Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 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.	G 000		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	04/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 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 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. 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 POC Accepted Compliance Date 5-2-14	

Utah Department of Health

MAY 13 2014

Bureau of Health Facility Licensing, Certification and Resident Assessment

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 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		

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

Administrator

AW

Utah Department of Health

PRINTED: 09/19/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	09/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 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		

Utah Department of Health

OCT 08 2013

Bureau of Health Facility Licensing, Certification and Resident Assessment

Americans United for Life

Your Agency Name Wasatch Women's Ctr

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

TITLE Administrator

(X6) DATE

STATE FORM 6899 8NBW11 If continuation sheet 1 of 1

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 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.	G 000		

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OCT 26 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 — TITLE: Administrator — (X6) DATE: 10/24/17

2

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	04/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 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.	G 000		

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5-9-17

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Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING _____ B. WING _____	11/15/2012

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

(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 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.	G 000	Utah Department of Health DEC 05 2012 Bureau of Health Facility Licensing, Certification and Resident Assessment	

Your Agency Name Wasatch Women's Center

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

TITLE Administrator

(X6) DATE 12-4-12

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 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 000	POC Accepted 10/22/19 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
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 065	Correction date 10/14/19 K Grimes	
G 610	R432-600-12(2)(a) Contracts (2) The contract shall include: (a) The effective and expiration dates;	G 610		

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Utah Department of Health
Health Facility Licensing
and Certification

Bureau of Licensing and Certification
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/21/19

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 610	Continued From page 1 This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY: Based on record review and interview, it was determined 1 of 2 sampled contracts did not include an expiration date. Findings include: On 10/2/19 at 12:10 PM, the agency contracts were requested and reviewed. A laboratory contract, effective March 2018, was reviewed. There was no expiration date located on the contract. At 12:20 PM, the agency Administrator was interviewed and acknowledged the laboratory contract did not include an expiration date.	G 610	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	10/2/19

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	R 10/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 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.	{G 000}		

Bureau of Licensing and Certification

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING _____ 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

(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 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 000		
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 435	6/8/12 POC Acceptable Compliance 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
G 975	R432-600-15(6)(a) Emergency and Disaster (a) The evacuation plan shall identify evacuation	G 975		

Utah Department of Health
JUN 27 2012
Bureau of Health Facility Licensing, Certification and Resident Assessment

Your Agency Name Wasatch Women's Center

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

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING _____ 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

(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: 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 hepnn lock and new needles. Both have been added.	6/1/12

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING _____ 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

(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 the drawer of contents of the emergency drug supply.	G1335		
G1340	R432-600-19(5)(c) Pharmacy Service (c) The use and regular inventory of the contents shall be documented by nursing staff. 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 regular inventory of the emergency drug supply was not being done. Findings include: On 5/09/12, the clinic owner/office manager identified the emergency drug supply to the surveyor. On 5/09/12, on interview with the owner/office manager, she said that regular inventory of the contents had not been done.	G1340	The regular controlled drug inventory is now being logged. The log is located inside the lock box. (See form). The emergency inventory log sheet is located in the drug container. If something is used it will be logged & reordered. (See form)	6/1/12 6/1/12
G1650	R432-600-22(6)(e) Medical Records (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; This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY. Based on a review of patient records with the administrator, the facility did not meet the	G1650	WWC has added a discharge summary to the bottom of the Operative report and will be filled out by the Physician (See form)	6/1/12

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING _____ 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

(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		

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 EAST 3900 SOUTH, SUITE 203 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 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.	G 000		

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

TITLE: Administrator

(X6) DATE: 10/24/18

Adele

PRINTED: 05/29/2013
FORM APPROVED

Utah Department of Health

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____ JUN 18 2013 Bureau of Health Facility Licensing, Certification and Resident Assessment	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 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) The new form now includes Patients first and last name. Date and time. And a space for staff Signature. See form -	
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. 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.	G1615	6-19-13 POC Acceptable Completion date 7-1-13 2. Office Administrator (Zandy Nicolosi) 3. Effective 7/1/13	

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	05/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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
G1640	Continued From page 1	G1640	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	
G1640	R432-600-22(6)(c) Medical Records (6) Each patient's medical record shall include the following: (c) Signed and dated physician orders for drugs and treatments; This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY 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. Findings Included: 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 Report" and stated she would ensure the physician starts signing the form, when medications are administered prior to the procedure.	G1640	2. Office Administrator (Zandy Nicolosi) 3. Effective 7/1/13	

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	04/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 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	R432-600-25(7) Maintenance Services (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. This STANDARD is not met as evidenced by: Electricial systems including cords shall be in compliance with the National Electric Code. Findings include: 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.	G1935	5-18-15 POC Accepted Date 4-29-15 1) The extension cord was replaced with a Surge Protetor on 4/29/15 by Zandy Nicolosi Zandy has added in the maintenance log book to check for extension cords monthly.	

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Zandy Nicolosi | TITLE: Wasatch Womens Center Administrater | (X6) DATE: 5/13/15

STATE FORM 6899 QNMI11 If continuation sheet 1 of 1

Utah Department of Health

MAY 13 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 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	11-13-15 POC Accepted Not Complete Date 11-4-15 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 any reason.	
G 985	R432-600-15(6)(c) Emergency and Disaster (c) Fire drills and documentation shall be in	G 985		

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-4-15

A

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 985	Continued From page 1 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 10/05/15, 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. 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.	G 985	Effective 11/1/15. 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.	
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:	G1900		

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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
G1900	Continued From page 2 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 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.	G1900	Smoke detectors were replaced and documented by Zandy on 10/14/15	

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 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.	G 000		

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/12/2017

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000523	A. BUILDING: _____ B. WING _____	04/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH WOMEN'S CENTER, INC	715 E 3900 S, SUITE 203 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 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.	G 000		

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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: 5/16

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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		

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

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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	Poc accepted 5-22-17 DM	
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 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 Deficiency (1) affects two of two clinic exit doors. Deficiency (2) affects one of one stairwell door. Findings include: 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. 2- During the facility tour it was observed that the exit corridor door by the fire stairwell escape	G 020		

Your Agency Name Planned Parenthood Metro Health Center
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE VP Clinical Programs (X6) DATE 5/12/17

2

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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	R432-600-25(7) Maintenance Services (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. 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) This deficiency affects two of several outlets. Findings include: 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 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	G1935		

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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
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	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 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	G2030		

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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
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		

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

Americans United for Life

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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 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.	G 000		

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Health Facility Licensing
and Certification

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

VP Clinical Programs 11-7-16

STATE FORM 6899 7BBN11 If continuation sheet 1 of 1

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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 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.	G 000		

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Utah Department of Health
Health Facility Licensing
and Certification

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] 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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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.	G 000		

Bureau of Licensing and Certification
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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PRINTED: 12/11/2012
FORM APPROVED

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING _____ B. WING _____	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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 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.	G 000	Utah Department of Health DEC 2 0 2012 Bureau of Health Facility Licensing, Certification and Resident Assessment	

Planned Parenthood Association of Utah Metro Health Center
Your Agency Name

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

TITLE VP Clinical Programs (X6) DATE 12/18/12

Americans United for Life

Utah Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING _____ B. WING _____	06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E #120 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
G1920	R432-600-25(4) Maintenance Services (4) All buildings, fixtures, equipment and spaces shall be maintained in operable conditions. This STANDARD is not met as evidenced by: 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 room (2009 IFC 315.2.4).	G1920	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 Utah Department of Health JUN 19 2012 Bureau of Health Facility Licensing, Certification and Resident Assessment	

6-7-12 DC Acceptable Angela Date 6-5-12

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

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

AW

PRINTED: 10/08/2013
FORM APPROVED

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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
G2015	R432-600-26(3) Emergency Electric Service (3) There shall be provision for emergency exit lighting according to NFPA 101. This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY 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. Findings: 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. 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. This observation was made in the presence of the facility manager.	G2015	11-8-13 PoC Acceptable Completion date 11-20-13 • Will install battery back-up emergency light in east exit stairwell. by Nov 20, 2013 • light will be check monthly with clinic emergency facility check list. • Point person will be responsible to check all emergency lights including emergency light in east exit stair well. • East emergency light will be added to monthly emergency facility checklist 11-20-13	

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: VGalindo — Veronica Galindo-Clinic Manager
TITLE: Utah Department of Health
(X6) DATE: 11-20-13

STATE FORM 6899 LU5911 If continuation sheet 1 of 1

OCT 28 2013

Bureau of Health Facility ...
Certification and Resident Assessme...

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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	POC Accepted 5/20/19	
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: THIS IS A CLASS II DEFICIENCY: 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	Correction Date 5/7/19. K Grimes Emergency Light Replaced 5-7-19	5-07-19
G2415	R432-600-30(3) Water Supply (3) Hot water temperature controls shall	G2415		

Bureau of Licensing and Certification
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Penny Davis — TITLE: VP Clinical Programs — (X6) DATE: 5-16-19

STATE FORM 6899 MW4Z11 If continuation sheet 1 of 2

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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
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 degrees Farenheit. At 2:55 PM, the Clinic Manager acknowledged the water temperature was not being maintained between 105 and 120 degrees.	G2415	5-7-19 Plumber adjusted water heater and temperature readings: Bathroom 1 - 117 Bathroom 2 - 118 Bathroom 3 - 117	5.07.19

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	R 05/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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.	{G 000}		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	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 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.	G 000		

Your Agency Name
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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	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	See attached POC	
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	6-1-15 POC Acceptable Corrective Action 5-18-15	
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 United for Life

Your Agency Name: Planned Parenthood Ass of Utah
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peg Davis
TITLE: VP
(X6) DATE: 5/28/15

Utah Department of Health

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	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
G2030	Continued From page 1 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.	G2030		
G2420	R432-600-30(4) Water Supply (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	G2420		

Utah Department of Health

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	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
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		

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	04/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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 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.	G 000		

Your Agency Name Metro Heath Center Planned Parenthood
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

VP Clinical Programs
TITLE

4/21/14
(X6) DATE

APR 24 2014

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A BUILDING _____ B WING _____	06/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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 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	G 000	Utah Department of Health JUL 03 2013 Bureau of Health Facility Licensing, Certification and Resident Assessment	

Your Agency Name Metro Health Center Penny Davis VP Clinical Programs 6/26/13
LABORATORY DIRECTOR S OR PROVIDER/SUPPLIER REPRESENTATIVE S SIGNATURE TITLE (X6) DATE

JUL 03 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465180	A. BUILDING 01 - SOUTHERN UTAH VETERANS HOME - IVINS B. WING _____	10/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN UTAH VETERANS HOME - IVINS	160 N 200 E IVINS, UT 84738

(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
K 000	INITIAL COMMENTS 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 during this survey.	K 000		

Utah Department of Health

NOV 12 2015

Bureau of Health Facility Licensing
Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11-9-2015

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 a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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.	G 000		

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE VP Clinical Services (X6) DATE 10/24/18

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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 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: 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.	G 985	11-13-15 POC Acceptable Complet date 12-2015	
G2415	R432-600-30(3) Water Supply	G2415		

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

VP Clinical Programs — 11/13/15

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 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
G2415	Continued From page 1 (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. This STANDARD is not met as evidenced by: THIS IS A CLASS I 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 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. 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.	G2415		

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

Class One X
Repeat Deficiency ☐

Facility: Metro Health Clinic 0535

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

Rule Citation: R432-600-30(3)

Observation: Based on observation & interviews, 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 heated is located. Building manager states there are several water heaters for all bussinesses and would prefer to change ~~water temperature~~ himself. Building Manager will change temp. tomorrow 10/9/15 morning. I Veronica Galindo clinic manager will check water temp tomorrow morning and the next 3 bussiness days after that monthly.

Completion Date: 10/22/15

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

Provider: VGalindo Date: 10/8/15

Americans United for Life

Planned Parenthood®
Care. No matter what.

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,

Penny Davies

Americans United for Life

State Administration and Education, 654 South 900 East, Salt Lake City, Utah 84102 (801) 532-1586 Fax: (801) 322-0065

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)**

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 R432-600-15(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)**

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 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 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.	G 000		

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

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000828	A. BUILDING: _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN HEALTH CLINIC	550 NORTH MAIN, SUITE 117 LOGAN, UT 84321

(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 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.	G 000		
G 210	R432-600-8(2) Administrator (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. 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 administrator did not designate a person to act as administrator in her absence. Findings include: On 4/3/18 at 10:10 AM, a record review was conducted for the Clinic Coordinator. There was no designation from the Administrator indicating that the Clinic Coordinator was the acting administrator in their absence. 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.	G 210	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.	04/23/2018

5-1-18 RC Acceptable Compliance Date 4-23-18

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Americans United for Life

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Planned Parenthood - Logan Clinic — Charlotte K Midkiff — TITLE: Clinic Coordinator / Asst. Administrator — (X6) DATE: 4/23/18

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000828	A. BUILDING: _____ B. WING _____	R 05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN HEALTH CLINIC	550 NORTH MAIN, SUITE 117 LOGAN, UT 84321

(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 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.	{G 000}		

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

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000828	A. BUILDING: _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN HEALTH CLINIC	550 NORTH MAIN, SUITE 117 LOGAN, UT 84321

(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 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.	G 000		

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

Clinic Coordinator - CO 10/15/19

Utah Department of Health, Health Facility Licensing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000828	A. BUILDING: _____ B. WING _____	10/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN HEALTH CLINIC	550 NORTH MAIN, SUITE 117 LOGAN, UT 84321

(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 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.	G 000		

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Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 11-2-18

STATE FORM 6899 I0EP11 If continuation sheet 1 of 1

Utah Department of Health, Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000828	A. BUILDING: _____ B. WING _____	04/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOGAN HEALTH CLINIC	550 NORTH MAIN, SUITE 117 LOGAN, UT 84321

(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 4/30/19, a scheduled relicensure survey was conducted. The facility was surveyed according to R432-600 Rules for Abortion Clinics. No deficiencies were cited.	G 000		

Bureau of Licensing and Certification

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