Utah Department of Health, Licensing and Certification (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING 04/16/2019 UT000523 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 715 EAST 3900 SOUTH, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G 000 G 000 **Initial Comments** 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.

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

TITLE

PRINTED: 04/18/2014 FORM APPROVED h Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ **B WING** UT000523 04/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 E 3900 S, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1. Each employee will have a signed Job G 000 Initial Comments G 000 A scheduled re-licensure survey was completed description in their 04/17/14. The facility was surveyed against the R432-600 rules for abortion clinics. A deficiency employee File. was cited. 2. Zandy Nicolosi (administrator) G 240 G 240 R432-600-8(6)(c) Administrator will be responsible for (6) Responsibilities shall include at least the following: (c) Develop clear and complete job descriptions 73. The Correction was Completed on 5/2/14 for each position; This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the administator 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. Utah Department of Health 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 MAY + 3 2014 job description was present in her record.

Your Agency Name

was provided.

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

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

Sureau of Health Facility Licensing,

Certification and Resident Assessment

Iministrator



Utah Department of Health, Health Facility Licensing at (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING UT000523 04/04/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST 3900 SOUTH, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) G 000 Initial Comments G 000 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. Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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If continuation sheet 1 of 1

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Utah Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___

UT000523

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107							
(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	G 000					
	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.	A					
		:	Utah Department of Health	S			
		~	OCT 0 8 2013 Amer	ican			
Agency	Name Waster Waster Waster	<u> </u>	Bureau of Health Facility Licensing, Certification and Resident Assessment	tec			
PRATORY	Y DIRECTOR'S ORPROVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE CONTINUE CONTIN	(X6) DATE			

Utah Department of Health, Health Facility Licensing a (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING UT000523 10/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST 3900 SOUTH, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) G 000 Initial Comments G 000 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. RECEIVED OCT 26, 2017 Utah Department of Hearth Health Facility Licensing and Certific at 0 1 Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE lministrator

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Utah De	partment of Health, I	Health Facility Licensing a			
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		UT000523	B. WING		04/25/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
WASATO	CH WOMEN'S CENTER	D INIC	3900 SOUTI	H, SUITE 203 84107	
(VA) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	TON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
G 000	Initial Comments		G 000		
	was conducted. Th	eduled re-licensure survey ne facility was surveyed -600 rules for abortion clinics. re cited			
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				RECEI\	درارث
Your Agency	Name			Utah Department o Health Facility Lie	mericans
LABORATOR	Y DIRECTOR'S OR PROVIDE	DENSUPPLIER REPRESENTATIVE'S SIG	NATURE	Administrator 1	or laife
STATE FOR	M /		6899 E	EXUI11	If continuation sheet 1 of 1

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Utah Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING B. WING UT000523 11/15/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

WASATCH WOMEN'S CENTED INC

3900 S 715 E, SUITE 203

			LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	/ FULL	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	-	G 000		
	A re-certification survey was completed. The facility was surveyed against the R rules for abortion clinics. No deficiencie cited.	432-600		Utah Department of Healt	h
				DEC 0 5 2012	
	-			Bureau of Health Facility Licensing, Certification and Resident Assessmen	nt
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ABORATORY DIRECTOR'S OR RESVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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If continuation sheet 1 of 1

Utah Department of Health, I	Licensing and Certification			101111111111111111111111111111111111111
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND I DAN OF GOTTALE TO		A. BUILDING.		
	UT000523	B. WING		10/02/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
WASATCH WOMEN'S CENTE			H, SUITE 203	
	JAET DAI	KE CITY, UT	PROVIDER'S PLAN OF CORRECT	TION (VE)
OPERIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE [
G 000 Initial Comments		GOOD POCYEG ACLEDING	0.000	recl
was conducted. Ti	scheduled re-licensure survey he facility was surveyed	Accept 19	Dr. Tiny was appoint	2012
according to R432-	-600 rules for Abortion Clinics.	10/01	Medical Director 1	n 2012.
Deficiencies were	mpliance was identified. cited.		Her agreement w	aS
G 065 R432-600-6(3)(d)	Organization	G 065	Her agreement w misplaced and ho	a S
	s shall include at least the	Verte N	signed a new one	e on
following: (d) Appoint, in writi	ing, a qualified medical director for clinical services;	JULY P	misplaced and he signed a new one loli4/19. Zandy Ninhas made the corr	10/05/ 10/14/19
•		I WE	that made the cor	reonor.
This STANDARD THIS IS A CLASS	is not met as evidenced by: II DEFICIENCY:	ktor.	Checking agreement and Job description	7S
	eview and interview, it was	ļ	and Job description	m_{\perp}
determined the lice	ensee did not appoint, in medical director to be		in employee file	s has
responsible for clir			been added to	the
Findings include:				
On 10/2/19 at 12:1	10 PM, the written appointment		quality assurance	
for the agency me	dical director was requested		Chack list	•
appointment was	dministrator. No written provided.		Check 11-11	· · · · · · · · · · · · · · · · · · ·
At 12:20 PM, the a	agency Administrator was			<u>}</u>
interviewed and a	cknowledged the licensee did		RECEI	VED
not appoint, in wri to be responsible	ting, a qualified medical director for clinical services.			CO
lo se resperiorare	, • • • • • • • • • • • • • • • • • • •		OCT 21	2019
G 610 R432-600-12(2)(a	i) Contracts	G 610	<u>Utah Departmen</u>	(パソ)
(2) The contract s	hall include:		Health Facility	
(a) The effective a	and expiration dates;		and Certifi	americans
			i 	Inited
Bureau of Licensing and Certificatio	n /IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE
Lall-1	m		Administration	or wha
STATE FORM	/	8899	II4Y11	If continuation sheet 1 of 2

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		UT000523	B. WING		10/0	2/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WASATC	H WOMEN'S CENTE	D INC	T 3900 SOUT KE CITY, UT	ГН, SUITE 203 [*] 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
G 610	Based on record redetermined 1 of 2 sinclude an expiration Findings include: On 10/2/19 at 12:1 were requested an Alaboratory contrareviewed. There won the contract. At 12:20 PM, the alinterviewed and according to the contract.	s not met as evidenced by: I DEFICIENCY: eview and interview, it was sampled contracts did not on date. 0 PM, the agency contracts	G 610	On 1012/19 Zandy N received Current contracts from our and steri cycle we exp dates. Checking Contracts for outson Services will also addled to the gur assurance Checking	sith ng de be	10/2/19
				A	mer	3 icans

Bureau of Licensing and Certification STATE FORM

PRINTED: 10/25/2019 FORM APPROVED

<u>Utah</u> De	partment of Health,	Licensing and Certification				,
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E CONSTRUCTION	(X3) DATE SU COMPLE	
			A, BUILDING:		R	
		UT000523	B. WING		10/22/	2019
NAME OF 9	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE		
		715 FAS		H, SUITE 203		
WASATO	H WOMEN'S CENTE	R, INC SALT LA	KE CITY, UT	84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{G 000}	Initial Comments		{G 000}			
{G 000}	A follow-up was co for all deficiencies		{G 000}		S	
						5
					Amer	cans
]		Uni	led
Bureau of L	icensing and Certification	n DER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	for	(X6) A F

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN B. WING		(X3) DATE S COMPLI	
		UT000523				05/0	9/2012
	PROVIDER OR SUPPLIER CH WOMEN'S CENTE	ER, INC	3900 S 7	DDRESS, CITY, 15 E, SUITE KE CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
G 000	Initial Comments			G 000			
	5/09/12. The facili	survey was conducte ty was surveyed agair abortion clinics. Def	nst the		Y . X		
G 435	R432-600-10(5)(a)	(i-iii) Health Surveilla	nce	G 435			
	are skin tested for of: (i) initial hiring; (ii) suspected exptuberculosis; and (iii) development This STANDARD THIS IS A CLASS	thall ensure that all entuberculosis within two cosure to a person with of symptoms of tuber is not met as evidence II DEFICIENCY:	th active culosis.	Contraction	Each employee a TB test in our on left the result were read by Mr. Frishop RN. The Chishop RN. The Chan the TB test can know the employee Both Physicians	opy of se found sles.	10/4/12
		e facility had not ensu e skin tested for tuber eks of initial hire.		12/2/2	Previous test	ought s and	
	completed. None	w of six employee file of the employee files TB testing being com f hire.	contained	y	are filed. (See form)		
	Administrator of the	terview was initiated ver facility. The Adminid not yet obtain TB testes.	strator		Utah Departmen	<u>~(</u>	S
G 975	R432-600-15(6)(a)	Emergency and Disa	aster	G 975	Bureau of Health Facili Certification and Reside	ty Licensing, nt Assessment	rican
		plan shall identify ev			•	Un	to
our Agency	Name Wasata	n Women	Jon't	~	TITLE	CIT	(X6) DATE
	DIRECTOR'S OR PROVI	DEK/SUPPLIER REPRESEN	TATIVE'S SIG	NATURE	Administrato	<u> </u>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

UT000523

B. WING

05/09/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WASATCH WOMEN'S CENTER, INC

3900 S 715 E, 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 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:	G 975	In the process of completing. Will be done and posted by levis. Will faxisend soon levis. Will faxisend soon as its completed.	6/15/12
	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.			
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	G1335	The emergency drug list is now located on the outside of the cupboard instead of the Contains The Supplies	
	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:		are now in the container so no list is needed	
	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		on the arms The nurse also suspected The nurse also suspected we add a heppin lock we add a heppin lock and new needles. Both have been added Ame	ricans
Your Agency	Name			
STATE FOR		6899	KS9U11	tion sheet 2 of 4
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

UT000523

B. WING

05/09/2012

for Life continuation sheet 4 of 4

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

WASATCH WOMEN'S CENTER, INC

3900 S 715 E, 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
G1335	Continued From page 2	G1335		
	the drawer of contents of the emergency drug supply.			
G1340	R432-600-19(5)(c) Pharmacy Service	G1340		
	(c) The use and regular inventory of the contents shall be documented by nursing staff.		The regular controlled drug inventory is now being logged. The log is located inside the lock	6/11/2
	This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY		being logged. The log	
	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.		MX. (See form),	
	Findings include:		The emercial control in short is located in	<i>y</i>
	On 5/09/12, the clinic owner/office manager identified the emergency drug supply to the surveyor.		The emergency Inventory log sheet is located in the drug container the drug container if something is used it will be logged a reproloved	
	On 5/09/12, on interview with the owner/office manager, she said that regular inventory of the contents had not been done.		(See form)	,
G1650	R432-600-22(6)(e) Medical Records	G1650	added 9	
	(6) Each patient's medical record shall include the following:(e) Discharge summary which contains a brief narrative of conditions and diagnoses of the		wwc. has added a discharge summary to the bottom of the	July 2-
	patient and final disposition; This STANDARD is not met as evidenced by:		the bottom of the operative report and will be filled out by the Physician American	3
	THIS IS A CLASS II DEFICIENCY.		by the Physician	ricona
	Based on a review of patient records with the administrator, the facility did not meet the		(See form) IIn	
our Agency	Name	<i>h</i>	- UII	TUU

PRINTED: 05/17/2012 FORM APPROVED Utah Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 05/09/2012 UT000523 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 S 715 E, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) G1650 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.

Your Agency Name
STATE FORM

FORM APPROVED Utah Department of Health, Health Facility Licensing a (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: ___ B. WING UT000523 10/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST 3900 SOUTH, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G 000 G 000 **Initial Comments** 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. RECEIVED NOV **Utah Department of Heal** Health Facility Licensing and Certification Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE ministrativ

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Utah Department of Health

PRINTED: 05/29/2013 FORM APPROVED

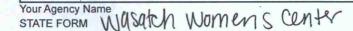
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: TITIN 1 8 2013 05/21/2013 UT000523 STREET ADDRESS, CITY, STATE, ZIP CODE and Resident Assessment NAME OF PROVIDER OR SUPPLIER 715 E 3900 S. SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1. The Staff Notes G 000 G 000 Initial Comments form has been A scheduled relicensure survey was conducted Changed to Comply on 5/21/13. The facility was surveyed against the R432-600 rules for abortion clinics. Deficiencies With R432-400-22(3) were cited. G1615 G1615 R432-600-22(3) Medical Records The new form now includes Patients (3) All entries shall be permanent and capable of being photocopied. Entries must be authenticated including date, name or identified first and last name. initials, and title of the person making the entry. late and time. And This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY space for Staff 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. 2. Office Administrator Findings Included: (Zandy Nicolosi) On 05/21/13, a review of patient records revealed a staff note for Patient 1 dated 04/25/13 which did 3. Effective 7/1/13 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. Your Agency Name TITLE Admini Wasaich Womens Center LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

OWL811

Utah Department of Health

STATE FORM

PRINTED: 05/29/2013 FORM APPROVED Utah Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING UT000523 05/21/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 715 E 3900 S, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1. The pre-op report form G1640 Continued From page 1 G1640 has been changed to G1640 G1640 R432-600-22(6)(c) Medical Records Comply with (6) Each patient's medical record shall include the 2432-600-22(6)(c). The new following: form has a line for (c) Signed and dated physician orders for drugs and treatments: the Physician signature approving any pre-op medications This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY Based on record review and interview, it was See attached form 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 2. Office Administrator 10. (Zandy Nicolosi) Findings Included: 3 Effective 7/1/13 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. On 05/21/13, the administrator acknowledged that the physician was not signing the "Pre-Op



procedure.

Report" and stated she would ensure the physician starts signing the form, when medications are administered prior to the



Litah De	partment of Health			,		APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	
	UT000523		B. WING		04/2	8/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WASATO	H WOMEN'S CENTER	< INC.	0 S, SUITE : KE CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
G 000	Initial Comments		G 000			
	was conducted at the found not to be in conducted at the	nnounced relicensure survey nis facility. The facility was ompliance with Abortion Clinic the following demonstrate non	4			
G1935	R432-600-25(7) Ma	intenance Services	G1935			
	cords, equipment, of the maintained to gue compliance with the This STANDARD is Electricial systems compliance with the Findings include: During the tour of the extension cord was power to some electrocordance with NF	ns including appliances, call lights, and switches shall parantee safe functioning and a National Electrical Code. Is not met as evidenced by: including cords shall be in a National Electric Code. The facility a residential style observed to be suppling etronics in the waiting room. In EPA 70 National Electric Code is shall not be used as a wiring.	MIKE	The extension Common replaced with a Surge Protector on by Zandy Nicolosi Zandy has added in the maintenance to check for extension cords mi		
					S	B
					mo	ioona
				P	In	tod
our Agency	Name DIRECTOR'S OF PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Kned	yNms	Wasatch Womens can		Administrate Vitah Dena	ore	Life

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STATE FORM

MAY 1 3 2015

PRINTED: 10/20/2015 Utah Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING UT000523 10/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 E 3900 S. SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) G 000 Initial Comments G_{000} 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 012 R432-600-4(2)(b) Licensure G 012 (2) An abortion clinic may be licensed as a Type I facility if the facility: Effective Immediately-Zandy held a staff meeting on 10/7/15 with all employees (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: and Physicians regarding Based on record review and interview, it was determined the Type I facility performed rule 74-7-301. Evenyone 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 985 R432-600-15(6)(c) Emergency and Disaster

(c) Fire drills and documentation shall be in

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 any reason.

Your Agency Name

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

Administrator

G 985

STATE FORM

TITLE

	OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	1 ' '	ELE CONSTRUCTION S:	COMPLETED
		UT000523	B. WING		10/05/2015
WASATO	PROVIDER OR SUPPLIER	R, INC 715 E 390 SALT LAI	00 S, SUITE KE CITY, UT	84107	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
G 985	accordance with Raprotection Board. The patients during a draw This STANDARD is THIS IS A CLASS Is Based on record redetermined fire drill in accordance with Protection Board. Findings Include: On 10/05/15, a revithe past year was of documented as part and 07/15/15. On 10/05/15, an interior drills were part the fire drill rule was administrator verbad drills were not to be	710-4, State of Utah Fire The actual evacuation of Fill is optional. In the state of Utah Fire The actual evacuation of Fill is optional. In the state of Utah Fire The Actual evacuation were not R710-4, State of Utah Fire The Actual Evacuation were not R710-4, State of Utah Fire The Actual Evacuation of The State of Olivinia Were at of an inservice on Olivinia Were to fan inservice. A review of a conducted. The clinic Mized understanding that fire the held as part of an inservice cted and documented inservice training.	G 985	Effective IIIIIs. Fire drills will now unannounced and september of Discister by done every le mergency Disastration of the log book by Zandy.	and and ining. will on this dy. deled
	to ensure that the fa grounds are maintal condition and in go accordance with ma the safety and well- visitors.	adequate maintenance service acility, equipment, and hined in a clean and sanitary od repair at all times, in anufacturer specifications for being of patients, staff, and so not met as evidenced by:			SS mericans
Your Agency STATE FORI			6899	S0BD11	If continuation sheet of 3
				f	or Life

PRINTED: 10/20/2015 FORM APPROVED Utah Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING UT000523 10/05/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 715 E 3900 S, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) G1900 Continued From page 2 G1900 THIS IS A CLASS II DEFICIENCY: Based on observation, record review and interview, it was determined facility equipment was not maintained in accordance with manufacturer specifications. Findings include: On 10/05/15, a tour of the facility was conducted Smoke detectors were replaced and documented by 2 and on 10/14/15 and single station smoke detectors were observed in use in facility corridors. 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.

Your Agency Name STATE FORM



If continuation sheet 1 of 1

Utah Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING_ 10/25/2016 UT000523 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 715 E 3900 S, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G 000 G 000 **Initial Comments** 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. Your Agency Name TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATE FORM

FORM APPROVED Utah Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING UT000523 04/20/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 715 E 3900 S, SUITE 203 WASATCH WOMEN'S CENTER, INC SALT LAKE CITY, UT 84107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G 000 Initial Comments G 000 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. RECEIVE MAY 17 2016 **Utah Department of Health** Health Facility Licensing and Certification Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

LILL D		Uselth Capility Licensing of			FORM	APPROVED
STATEMEN	T OF DEFICIENCIES	Health Facility Licensing al (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		UT000535	B. WING		04/0	4/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
METRO I	HEALTH CENTER		TH 1000 EAS KE CITY, UT	T, SUITE 120 84102		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5) COMPLETE
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE
G 000	Initial Comments		G 000			
	A scheduled relicer	nsure survey was conducted				
	on 4/4/18. The fact R432-600 rules for deficiencies were c	ility was surveyed against the abortion clinics. No cited.				
					-ر	C
					Ś	B
					Amos	icans
					Amei	icans

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

TITLE

If continuation sheet 1 of 1

Utah De	partment of Health.	Health Facility Licensing a			FORM APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		UT000535	B. WING		04/26/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
METRO	HEALTH CENTER		TH 1000 EAS KE CITY, UT	ST, SUITE 120 - 84102	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTE DATE
G 000	conducted. The fa	duled relicensure survey was cility was surveyed against the abortion clinics. A deficiency	G 000	Poc acceptal	
G 020	R432-600-5(1) Cor	all conform with the l32-4-1 through R432-4-22,	G 020		
	Based upon obsert of the Clinic managed determined that the access to be readily accordance with Research	is not met as evidenced by: vations made in the presence ger on 04/26/2017, it was e facility did not maintain exit y accessible at all times in 432-600-5-1 ets two of two clinic exit doors.			
		cts one of one stairwell door.			
	the two clinic exit of not a readily visible readily visible dura egress side on or a	lity tour it was observed that loors had bolt locks, there was a sign posted on the doors. A ble sign is posted on the adjacent to the door stating: EMAIN UNLOCKED WHEN			
	THIS SPACE IS O	CCUPIED. The sign shall be in nm) high on a contrasting			Y 17 2017
	the exit corridor do	lity tour it was observed that or by the fire stairwell escape		Health	Partinent of Health Cans
Your Agency LABORATOR	Name Dlanned Y Y DIRECTOR'S OR PROVI	Carentler Representatives sh O d	Who Cen	fer TITLE VP Clini	Cal Program (X6) DATE (7)
STATE FOR	M		6199	488311	If continuation sheet 1 of 4

STATE FORM

,): 05/02/2017 APPROVED
STATEMEN	partment of Health, IT OF DEFICIENCIES OF CORRECTION	Health Facility Licensing a (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		SURVEY PLETED
		UT000535	B. WING		04/	26/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
METRO	HEALTH CENTER		TH 1000 EAST KE CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
G 020	Continued From pa	age 1	G 020			
	door, Manually ope	stalled on the exterior of the erated flush bolts or surface itted in accordance with IFC				
G1935	R432-600-25(7) M	aintenance Services	G1935			
	cords, equipment, be maintained to g compliance with th This STANDARD Based upon obsert of the clinic managed determined that the electrical equipment 432-600-25 (7)	ms including appliances, call lights, and switches shall uarantee safe functioning and e National Electrical Code. is not met as evidenced by: vations made in the presence per on 04/26/2017, it was e facility did not maintain in accordance with R				
	This deficiency affe	ects two of several outlets.				
	Findings include:					
	observed in use in desk coming out of equipment on top of Extension cords are substitute for permand flexible cords structures, extended or under doors to for cords be subject to physical impact in 2- During the fact observed in use in	lity tour an extension cord was the main reception/check in f the ceiling powering of the upper cabinets. In the ceiling power in the upper cabinets and flexible cords shall not be a meant wiring. Extension cords shall not be affixed to ed thru walls, ceilings or floors accordance with IFC 605.5 lity tour an extension cord was the employee break room, it			S	
		the ceiling and into the next or power to a television in the			Amer	icans

Your Agency Name STATE FORM



PRINTED: 05/02/2017 FORM APPROVED Utah Department of Health, Health Facility Licensing a (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 04/26/2017 UT000535 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 160 SOUTH 1000 EAST, SUITE 120 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G1935 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 G2030 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 equipment shall be functionally tested every 30 days and load tested at least annually, for 90 minutes. 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) This deficiency affects all of the emergency lighting. Findings Include: 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

Your Agency Name STATE FORM

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



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Litah De	nartment of Health	Health Facility Licensing a			FORM	APPROVED
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		UT000535	B. WING		04/2	26/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
				ST, SUITE 120		
WETRO	HEALTH CENTER	SALT LAP	KE CITY, UT	84102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
G2030	Continued From pa	age 3	G2030			
	passed or failed, ar person completing	nd the date of the test and the the test.				
	emergency lighting	ower test shall operate the for not less than 90 minutes ufficiently illuminated for the .				
ļ				A	mer	icans
				T	Ini	tod
Your Agency STATE FOR			6899	488311	If continu	tion the 14 of 4
				10		LIIC

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 5/316/17
		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

Davis VI Chinical Programs 5/12/17



PRINTED: 10/26/2016

FORM APPROVED Utah Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING UT000535 10/25/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #120 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) G 000 Initial Comments G 000 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. RECEIVED NOV 0 8 2016 A Utah Department of Heelth Health Facility Licensing and Certification Your Agency Name

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

STATE FORM

FORM APPROVED Utah Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING UT000535 04/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #120 **METRO HEALTH CENTER** SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G 000 Initial Comments G 000 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. **RECEIVED** MAY 0 5 2016 Utah Department of Health Health Facility Licenting and Certification Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1

PRINTED: 10/07/2019 FORM APPROVED

Jtah De	partment of Health,	Licensing and Certification			FORM APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		UT000535	B. WING		10/02/2019
IAME OF F	PROVIDER OR SUPPLIER	'	DDRESS, CITY, S	TATE ZIP CODE	10/02/2019
	HEALTH CENTER	160 SOU	TH 1000 EAST	Γ, SUITE 120	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
G 000	Initial Comments		G 000		
:	was conducted. The	scheduled re-licensure survey ne clinic was surveyed 600 Rules for Abortion Clinics. re cited.			
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE	R/CLIA MBER:	(X2) MULTI A. BUILDIN B. WING _		(X3) DATE SU COMPLE	TED		
		UT000535	CTREET ARR	<u> </u>		12/00	5/2012		
160			160 S 1000	TREET ADDRESS, CITY, STATE, ZIP CODE 60 S 1000 E SUITE #120 ALT LAKE CITY, UT 84102					
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G 000	The facility was sur	ey was completed 12 rveyed against the Ra linics. No deficiencie	432-600	G 000	Utah Departmen DEC 2 0 2 Bureau or meanin raom Certification and Reside	2012			
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Plani Your Agency	ned favorthood As	sociation of which	Metro Ha	ealth Co	nter.	Amer	Sicans ted		
, LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESEN	NTATIVE'S SIGN	ATURE		tor	Lite		
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Utah Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING UT000535 06/04/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 160 S 1000 E #120 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) 1D (X4) ID (FACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R432-600-25(4) G1920 G1920 R432-600-25(4) Maintenance Services (4) All buildings, fixtures, equipment and spaces Director of It will replace the 2 ceiling tiles in the communications shall be maintained in operable conditions. This STANDARD is not met as evidenced by: This was completed by Fred Pennington, Director of It on 4/5/12 THIS IS A CLASS II DEFICIENCY. Based on a facility walk through with the administrator, the facility did not meet the requirements of this statute. Findings include: The facility's communications room did not have two ceiling tiles firmly secured in place. This situation compromised the fire integrity of the Utah Department of Health room (2009 IFC 315.2.4). JUN 1 9 2012 Bureau or meanth racincy Electronity. Certification and Resident Assessment

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

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		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			UT000535	B. WNG		10/0	3/2013
	NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	-	
F	VIETRO I	HEALTH CENTER		00 E SUITE∄ KE CITY, UT			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROVIDER OF CORRECT PRO	OULD BE	(X5) COMPLETE DATE
	G2015	R432-600-26(3) En	nergency Electric Service	G2015		"	
		(3) There shall be p lighting according to	provision for emergency exit to NFPA 101.				
	ır Agency	Based on observatifacility manager on provide emergency areas. Findings: 1. The east exit statwo required paths was observed to not emergency light to event of a power fair clude evening how indicated the normal include evening how natural light from the illuminate the path of the facility manager.	in and interview with the 10/02/13, the facility did not exit lighting at all required airwell that serves as one of of egress from the clinic area of have a battery back-up illuminate the stairwell in the illure. With the facility manager, she all hours of facility operation are on Monday when the estairwell window would not of egress as required.	70,3	evill install battery emergency light in exit stairwell. by No light will be check in with clinic emergency facility check list. Point person will responsible to che emergency lights in exit stair well. East emergency light be added to monthly emergency facility	be all acluding east will checklish	Ş
ΑB	ORATORY	DIRECTOR'S OR PROVID	ersupplier representative'ş siç VCronica Ga	1 1	OK. Makagara OK. Makagara	f Healtl.	(X6) DATE
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TATEMEN	T OF DEFICIENCIES	Licensing and Certification (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NOWIDER.	A. BUILDING:		OOM! EETEB
		UT000535	B. WING		04/18/2019
AME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
ETRO F	HEALTH CENTER		TH 1000 EAS		
			KE CITY, UT		DESCRIPTION AND ADDRESS OF THE PROPERTY OF THE
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G 000	Initial Comments		G 000		
	On 4/18/19, a sche	duled recertification survey	1000	QQ	
	was conducted. The	ne clinic was surveyed	I WILL	1,9	
		600 Rules for Abortion Clinics	Ha 1	2/1	
	Deficiencies were	nied.	5\2	` ` `	
G1900	R432-600-25(1) Ma	aintenance Services	G1900`	10/19.	
	(1) There shall be	adequate maintenance service	$_{\rm e}$ $_{\rm L}$ 0	() 1 ()	
		acility, equipment, and	NOV.	5\ '	
	grounds are mainta	ained in a clean and sanitary	$ \mathcal{O} \setminus a \rangle$,	
	condition and in go	od repair at all times, in	12.30	5	
		anufacturer specifications for being of patients, staff, and	10° m	9/	
	visitors.	being of patients, stan, and	Dogin		
			150,		
	This STANDARD THIS IS A CLASS	s not met as evidenced by:			
	Based on observat	ion and interview, it was			
	determined the age	ency did not conduct adequate	: [
	maintenance servi	ce to ensure that the facility			
	equipment was ma	intained in good repair for the			
	safety and well-bei visitors.	ng of patients, staff and			
	Findings include:				
	On 4/18/19 during	the facility tour, the		c 1.11	
		th battery back up failed when		Emergency Light Replaced 5-7-19	5-07-1
	tested. A new batte	ery was installed and the light		Replaced 5-7-19	
	still failed when tes	ited. The light is #1 in the main	ו	9	
		Clinic Manager was present	ļ		-C/C-
		and acknowledged the the maintained in good repair.			Q ¹ Q
	equipment was no	mantanios in good ropuii.			داهن
G2415	R432-600-30(3) W	ater Supply	G2415		A 100 5
	(2) 11=4=4=4=	aratura cantrola aball			American
	(3) Hot water temp	erature controls shall			Unito
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FORM APPROVED Utah Department of Health, Licensing and Certification (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: B. WING 04/18/2019 UT000535 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 SOUTH 1000 EAST, SUITE 120 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G2415 G2415 Continued From page 1 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. This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY: 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. Findings include: 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 5.7-19
Plumber adjusted worter
heater and temperature
readings:
Battroom 1-117
Bathroom 3-118
Buttroom 3-117 degrees Farenheit. At 2:55 PM, the Clinic Manager acknowledged the water temperature was not being maintained between 105 and 120 degrees.

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PRINTED: 05/21/2019 FORM APPROVED

Utah Department of Health, Licensing and Certification (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: _____ R B. WING 05/20/2019 UT000535 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 160 SOUTH 1000 EAST, SUITE 120 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {G 000} {G 000} Initial Comments 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.

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

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PRINTED: 10/21/2014 FORM APPROVED Utah Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING UT000535 10/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #100 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY G 000 Initial Comments G 000 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.

Your Agency Name

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

TITLE

PRINTED: 05/20/2015 FORM APPROVED

Utah Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING UT000535 05/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #100 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) G 000 Initial Comments G 000 See a Hacked FOC. 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 020 R432-600-5(1) Construction G 020 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 Utah Department of Health the facility manager. G2030 R432-600-26(5)(b) Emergency Electric Service G2030 MAY 2 9 2015 (5) All emergency electrical power systems shall Bureau of Health Facility (10 ns ng be maintained in operating condition and tested Certification and Resident Assessment as follows: (b) Transfer switches and battery operated ed Parenthood Ass of What LABORATORY DIRECTOR'S VIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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FORM APPROVED Utah Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: B. WING UT000535 05/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #100 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) G2030 Continued From page 1 G2030 equipment shall be functionally tested every 30 days and load tested at least annually, for 90 minutes. 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. Findings: 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. 2. The east side exit sign was observed to have only one of the two internal light bulbs functioning. These observations were made in the presence of the clinic manager. G2420 R432-600-30(4) Water Supply G2420 (4) There shall be grab bars at each toilet, bathtub, and shower used by patients. This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY: Based on observation and interview, it was determined the facility failed to provide grab bars at all toilets used by patients. Findings Include: On 05/06/15 at 1:30 pm, a patient bathroom was

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FORM APPROVED Utah Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING UT000535 05/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #100 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) G2420 Continued From page 2 G2420 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.

Your Agency Name STATE FORM

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Utah Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION -**IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ____ B. WING _ UT000535 04/15/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #120 **METRO HEALTH CENTER** SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) G 000 Initial Comments G 000 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. ۲. Your Agency Name Metro Heath Confir LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) G 000 Initial Comments A scheduled re-licensure survey was completed 06/18/13 The facility was surveyed against the R432-800 rules for abortion clinics. No deficiencies were cited Utah Department of Health J'	METRO	HEALTH CENTER							
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 Bureau or Health Facility Licensing, Certification and Resident Assessment. A scheduled re-licensure survey was completed 06/18/13. The facility Licensing is a 2.13. Bureau or Health Facility Licensing, Certification and Resident Assessment. Americans Bureau or Health Assessment.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS REFERENCED TO THE	SHOULD BE	COMPLETE	
A scheduled re-licensure survey was completed 06/18/13. The facility was surveyed against the R432-600 rules for aborton clinics. No deficiencies were cited With Department of Health JUL 0.3 ZJ13 Bureau or Health 1-2-11/15 Licensing, Certification and Resident Assessment Americans Uragency Name Metro Health 2-2-4 Americans Boratory Directors on Provider/Supplier Representatives signature	G 000	Initial Comments			G 000				
WI Agency Name Metra Health Carty Lindows VICTION INTERESTRICT SON PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE	A scheduled re-licensure survey was completed 06/18/13 The facility was surveyed against the R432-600 rules for abortion clinics No				JUL 0 3 2 Bureau of Health Facilit	J13 v Licensina.			
Ur Agency Name Metro Health Centry Pun Davis Viction of Programs (x6) NATE BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	-		, ",	-			J		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - SOUTHERN UTAH VETERANS HOME - IVINS			(X3) DATE SURVEY COMPLETED	
465180		B. WING			10/21/2015	
NAME OF PROVIDER OR SUPPLIER SOUTHERN UTAH VETERANS HOME - IVINS				STREET ADDRESS, CITY, STATE, ZIP CODE 160 N 200 E IVINS, UT 84738		
PREFIX (EACH DEFICIENC			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
Statutory and regularized Safety Code surve 10/21/2015 at 9:00 administrator and the 20 Code of Federa (a)(1)(i), and the 20 Safety Code including referenced therein compliance with the in Medicare and Medicare and Medicare surveys to the surveys of the surveys	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. There were no life safety code deficiencies cited		000			
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	y ·			NOV 1 2 2015	nsila	
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting projecting it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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.

PRINTED: 10/10/2018 FORM APPROVED

Utah Department of Health, Health Facility Licensing a (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING UT000535 10/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 SOUTH 1000 EAST, SUITE 120 **METRO HEALTH CENTER** SALT LAKE CITY, UT 84102 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) G 000 Initial Comments G 000 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. RECEIVED OCT 2 4 2018 **Utah Department of Health** Health Facility Licensing and Certification Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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Utah Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING; __ UT000535 B. WING 10/13/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #120 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) G 000 Initial Comments G 000 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 985 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: THIS IS A CLASS II DEFICIENCY: 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. G2415 G2415 R432-600-30(3) Water Supply Your Agency Name LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE S SIGNATURE STATE FORM

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FORM APPROVED Utah Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _____ UT000535 10/13/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 S 1000 E SUITE #120 METRO HEALTH CENTER

METRO	HEALTH CENTER		(E CITY, UT	84102		
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G2415	Continued From page 1		G2415			
	(3) Hot water temperature controls automatically regulate temperature delivered to plumbing fixtures used. The facility shall maintain hot water patient care areas at temperature degrees and 120 degrees F.	es of hot water d by patients. er delivered to				
	This STANDARD is not met as ev THIS IS A CLASS I DEFICIENCY:					
	Based on observation and intervie determined the facility was not ma water delivered to patient care are temperature between 105 degrees degrees.	intaining hot as at a				
İ	Findings include:					
	On 10/8/15, at 4:00 PM, the temper water in front bathroom waiting are recovery room bathroom was tested clinic manager present and found Farenheit. The Clinic Manager act water temperature was not safe for areas.	ea and the back ed with the to be 137 knowledged the				
	A CLASS I DEFICIENCY WAS ISS 10/8/15 AND AN ACCEPTABLE P CORRECTION WAS OBTAINED FACILITY MANAGER. SEE ATTA	LAN OF FROM THE				
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UTAH DEPARTMENT OF HEALTH BUREAU OF HEALTH FACILITY LICENSING CERTIFICATION AND RESIDENT ASSESSMENT CLASS ONE/REPEAT DEFICIENCY STATEMENT

Class One X
Repeat Deficiency [
Facility: Motro Health Clinic 3535
Survey/ Investigation Date:Follow-up Date:
Rule Citation: $R432-600-30(3)$
Observation: Based on Abservation Sinterview, at was determined the
Care areas at temperatures between 105 degrees & 120 cleaners.
On 10/8/15, at 4:00pm, the temperature of hot water in front hathroom
waiting area and the back recovery room bathroom was tested
with the clinic marker present and found to be. 137 F.
The Clinic Manager, acknowledged the water temporature
was not safe for patient care news.
Plan of Correction: contacted building manager to find out where
the clinic water heated is located. Building manager states
there are several water heaters for all bussinesses and would
prefer to change wester temperature himself. Building Manager
will change temp. tomornow 10/9/15 morning. I Veronica Galinch
clinic manager will check water temp tomorrow morning and
the next 3 bussiness days after that monthly.
Completion Date: 10/22/5
Surveyor: alen Wathins Mr Date: 10/8/15 United
Provider Machaela Date: 10/8/15 for Life



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.

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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.



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

- 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 footcandles 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)

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)(fricans
 - 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 Content 15(6)

FORM APPROVED Utah Department of Health, Health Facility Licensing at (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING _ UT000535 10/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 160 SOUTH 1000 EAST, SUITE 120 METRO HEALTH CENTER SALT LAKE CITY, UT 84102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) G 000 G 000 Initial Comments 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.

Your Agency Name

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

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Utah De	partment of Health. I	Health Facility Licensing a			
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	facility was surveyed	s conducted on 4/3/18. The dagainst the R432-600 rules A deficiency was cited.			
G 210	act as administrato person shall have s freedom to act in the safety and well-being a de facto administ designated facility at This STANDARD in THIS IS A CLASS IN Based on record redetermined that the	or shall designate a person to r in his or her absence. This sufficient power, authority, and he best interests of patienting. It is not the intent to permit rator to supplant or replace the administrator. s not met as evidenced by:	G 210	As per Utah Administrative Code f Abortion Clinic Rule R432-600-8(2 Documentation has been created, and subsequently added to clinic p which states that the Assistant Adhas sufficient power, authority, and to act in the best interest of patient and well being in the absence of the Administrator.	2): protocol, ministrator d freedom t safety
	There was no design indicating that the Cacting administrato At 10:15 AM, an infolioric Coordinator, was no written des	gnation from the Administrator Clinic Coordinator was the r in their absence. Terview was conducted with the who acknowledged that there		Uah Departin	7 2018 ; lent of Health ty Licansing
	Name Y DIRECTOR'S OR PROVID Porenthood - Lo	DERVSUPPLIER REPRESENTATIVE'S SIG	NATURE A Mid	TITLE Clinic Correlinator	or/s/fe
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Utah Department of Health, Health Facility Licensing a (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ B. WING 05/11/2018 UT000828 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH MAIN, SUITE 117 LOGAN HEALTH CLINIC **LOGAN, UT 84321** (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {G 000} {G 000} Initial Comments 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.

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

TITLE

PRINTED: 10/07/2019 FORM APPROVED

Utah Department of Health, Licensing and Certification (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING UT000828 10/02/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 NORTH MAIN, SUITE 117 **LOGAN HEALTH CLINIC LOGAN, UT 84321** SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) G 000 Initial Comments G 000 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. RECEIVE NOV 2 0 2019 Utah Department of Health Health Facility Licensing Bureau of Licensing and Certification TITLE Linic Conclinator - C LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPROSENTATIVE'S SIGNATURE

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