:</p> <p>On 10/05/15, a review of the facility fire drills for the past year was conducted. Two fire drills were documented as part of an inservice on 01/15/15 and 07/15/15.</p> <p>On 10/05/15, an interview was initiated with the clinic administrator, who acknowledged the two fire drills were part of an inservice. A review of the fire drill rule was conducted. The clinic administrator verbalized understanding that fire drills were not to be held as part of an inservice and must be conducted and documented independent from inservice training.</p>	G 985	<p><i>Effective 11/15.</i></p> <p><i>Fire drills will now be unannounced and separate from in-service training. Emergency Disaster will be done every 6 months. Fire drills quarterly. Emergency Disaster drills have been added to the log book by Zandy.</i></p>	
G1900	<p>R432-600-25(1) Maintenance Services</p> <p>(1) There shall be adequate maintenance service to ensure that the facility, equipment, and grounds are maintained in a clean and sanitary condition and in good repair at all times, in accordance with manufacturer specifications for the safety and well-being of patients, staff, and visitors.</p> <p>This STANDARD is not met as evidenced by:</p>	G1900		

Your Agency Name  
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If continuation sheet 2 of 3

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/05/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G1900	<p>Continued From page 2</p> <p><b>THIS IS A CLASS II DEFICIENCY:</b></p> <p>Based on observation, record review and interview, it was determined facility equipment was not maintained in accordance with manufacturer specifications.</p> <p>Findings include:</p> <p>On 10/05/15, a tour of the facility was conducted and single station smoke detectors were observed in use in facility corridors.</p> <p>On 10/05/15, an interview was initiated with the clinic administrator, who stated she tested the smoke detectors monthly as required, however the clinic administrator could not provide documentation when the single station smoke detectors were last replaced. Single station smoke detectors shall not remain in service for more than 10 years per NFPA 72, 2010 edition. 14.4.8.1.</p>	G1900	<p><i>Smoke detectors were replaced and documented by Zandy on 10/14/15</i></p>	
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Your Agency Name  
STATE FORM

6899

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If continuation sheet 3 of 3

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/25/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G 000	<p>Initial Comments</p> <p>On 10/25/16, an unscheduled relicensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiency was cited.</p>	G 000		
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 JAN 18 2017  
 Americans United for Life  
 Utah Department of Health  
 Health Facility Licensing  
 200 South State Street, Salt Lake City, UT 84143

Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE <b>Administrator</b>  (X6) DATE <b>1/12/2017</b>
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Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000523</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/20/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASATCH WOMEN'S CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 E 3900 S, SUITE 203 SALT LAKE CITY, UT 84107</b>
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G 000	<p>Initial Comments</p> <p>On 04/20/16, a scheduled relicensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiency was cited.</p>	G 000		
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MAY 17 2016

Utah Department of Health  
Health Facility Licensing  
and Certification



Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

5/17/16

Utah Department of Health, Health Facility Licensing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/04/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	<p>Initial Comments</p> <p>A scheduled relicensure survey was conducted on 4/4/18. The facility was surveyed against the R432-600 rules for abortion clinics. No deficiencies were cited.</p>	G 000		
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Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE



(X6) DATE

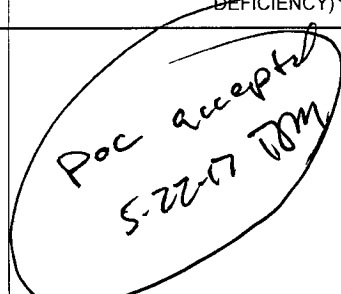


Utah Department of Health, Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	Initial Comments  On 4/26/17 a scheduled relicensure survey was conducted. The facility was surveyed against the R432-600 rules for abortion clinics. A deficiency was cited.	G 000		
G 020	<p>R432-600-5(1) Construction</p> <p>(1) Each facility shall conform with the requirements of R432-4-1 through R432-4-22, with the exception of R432-4-8(1)(b).</p> <p>This STANDARD is not met as evidenced by: Based upon observations made in the presence of the Clinic manager on 04/26/2017, it was determined that the facility did not maintain exit access to be readily accessible at all times in accordance with R432-600-5-1</p> <p>Deficiency (1) affects two of two clinic exit doors. Deficiency (2) affects one of one stairwell door.</p> <p>Findings include:</p> <p>1- During the facility tour it was observed that the two clinic exit doors had bolt locks, there was not a readily visible sign posted on the doors. A readily visible durable sign is posted on the egress side on or adjacent to the door stating: THIS DOOR TO REMAIN UNLOCKED WHEN THIS SPACE IS OCCUPIED. The sign shall be in letters 1 inch (25 mm) high on a contrasting background in accordance with IFC 1010.1.9.3.2.2.</p> <p>2- During the facility tour it was observed that the exit corridor door by the fire stairwell escape</p>	G 020		

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Utah Department of Health  
Health Facility Licensing and Certification  
**United for Life**

Your Agency Name Planned Parenthood Metro Health Center  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [Signature]

TITLE VP Clinical Programs (X6) DATE 5/2/17

2

Utah Department of Health, Health Facility Licensing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 020	Continued From page 1  had a barrel bolt installed on the exterior of the door, Manually operated flush bolts or surface bolts are not permitted in accordance with IFC 1010.1.9.4	G 020		
G1935	<p>R432-600-25(7) Maintenance Services</p> <p>(7) Electrical systems including appliances, cords, equipment, call lights, and switches shall be maintained to guarantee safe functioning and compliance with the National Electrical Code.</p> <p>This STANDARD is not met as evidenced by: Based upon observations made in the presence of the clinic manager on 04/26/2017, it was determined that the facility did not maintain electrical equipment in accordance with R 432-600-25 (7)</p> <p>This deficiency affects two of several outlets.</p> <p>Findings include:</p> <p>1- During the facility tour an extension cord was observed in use in the main reception/check in desk coming out of the ceiling powering equipment on top of the upper cabinets. Extension cords and flexible cords shall not be a substitute for permeant wiring. Extension cords and flexible cords shall not be affixed to structures, extended thru walls, ceilings or floors or under doors to floor coverings, nor shall such cords be subject to environmental damage or physical impact in accordance with IFC 605.5</p> <p>2- During the facility tour an extension cord was observed in use in the employee break room, it was going up thru the ceiling and into the next room being used for power to a television in the</p>	G1935		

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Utah Department of Health, Health Facility Licensing and Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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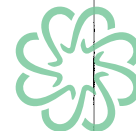
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G1935	Continued From page 2  lobby. Extension cords and flexible cords shall not be a substitute for permeant wiring. Extension cords and flexible cords shall not be affixed to structures, extended thru walls, ceilings or floors or under doors to floor coverings, nor shall such cords be subject to environmental damage or physical impact in accordance with IFC 605.5	G1935		
G2030	<p>R432-600-26(5)(b) Emergency Electric Service</p> <p>(5) All emergency electrical power systems shall be maintained in operating condition and tested as follows: (b) Transfer switches and battery operated equipment shall be functionally tested every 30 days and load tested at least annually, for 90 minutes.</p> <p>This STANDARD is not met as evidenced by: Based upon observations made in the presence of the clinic manager on 04/26/2017, it was determined that the facility did not provide an emergency lighting system in accordance with R 432-600-26 (5) (b)</p> <p>This deficiency affects all of the emergency lighting.</p> <p>Findings Include:</p> <p>During the record review it was observed that the facility failed to document the annual testing of the emergency lights with battery backup for the year, in accordance with</p> <p>IFC 604.6.1.1, Records of the tests shall be maintained. The record shall include the location of the emergency light tested, weather the light</p>	G2030		

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If continuation sheet 3 of 4

Utah Department of Health, Health Facility Licensing and Enforcement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G2030	Continued From page 3  passed or failed, and the date of the test and the person completing the test.  IFC 604.6.2. The power test shall operate the emergency lighting for not less than 90 minutes and shall remain sufficiently illuminated for the duration of the test.	G2030		
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Your Agency Name  
STATE FORM

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If continuation sheet 4 of 4

Metro Health Center  
 160 S 1000 E #120  
 Salt Lake City, Utah 84102

Plan of Correction

G 020	R432-600-5(1) Construction	2 exit doors had bolt locks, there was no visible sign posted	Penny Davies ordered signage 5/10/17 : – This Door will remain unlocked during business hours. Expected to be posted by 5/31/17
		Door had barrel bolt	Bolt removed 5/11/17
G1935	R432-600-25(7)	Extension cord was observed coming out of ceiling in front reception area	5/5/17: Extension cord removed. Fred Pennington CIO
		Extension cord was observed in staff break room	5/5/17: Extension cord removed. Fred Pennington CIO
G2030	R432-600-26(5)(b)	No documentation of annual testing of emergency lighting	5/12/17: Clinic form updated to include testing of emergency lighting, pass or fail, date and the person completing the test. Battery operated equipment was tested for 90 minutes 5/11/17, passed and this test has been documented. Veronica Galindo

*Penny Davies VP Clinical Programs 5/12/17*



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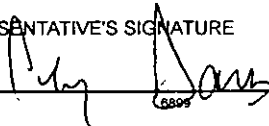

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/25/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	<p>Initial Comments</p> <p>On 10/25/16, a relicensure survey was conducted at the facility. The facility was surveyed according to R432-600 abortion clinic rules. No deficiency was cited.</p>	G 000	<p><b>RECEIVED</b></p> <p>NOV 08 2016 <sup>A</sup></p> <p>Utah Department of Health Health Facility Licensing and Certification</p>	
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Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE Clinical Director	 (X6) DATE 11-7-16
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Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/20/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	<p>Initial Comments</p> <p>On 04/20/2016 a scheduled relicensure survey was conducted at the facility. The facility was surveyed and found to be compliant with abortion clinic rules R432-600. No regulatory non-compliance was identified. No deficiency was cited.</p>	G 000		
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MAY 05 2016

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Health Facility Licensing  
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Your Agency Name \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Ben Davis* TITLE *VP Clinical Programs* (X6) DATE *5-2-16*

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/02/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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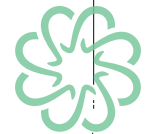
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G 000	<p>Initial Comments</p> <p>On 10/2/19, an unscheduled re-licensure survey was conducted. The clinic was surveyed according to R432-600 Rules for Abortion Clinics. No deficiencies were cited.</p>	G 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE

*VP Clinical Services*

(X6) DATE

*10/24/19*

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Utah Department of Health

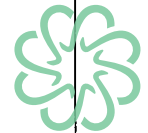
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/06/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	<p><b>Initial Comments</b></p> <p>A re-licensure survey was completed 12/06/12. The facility was surveyed against the R432-600 rules for abortion clinics. No deficiencies were cited.</p>	G 000	<p><b>Utah Department of Health</b></p> <p><b>DEC 20 2012</b></p> <p>Bureau of Health Facility Licensing, Certification and Resident Assessment</p>	
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Your Agency Name <i>Planned Parenthood Association of Utah Metro Health Center</i>  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Penny Davis</i>	TITLE <i>VP Clinical Programs</i> (X6) DATE <i>12/18/12</i>
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Utah Department of Health

*add*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/04/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E #120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G1920	<p>R432-600-25(4) Maintenance Services</p> <p>(4) All buildings, fixtures, equipment and spaces shall be maintained in operable conditions.</p> <p>This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY.</p> <p>Based on a facility walk through with the administrator, the facility did not meet the requirements of this statute.</p> <p>Findings include:</p> <p>The facility's communications room did not have two ceiling tiles firmly secured in place. This situation compromised the fire integrity of the room (2009 IFC 315.2.4).</p>	G1920	<p>R432-600-25(4) (4) 2009 IFC 315.24 Director of IT will replace the 2 ceiling tiles in the communications room. This was completed by Fred Pennington, Director of IT on 6/5/12</p> <p>Utah Department of Health</p> <p><b>JUN 19 2012</b></p> <p>Bureau of Health Facility Licensing, Certification and Resident Assessment</p>	
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*Acceptable  
Complete  
6-5-12*

Your Agency Name *Metro Health Center* *Pen Davies* TITLE *VP* *6/13/12* (X6) DATE

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



Utah Department of Health

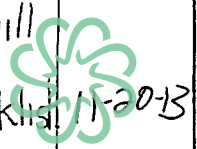
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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G2015	<p>R432-600-26(3) Emergency Electric Service</p> <p>(3) There shall be provision for emergency exit lighting according to NFPA 101.</p> <p>This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY</b></p> <p>Based on observation and interview with the facility manager on 10/02/13, the facility did not provide emergency exit lighting at all required areas.</p> <p>Findings:</p> <p>1. The east exit stairwell that serves as one of two required paths of egress from the clinic area was observed to not have a battery back-up emergency light to illuminate the stairwell in the event of a power failure.</p> <p>2. In an interview with the facility manager, she indicated the normal hours of facility operation include evening hours on Monday when the natural light from the stairwell window would not illuminate the path of egress as required.</p> <p>This observation was made in the presence of the facility manager.</p>	G2015	<p>will install battery back-up emergency light in east exit stairwell. by NOV 20, 2013</p> <p>light will be check monthly with clinic emergency facility check list.</p> <p>Point person will be responsible to check all emergency lights including emergency light in east exit stair well.</p> <p>East emergency light will be added to monthly emergency facility checklist</p>	
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*11-8-13  
POC  
Acceptable  
Complete  
date  
11-20-13*



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Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Ver Galindo*

*Veronica Galindo - Clinic Manager*

TITLE  
Utah Department of Health

STATE FORM

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(X6) DATE OF CONTINUATION SHEET 1 of 1

OCT 28 2013

Bureau of Health Planning, Certification and Resident Assessment

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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G 000	Initial Comments  On 4/18/19, a scheduled recertification survey was conducted. The clinic was surveyed according to R432-600 Rules for Abortion Clinics. Deficiencies were cited.	G 000		
G1900	R432-600-25(1) Maintenance Services  (1) There shall be adequate maintenance service to ensure that the facility, equipment, and grounds are maintained in a clean and sanitary condition and in good repair at all times, in accordance with manufacturer specifications for the safety and well-being of patients, staff, and visitors.  This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY:</b>  Based on observation and interview, it was determined the agency did not conduct adequate maintenance service to ensure that the facility equipment was maintained in good repair for the safety and well-being of patients, staff and visitors.  Findings include:  On 4/18/19, during the facility tour, the emergency light with battery back up failed when tested. A new battery was installed and the light still failed when tested. The light is #1 in the main waiting room. The Clinic Manager was present during the testing and acknowledged the equipment was not maintained in good repair.	G1900	<i>POC Accepted 5/20/19</i> <i>Correction Date 5/17/19</i> <i>K Grimes</i>	
G2415	R432-600-30(3) Water Supply  (3) Hot water temperature controls shall	G2415	<i>Emergency Light Replaced 5-7-19</i>	<i>5-07-19</i>

Bureau of Licensing and Certification LABORATORY DIRECTOR'S OR PROVIDER REPRESENTATIVE'S SIGNATURE <b>RECEIVED</b> <i>Penny Davis</i>	TITLE <i>VP Clinical Programs</i>	(X6) DATE <i>5-15-19</i>
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*Patrice*  
*MA*

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/18/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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G2415	<p>Continued From page 1</p> <p>automatically regulate temperatures of hot water delivered to plumbing fixtures used by patients. The facility shall maintain hot water delivered to patient care areas at temperature between 105 degrees and 120 degrees F.</p> <p>This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY:</b></p> <p>Based on observation and interview, it was determined the facility was not maintaining hot water delivered to patient care areas at a temperature between 105 degrees and 120 degrees.</p> <p>Findings include:</p> <p>On 4/18/19, at 2:40 PM, the water temperature in the front bathroom waiting area was tested and found to be 123 degrees Farenheit. At 2:50 PM, the water temperature in the central clinic bathroom was tested and found to be 100.4 degrees Farenheit.</p> <p>At 2:55 PM, the Clinic Manager acknowledged the water temperature was not being maintained between 105 and 120 degrees.</p>	G2415	<p>5-7-19 Plumber adjusted water heater and temperature readings:</p> <p>Bathroom 1 - 117 Bathroom 2 - 118 Bathroom 3 - 117</p>	5-07-19
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Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/20/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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{G 000}	<p>Initial Comments</p> <p>A follow-up was completed on May 20, 2019, for all deficiencies previously cited on April 18, 2019. All cited deficiencies have been corrected as of May 7, 2019, and no new non-compliance was found.</p>	{G 000}		
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Bureau of Licensing and Certification  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE



(X6) DATE

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/20/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #100 SALT LAKE CITY, UT 84102</b>
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G 000	<p>Initial Comments</p> <p>On 10/20/14 an unannounced relicensure survey was conducted at the facility. The facility was surveyed and found to be compliant with abortion clinic rules R432-600. No regulatory non-compliance was identified. No deficiency was cited.</p>	G 000		
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Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE





Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  UT000535	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/06/2015
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NAME OF PROVIDER OR SUPPLIER  
**METRO HEALTH CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**160 S 1000 E SUITE #100  
SALT LAKE CITY, UT 84102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 000	Initial Comments  On 05/06/15 a scheduled relicensure survey was conducted at the facility. The facility was surveyed according to abortion clinic rules R432-600. Regulatory non-compliance was identified and deficiencies were cited.	G 000	<i>See attached POC</i>	
G 020	R432-600-5(1) Construction  (1) Each facility shall conform with the requirements of R432-4-1 through R432-4-22, with the exception of R432-4-8(1)(b).  This STANDARD is not met as evidenced by: Based on observation during the fire safety inspection conducted on 05/06/2015, the facility did not provide integrated smoke detection at all required locations in accordance with NFPA 72, The National Fire Alarm Code.  Findings:  Observation and inspection of the data/computer room revealed the room houses the facility fire alarm control panel. The room was not protected by an integrated smoke detector.  This observation was made in the presence of the facility manager.	G 020	<i>6-1-15 POC Acceptable Cynthia 5-18-15</i>	
G2030	R432-600-26(5)(b) Emergency Electric Service  (5) All emergency electrical power systems shall be maintained in operating condition and tested as follows: (b) Transfer switches and battery operated	G2030		

Utah Department of Health

MAY 29 2015

Bureau of Health Facility Licensing,  
Certification and Resident Assessment

**Americans  
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for Life**

Your Agency Name *Planned Parenthood Ass of Utah*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Pen Davis*

TITLE

*VP*

(X6) DATE



Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #100 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G2030	<p>Continued From page 1</p> <p>equipment shall be functionally tested every 30 days and load tested at least annually, for 90 minutes.</p> <p>This STANDARD is not met as evidenced by: Based on observation during the fire safety inspection conducted on 05/06/2015, the facility did not maintain emergency lighting and exit fixtures to be in reliable operating condition as required.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The exit sign above the door accessing the garage area was observed to be not illuminated as both internal light bulbs were not functioning.</li> <li>2. The east side exit sign was observed to have only one of the two internal light bulbs functioning.</li> </ol> <p>These observations were made in the presence of the clinic manager.</p>	G2030		
G2420	<p>R432-600-30(4) Water Supply</p> <p>(4) There shall be grab bars at each toilet, bathtub, and shower used by patients.</p> <p>This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY:</p> <p>Based on observation and interview, it was determined the facility failed to provide grab bars at all toilets used by patients.</p> <p>Findings Include:</p> <p>On 05/06/15 at 1:30 pm, a patient bathroom was</p>	G2420		

Your Agency Name *Planned Parenthood Ass of Utah*  
STATE FORM *Rely Dawns VP*

8899

O56W11

*5.28.15*



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If continuation sheet 2 of 3

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #100 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G2420	Continued From page 2 observed that lacked grab bars at the toilet.  On 05/06/15 at 1:45 pm, an interview was initiated with the facility manager, who acknowledged the lack of grab bars at the toilet.	G2420		

Your Agency Name  
STATE FORM

*Planned Parenthood Ass. of Utah*  
*Pey Dawes VP*

8899

O56W11

*5/28/15*



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If continuation sheet 3 of 3

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/15/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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G 000	<p><b>Initial Comments</b></p> <p>A scheduled re-licensure survey was completed 04/15/14. The facility was surveyed against the R432-600 rules for abortion clinics. No deficiencies were cited.</p>	G 000		
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Your Agency Name *Metro Health Center Planned Parenthood*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*VP Clinical Programs*  
*Pen Davis*  
TITLE



APR 24 2014

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/18/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS CITY STATE ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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G 000	<p>Initial Comments</p> <p>A scheduled re-licensure survey was completed 06/18/13. The facility was surveyed against the R432-600 rules for abortion clinics. No deficiencies were cited.</p>	G 000	<p>Utah Department of Health</p> <p>JUL 03 2013</p> <p>Bureau of Health Facility Licensing, Certification and Resident Assessment</p>	
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Your Agency Name: *Metro Health Center*      *Pam Davis*      *VP Clinical Programs*      *6/25/13*

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



JUL 03 2013


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES


PRINTED: 11/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - SOUTHERN UTAH VETERANS HOME - IVINS B. WING _____	(X3) DATE SURVEY COMPLETED  10/21/2015
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NAME OF PROVIDER OR SUPPLIER  SOUTHERN UTAH VETERANS HOME - IVINS	STREET ADDRESS, CITY, STATE, ZIP CODE 160 N 200 E IVINS, UT 84738
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Statutory and regulatory authority for this Life Safety Code survey that was conducted on 10/21/2015 at 9:00 am in the presence of the administrator and the plant manager are found in 42 Code of Federal Regulations, Section 483.70, (a)(1)(i), and the 2000 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>There were no life safety code deficiencies cited during this survey.</p>	K 000	<p>Utah Department of Health</p> <p>NOV 12 2015</p> <p>Bureau of Health Facility Licensing Certification and Resident Assessment</p> 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator
--	------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Utah Department of Health, Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/09/2018</b>
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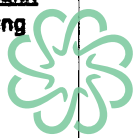
NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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G 000	<p>Initial Comments</p> <p>On 10/9/18, an unscheduled relicensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiency was cited.</p>	G 000		
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**RECEIVED**  
OCT 24 2018

Utah Department of Health  
Health Facility Licensing  
and Certification



**Americans  
United  
for Life**

Your Agency Name \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Pen Davis* TITLE *VP Clinical Programs* (X6) DATE *10/5/18*



Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/13/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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G 000	Initial Comments  On 10/8/15 a relicensure survey was conducted. The facility was surveyed according to R 432-600 rules for abortion clinics and a class I deficiency was cited.	G 000		
G 985	R432-600-15(6)(c) Emergency and Disaster  (c) Fire drills and documentation shall be in accordance with R710-4, State of Utah Fire Protection Board. The actual evacuation of patients during a drill is optional.  This STANDARD is not met as evidenced by: <b>THIS IS A CLASS II DEFICIENCY:</b>  Based on record review and interview, it was determined fire drills and documentation were not in accordance with R710-4, State of Utah Fire Protection Board.  Findings Include:  On 10/08/15, a review of the facility fire drills for the past year was conducted. Two fire drills were documented as part of an inservice on 03/19/15 and 09/17/15.  On 10/08/15, an interview was initiated with the clinic manager, who acknowledged the two fire drills were part of an inservice. A review of the fire drill rule was conducted. The clinic manager verbalized understanding that fire drills were not to be held as part of an inservice and must be conducted and documented independent from inservice training.	G 985  <i>POC 11-13-15 Acceptable Complete date 12-20-15</i>		
G2415	R432-600-30(3) Water Supply	G2415		

Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <i>VP Clinical Programs</i>	(X6) DATE  <i>10/20/2015</i>
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STATE FORM

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If continuation sheet 1 of 2



NOV 10 2015

Bureau of Health Facility Licensing,  
Certification and Resident Assessment

A

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/13/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102</b>
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G2415	<p>Continued From page 1</p> <p>(3) Hot water temperature controls shall automatically regulate temperatures of hot water delivered to plumbing fixtures used by patients. The facility shall maintain hot water delivered to patient care areas at temperature between 105 degrees and 120 degrees F.</p> <p>This STANDARD is not met as evidenced by: THIS IS A CLASS I DEFICIENCY:</p> <p>Based on observation and interview, it was determined the facility was not maintaining hot water delivered to patient care areas at a temperature between 105 degrees and 120 degrees.</p> <p>Findings include:</p> <p>On 10/8/15, at 4:00 PM, the temperature of hot water in front bathroom waiting area and the back recovery room bathroom was tested with the clinic manager present and found to be 137 Farenheit. The Clinic Manager acknowledged the water temperature was not safe for patient care areas.</p> <p>A CLASS I DEFICIENCY WAS ISSUED ON 10/8/15 AND AN ACCEPTABLE PLAN OF CORRECTION WAS OBTAINED FROM THE FACILITY MANAGER. SEE ATTACHED COPY.</p>	G2415		
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Your Agency Name  
STATE FORM

6899

WV5M11



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If continuation sheet 2 of 2



UTAH DEPARTMENT OF HEALTH  
BUREAU OF HEALTH FACILITY LICENSING CERTIFICATION AND  
RESIDENT ASSESSMENT  
CLASS ONE/REPEAT DEFICIENCY STATEMENT

Class One   
Repeat Deficiency

Facility: Metro Health Clinic 6535

Survey/ Investigation Date: 10/8/15 Follow-up Date: 10/22/15

Rule Citation: R 432-600-30 (3)

Observation: Based on observation & interview, it was determined the facility was not maintaining hot water delivered to patient care areas at temperatures between 105 degrees & 120 degrees. On 10/8/15, at 4:00pm, the temperature of hot water in front bathroom waiting area and the back recovery room bathroom was tested with the clinic manager present and found to be 137°F. The Clinic Manager acknowledged the water temperature was not safe for patient care areas.

Plan of Correction: contacted building manager to find out where the clinic water heater is located. Building manager states there are several water heaters for all businesses and would prefer to change water temperature himself. Building Manager will change temp tomorrow 10/9/15 morning. Veronica Galindo clinic manager will check water temp tomorrow morning and the next 3 business days after that monthly.

Completion Date: 10/22/15

Surveyor: Aileen Watkins RN Date: 10/8/15

Provider: V Galindo Date: 10/8/15



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Planned Parenthood Association of Utah

Dear Ms. Richins;

This is Planned Parenthood's response to Meto Health Center's recent survey and the Statement of Findings.

In response to the finding related to: R432-600-30(3): G2415; Water Supply, I am attaching the documentation of water temperatures for 2 weeks. I have also included the revised policy and procedures for Water Supply issues at the clinic.

The Plan of Correction related to the R432-600-15(6) (c) Emergency Disaster has been completed as follows:

Finding: Fire drills and documentation were not in accordance with R710-4.

Plan: The clinic manager revised the clinics Emergency Procedure policy and procedure to include: Fire drills and disaster drills must be done twice a year and must be separate. The fire drill schedule is June and December and the Disaster Drills will be conducted in March and September. The revision date noted is 10/2015.

If you any additional information, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Penny Davies', written over a white rectangular area.

Penny Davies



Americans  
**United  
for Life**

Planned Parenthood Association of Utah  
Metro Health Center  
160 South 1000 East #120  
Salt Lake City, Utah 84102

October 9, 2015

On October 8, 2015 the Department of Health came to Metro Clinic to do an inspection on the facility. It was determined that the water temperature in the facility was too hot. The water temperature should be 105-120 degrees F but the water temperature of in the clinic was 137 degrees F.

October 9 –Water temperature was adjusted at 9am. Water temperature tested at 9:35am: 122 degrees F, water temperature retested at 4pm, 119 degrees F

October 12 – Water temperature tested at 4:45pm, 137 degrees F. Temperature readjusted.

October 13 – water temperature tested 10:00am, 115 degrees F.

October 14 – Water temperature tested at 3:25pm, 117 degrees F.

October 15 – Water temperature tested at 11:15am, 120 degrees F.

October 16 – Water temperature tested at 9:00am, 125 degrees F. Temperature readjusted.

October 19 – Clinic close

October 20 - Water temperature tested at 11:00am, 120 degrees F

October 21 – Water temperature tested at 4:00pm, 117 degrees F

October 22 – Water temperature tested at 1:20pm 116 degrees F

October 23 – Water temperature tested at 2:15pm, 115 degrees F

October 24 – Water temperature tested at 10:40am, 114 degrees F

Water will be tested once a week for a month to ensure temperature is within range of 105-120 degrees F.



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2. Cylinders will be stored in well ventilated area and be checked routinely to assure proper working order.

### **Metro Health Center**

**Policy:** Workspaces will provide proper foot-candles of lighting to assure adequate light.

**Rule:** R432-600-29

1. At least 30 foot-candles of light shall illuminate reading, pt care and working areas in pt treatment areas and not less than 20 foot-candles of light shall be provided in the rest of the room. R432-600-29 (1)
2. All accessible storeroom, stairway, exit and entrance areas shall be illuminated by at least 20 foot-candles of light at floor level. R432-600-29 (2)
3. All corridors shall be illuminated with a minimum of 20 foot-candles of light at floor level. R432-600-29 (3)
4. Other areas shall have the following lighting:
  - a. Procedure rooms- 50 foot candles
  - b. Medication preparation areas- 50 foot-candles
  - c. Charting areas- 50 foot-candles
  - d. Reading rooms- no such rooms
  - e. Laundry areas- no such rooms
  - f. Bathrooms (no showers) - 20 foot-candles R432-600-29 (4)(a)(b)(c)(d)(e)(f)

### **Metro Health Center**

**Policy:** Plumbing and drainage facilities shall be maintained in compliance with the Utah Plumbing Code. R432-600-30 (1)

**Rule:** R432-600-30

### **Water Supply**

1. Requirements of Utah Plumbing code and Utah Public Drinking Water Regulations were met when the building was built and passed inspection. R432-600-30 (2)
2. Hot water temperatures controls are set and controlled by the building manager. Hot water tanks are set between 105 and 120 degrees F. R432-600-30 (3)
  - a. Water temperature shall be tested monthly to ensure that hot water temperatures are within range.
  - b. Water temperature shall be tested using an instant read thermometer and recorded in the monthly Facility Checklist.
  - c. In the case that hot water temperature is out of range staff shall alert Clinic Manager immediately or alert building manager to set hot water tank to the correct temperature.
3. There shall be grab bars at each toilet used by patients. R432-600-30 (4)
4. Toilets and hand washing facilities shall be maintained in operating condition. Any plugged system must be reported to facility manager and repaired as soon as possible. R432-600-30 (5)



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## **Metro Health Center**

**Policy:** The clinic staff will follow emergency evacuation procedures to assure all occupants safety in case of an emergency. Fire drills and Disaster drills must be done twice a year and must be separate. Regular trainings will take place to assure familiarity with situations. Emergency drill documentation must include date, time, participant names and brief description of the emergency situation and outcome.

Fire drill Schedule: June and December

Disaster drill Schedule: March and September

### **Rule: R432-600-15**

1. Metro Health Center has the responsibility to assure the safety and well-being of patients in the event of an emergency or disaster. An emergency or disaster may include but is not limited interruption of public utilities, explosion, fire, earthquake, bomb threat, or any other event. **R432-600-15(1)**
2. The clinic manager shall be in charge of facility operations during any significant emergency. If not on the premises, the manger shall may every reasonable effort to get to the facility or alert administration staff (VP Clinical Programs, IT, CEO, etc) so they can get to the facility to relieve subordinates and take charge during the emergency. **R432-600-15(2)**
3. PPAU along with Metro staff will have a developed plan, coordinated with state and local officials, to respond to emergencies. **R432-600-15(3)**
  - a. The plan is in writing and shall be distributed/or made available to all staff to assure prompt and efficient implementation. All new staff receives training during orientation. **R432-600-15(3)(a)**
  - b. The emergency plan shall be reviewed and updated at least annually by administrative staff **R432-600-15(3)(b)**
4. The names and telephone numbers of administration and clinic staff and emergency responders shall be maintained and readily accessible to all staff **R432-600-15(4)**
5. The emergency plan will include the following: **R432-600-15(5)** see plan (page 2-3) and PPAU security procedures (pages 4-54)
  - a. Evacuation of occupants to a safe place within the facility or to another location **R432-600-15(5)(a)** see
  - b. Delivery of emergency care and services to facility occupants when staff is reduced due to the emergency **R432-600-15(5)(b)**
  - c. The person(s) with decision making authority for fiscal, medical and personnel management **R432-600-15(5)(c)**
  - d. An inventory of available personnel, equipment, and supplies and instructions on how to acquire additional assistance. **R432-600-15(5)(d)**
  - e. Assignment of personnel to specific tasks during an emergency **R432-6 R432-600-1500-15(5)(e)**
  - f. Names and numbers of on call providers and staff shall be available **R432-600-15(5)(f)**
  - g. Written incident reports need to be sent to administration offices **R432-600-15(5)(g)**
6. There is a written fire emergency and evacuation plan developed for Metro Health Center. **R432-600-15(6)**



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Utah Department of Health, Health Facility Licensing a:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000535</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/03/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>METRO HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 000	<p>Initial Comments</p> <p>On 10/3/17, an unscheduled relicensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiencies were cited.</p>	G 000		

Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE  (X6) DATE
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Utah Department of Health, Health Facility Licensing a

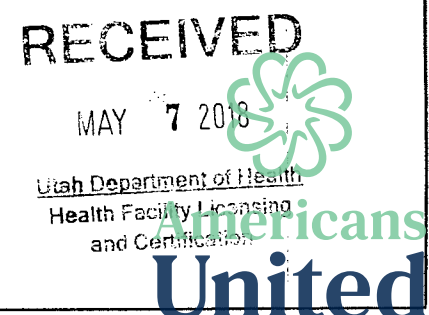
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  UT000828	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/03/2018
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NAME OF PROVIDER OR SUPPLIER  LOGAN HEALTH CLINIC	STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH MAIN, SUITE 117 LOGAN, UT 84321
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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G 000	<p>Initial Comments</p> <p>An initial survey was conducted on 4/3/18. The facility was surveyed against the R432-600 rules for abortion clinics. A deficiency was cited.</p>	G 000		
G 210	<p>R432-600-8(2) Administrator</p> <p>(2) The administrator shall designate a person to act as administrator in his or her absence. This person shall have sufficient power, authority, and freedom to act in the best interests of patient safety and well-being. It is not the intent to permit a de facto administrator to supplant or replace the designated facility administrator.</p> <p>This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY:</p> <p>Based on record review and interview, it was determined that the administrator did not designate a person to act as administrator in her absence.</p> <p>Findings include:</p> <p>On 4/3/18 at 10:10 AM, a record review was conducted for the Clinic Coordinator.</p> <p>There was no designation from the Administrator indicating that the Clinic Coordinator was the acting administrator in their absence.</p> <p>At 10:15 AM, an interview was conducted with the Clinic Coordinator, who acknowledged that there was no written designation from the Administrator, to act as the administrator, in their absence.</p>	G 210	<p>As per Utah Administrative Code for Abortion Clinic Rule R432-600-8(2): Documentation has been created, and subsequently added to clinic protocol, which states that the Assistant Administrator has sufficient power, authority, and freedom to act in the best interest of patient safety and well being in the absence of the Administrator.</p>	04/23/2018

5-1-18  
 AC  
 Acceptable  
 Compliance  
 4-23-18



Your Agency Name: Planned Parenthood - Logan Clinic

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Charlotte A. Middlefield* TITLE: Clinic Coordinator

STATE FORM 6899 8/7/11 Asst. Administrator (K6) DATE: 4/23/18

*R*



Utah Department of Health, Health Facility Licensing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000828</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/11/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LOGAN HEALTH CLINIC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 NORTH MAIN, SUITE 117 LOGAN, UT 84321</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{G 000}	<p>Initial Comments</p> <p>A follow-up was completed on May 11, 2018, for all deficiencies previously cited on April 3, 2018. All cited deficiencies have been corrected as of April 23, 2018, and no new non-compliance was found.</p>	{G 000}		
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Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE  <b>(X6) DATE</b>
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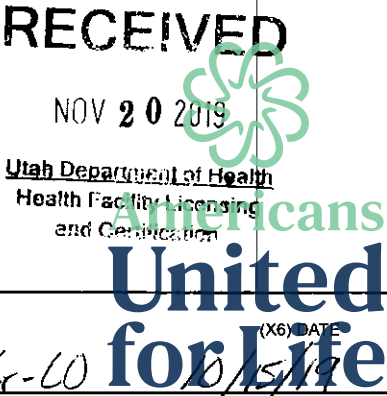
Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000828</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/02/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LOGAN HEALTH CLINIC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 NORTH MAIN, SUITE 117 LOGAN, UT 84321</b>
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G 000	<p>Initial Comments</p> <p>On 10/2/19, an unscheduled re-licensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiencies were cited.</p>	G 000		
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Bureau of Licensing and Certification  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

STATE FORM 6899 E5MR11 If continuation sheet 1 of 1

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Utah Department of Health, Health Facility Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  UT000828	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  10/10/2018
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NAME OF PROVIDER OR SUPPLIER  LOGAN HEALTH CLINIC	STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH MAIN, SUITE 117 LOGAN, UT 84321
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
G 000	<p>Initial Comments</p> <p>On 10/10/18, an unscheduled relicensure survey was conducted. The facility was surveyed according to R432-600 rules for Abortion Clinics. No deficiency was cited.</p>	G 000		

**RECEIVED**

NOV 7 2018

Utah Department of Health  
Health Facility Licensing  
and Certification



Your Agency Name  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Pen Das*

TITLE

*VP Clinical Programs*

(X6) DATE

*11-7-18*

Americans  
**United**  
for Life

*P*

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>UT000828</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/30/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LOGAN HEALTH CLINIC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>550 NORTH MAIN, SUITE 117 LOGAN, UT 84321</b>
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G 000	<p>Initial Comments</p> <p>On 4/30/19, a scheduled relicensure survey was conducted. The facility was surveyed according to R432-600 Rules for Abortion Clinics. No deficiencies were cited.</p>	G 000		
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Bureau of Licensing and Certification  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

