PLANNED PARENTHOOD - GLENDALE

5771 WEST EUGIE AVENUE
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Facility ID: MED0053

License: OTCAC4848

Health Survey Comments

The following deficiencies were cited during the State Compliance Survey (Event #JGOP11) conducted on 2/9/15, 2/12, 2/13, and 2/23/15._____
ADHS Representative Date

Findings Report Summary

Findings for: Citation 1 **Corrected Date:** 03/18/2015	**Rule/Statute:** Administration **Rule Text:** R9-10-1003. Administration D. An administrator shall ensure that: 2. Policies and procedures for services provided at or by an outpatient treatment center are established, documented, and implemented to protect the health and safety of a patient that: d. Cover obtaining, administering, storing, and disposing of medications, including provisions for controlling inventory and preventing diversion of controlled substances;	**Survey Text:** **R9-10-1003.D.2.d**~ Based on observation on tour, review of facility laboratory manual, review of center manager job description, review of facility CLIA (Clinical Laboratory Improvement Amendments) audit, and staff interviews, the Department determined the Administrator failed to demonstrate current monitoring of medications and supplies for expiration, which have a potential risk for expired medications being administered to a patient or risk of a non sterile item being utilized on patients. Findings include: During tour of the entire facility, the Surveyors identified the following expired and/or not dated medications and supplies currently available for use in the clinic: 13 "...PDI Povidone-iodine swabsticks exp...10/2014...." 1 "...16 fluid ounce bottle of Hibiclens chlorhexidine gluconate solution exp...1/13/15...." 1 "...16 fluid ounce bottle of Aplicare povidone-iodine solution exp...5/2014...." 1 "...30 ml tube Xylocaine jelly 2%, 20 mg/ml exp...6/13...." 1 "...Oxytocin 10 u/ml (units per milliliter) expiration...1/15...." 1 "...Insyte autoguard shielded IV catheter exp...10/2014...." 1 "...Specimen container of Ferric Subsulfate solution: mixed on 7-18-14 and expiration date of 9/8/14...." Review of facility Laboratory Manual policy "CH 13 FERRIC SULFATE SOLUTION" revealed: "...Ferric Sulfate Solution (Monsel's solution)...Note: on the label place date mixed and the expiration date (two months from mix date)...." Ferric Sulfate Solution (Monsel's solution) may be used as a styptic or hemostatic agent. The medication and supplies identified above

		were located in the examination rooms and procedure rooms. 1 of 1 "...Tubersol vial...opened 10/19/14...." Review of the manufacturer's instructions revealed: "...A vial of TUBERSOL which has been entered and in use for 30 days should be discarded...." 36 "...Compro suppositories 25 mg each...expire 1/15...." 4 "...Compro suppositories 25 mg each...expire 1/15...." 10 bags "0.9% NaCl 1000 ml (milliliter) intravenous solution...exp...12/31/2014...." The Tubersol, suppositories and intravenous solutions was located in the medication area. 8 "...BD Probe Tec-Q Collection Kit-Endocervical or lesion Specimens...expire 3/31/14...." 7 blue angiocaths, not in their sterile manufacturer's packaging, placed in a pink emesis basin in one of the small laboratory drawers. 5 pink angiocaths, not in their sterile manufacturer's packaging, placed in a pink emesis basin with the blue angiocaths identified above. The probes and blue and pink angiocaths were located in the laboratory room. 1 of 1 "...18 gauge angiocath...exp...8/13...." The 18 gauge angiocath was located in the IV start container placed on the top shelf in one of the laboratory closets. 1 "...0.9% normal saline solution...IV...exp...8/13...." The bag of normal saline solution identified above was located in a procedure room. Review of the facility's job description for the "CENTER MANAGER" revealed: "...Responsible for...inventory procedures...CLIA guidelines...." Review of the facility CLIA audit performed by Center Manager #11 on 1/31/15 revealed: "...no expired medication on site...100%...." Center Manager #11 and HCA #6 verified, during an interview conducted on 2/9/15, that the medications and supplies identified above are expired; and the CLIA audit does not identify the expired medications currently available for use in the clinic.
Findings for: Citation 2 **Corrected Date:** 03/25/2015	**Rule/Statute:** Administration **Rule Text:** R9-10-1003. Administration D. An administrator shall ensure that: 2. Policies and procedures for services provided at or by an outpatient treatment center are established, documented, and implemented to protect the health and safety of a patient that: f. Cover infection control;	**Survey Text:** **R9-10-1003.D.2.f~** sl276 slmult1 Based on review of policy and procedure, observation on tour, review of manufacturer's instructions for use (IFU), and staff interview, the Department determined the Administrator failed to implement the facility infection control policy related to: a. cleaning blood/body fluid spills; b. identification of the disinfecting solution, currently in use, for disinfecting semi-critical items (speculums) in the patient examination

rooms; and c. Occupational Health and employee screening for communicable disease i.e., Tuberculosis (TB) per facility policy on 4 of 9 HCA's (HCA #3, #6, #8, and #9). Findings include: a. Review of facility policy "GUIDELINES FOR CLEANING/DISINFECTING AFTER A BLOOD/BODY FLUID SPILL" revealed: "...Don gloves and other PPE (Personal Protective Equipment) as necessary...Spilled blood/body fluids should first be contained and wiped up...The contaminated area should then be thoroughly saturated with bleach mixed 1:10 (1 part bleach to 10 parts water)...Let stand 5 minutes...If an excess of bleach remains on the surface it can then be wiped dry...." During tour of Exam room one (1), just after a patient exited the room, the Surveyor observed the HCA #6 cleaning what he/she identified as fresh blood on the floor, to the left of the exam table and in front of the large white bucket bearing a biohazard label. The white bucket contained a used metal vaginal speculum. Employee #6 (HCA) verified, during an interview conducted on 2/9/15, that the fresh blood appears to have dripped from the speculum that was just used during the pelvic exam. The Surveyor observed HCA #6 cleaning up the blood spill with paper towels and several sprays of Oxivir TB solution, instead of the appropriate bleach solution per facility policy. The Center Manager #11 verified, during an interview conducted on 2/9/15, that HCA #6 did not clean the blood/body fluid spill per facility policy and procedure. b. Review of facility policy "CH 2 CLEANING, DISINFECTION AND STERILIZATION" revealed: "...disinfection...cleaning and disinfecting medical instruments...vaginal probes...semi-critical items have contact with mucous membranes...Each category requires a different level of disinfection or sterilization to reduce the microbes present on the article...Cleaning is the process of removing visible signs of contamination before the disinfection and sterilization processes...If cleaning is not completed, disinfection and sterilization will be ineffective...Disinfection...All semi-critical items need disinfection...high level disinfection...instruments that touch mucous membranes...Speculums...clean with Detergesol...Direction for cleaning and disinfecting medical instruments: Dirty instruments...All disinfectants must be

prepared, changed, and discarded according to instruction on the package label...The container must be labeled with the date the solution was prepared...Speculums: following the procedure, all speculums should be kept wet until cleaning...Soak in detergosol...." Review of facility policy "DETERGESOL DIRECTIONS FOR USE" revealed: "...Soak in 1:10 dilution of 5% sodium Hypochlorite (bleach) x 30 minutes...Speculums-Clean with Detergesol and place in autoclave, time per manufacturer's instructions...." The current bleach concentration available at the facility and located in the sterilization room is "PUREBRIGHT" which is a 6% concentration, contrary to facility policy. Review of facility policy "CH 7. HAZARDOUS COMMUNICATION PROGRAM" revealed: "...Container labeling...The CM (Center Manager) is responsible for ensuring that warning labels are placed on In-house containers, if chemical are transferred from the original container(s)...Labels are available on SharePoint/compliance/medical labels...has identified a list of hazardous chemicals that are commonly transferred from their original containers: Detergo-Sol...List of hazardous chemical that may be removed from original contains and need a hazardous label: Ferric Subsaltfate (sic)...Detergosol...." HCA #6 verified, during an interview conducted on 2/9/15, that there is no identification on the white buckets, of the soaking and disinfecting solution that is currently being used to disinfect the semi-critical items in the large white buckets; identified with biohazard labels in the examination rooms. Review of the manufacturer's IFU for the disinfectant "DETERGOSOL" revealed: "...Detergesol MedChem Corporation...1-2 heaping teaspoons to one (1) gallon of water...." The Surveyor requested the measuring tools used to measure out the Detergosol, none was provided. During tour of the examination rooms, the Surveyors observed at least three (3) large white buckets, located next to the foot of the examination table, with a red/orange biohazard label on the lid of the buckets. There was no identification of what type of disinfecting solution was in these large white buckets. In examination room one (1) there was one (1) speculum currently soaking in the unidentified solution. On the opposite side of the examination tables, the Surveyors observed at least three (3) small

		white buckets, located next to the top (head) of the same examination tables, with a biohazard label on the lid of the buckets. The smaller buckets did not have biohazard bags lining the containers. HCA #6 verified, during an interview conducted on 2/9/15, that these smaller white buckets are used as biohazard disposal containers for swab sticks, tissues, etc. by the medical staff; and there should be a red biohazard bag placed in the containers. c. Review of facility policy "CH 5. OCCUPATIONAL HEALTH" revealed: "...The employee's vaccination and immunity status must be evaluated...An assessment of TB status must be made...Tuberculosis...annual screening must occur for all employees in January...Employees with a negative skin test history will have, at minimum, an annual PPD (Purified protein derivative) skin test which is completed in January for ongoing staff...." Review of electronic personnel files for four staff members submitted for review on 2/9/15 revealed: HCA #3 A date of hire of 6/2/14 revealed employee submitted documentation of negative TB screening, which was performed by an outside provider on 2/2/14 and interpreted on 2/3/14, 24 hours after administering skin test. Review of Tubersol manufacturer's directions for administration and interpretation of PPD skin test revealed: "...read and record at 48 to 72 hours...." Center Manager #11 verified, during an interview conducted on 2/9/15, that the TB test submitted by HCA #3 was not a valid test indicating freedom from TB. HCA #6 Revealed TB skin test last evaluated on 1/27/14. HCA #8 Revealed TB skin test last evaluated on 1/27/14. HCA #9 Revealed TB skin test last evaluated on 1/29/14. The Surveyor requested documentation of current TB test screening performed in January 2015 per facility policy, none was provided. Center Manager #11 verified, during an interview conducted on 2/9/15, that the TB screening for HCA #6, #8, and #9 is overdue per facility policy.
Findings for: Citation 3 **Corrected Date:** 03/18/2015	**Rule/Statute:** Quality Management **Rule Text:** R9-10-1004. Quality Management An administrator shall ensure that: 1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes: a. A method to identify, document, and evaluate incidents;	**Survey Text:** **R9-10-1004.1.a**~ Based on a review of job description, quality assurance meeting minutes, medical record reviews, and staff interviews, the Department determined the Administrator failed to present documentation that an incident and adverse event was submitted to the QA committee for review and discussion. Findings include:

		Review of the facility job description for "CENTER MANAGER" revealed: "...position is responsible for the oversight of the health center's overall risk, quality and compliance, as well as quality assurance to provide top notch quality care in a safe environment for both patients and staff...Maintains and analyzes monthly clinical program (s) statistics, makes recommendations for service improvement and submits reports, as needed (to include management, incident/occurrence...)...." Review of facility Incident log dated 7/8/14 revealed a HIPAA (Health Insurance Portability & Accountability Act of 1996) breech, of a patient identity, by HCA #5. Review of redacted medical record dated 10/14 revealed 1 of 1 patient (patient #2) had an adverse reaction to medication administered as preprocedure sedation. Review of the organization "QUALITY ASSURANCE MEETING MINUTES" dated 8/19/14, 9/21/14, and 1/26/15 revealed no identification or discussion of the HIPAA breech and medication adverse event that occurred at this clinic. Center Manager #11 verified, during an interview conducted on 2/9/15, that there is no documentation in the QA meeting minutes from 4/14 through 1/15 identifying the above events.
Findings for: Citation 4 **Corrected Date:** 03/18/2015	**Rule/Statute:** Staffing Requirements **Rule Text:** R9-10-1506. Staffing Requirements B. A licensee shall ensure that: 1. A member of the patient care staff, except for a surgical assistant, who is current in cardiopulmonary resuscitation certification is in the physical facilities until all patients are discharged;	**Survey Text:** **R9-10-1506.B.1**~ Based on review of facility job description, credentialing file, independent contractor agreement, and staff interviews, the Department determined the Administrator failed to: a. ensure that physician #2, a member of the patient care staff, maintained current cardiopulmonary resuscitation (CPR) training per job description; and b. ensure the physician #3, a member of the patient care staff, maintained current cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS) training per independent contractor agreement. Findings include: a. Review of the facility's current job description "MEDICAL DIRECTOR" presented on 2/9/15, revealed the CPR requirement. Review of the electronic credentialing file for physician #2, presented on 2/9/15, revealed: "...CPR...renew by 29 OCT 14..." Review of the electronic credentialing file for physician #2 revealed he/she is currently performing medical and surgical procedures. Center Manager #11 verified during an interview conducted on 2/9/15, that the CPR

		certification for physician #2 is expired. The Surveyors requested verification of updated CPR training and none was provided by 2/13/15. b. Review of the facility 'INDEPENDENT CONTRACTOR AGREEMENT" for physician #3 revealed: "...Contractor agrees...to remain current...and to maintain CPR/ACLS proficiency, by annually participating in programs provided either by PPAZ (Planned Parenthood of Arizona) or hospital where Contractor maintains staff membership...." Agreement was dated 9/27/13 and signed by physician #3 on 9/9/13. Review of the electronic credentialing file for physician #3, presented on 2/9/15 revealed no expired or current CPR/ACLS proficiency documentation for 2013, 2014, or 2015. Review of the electronic credentialing file for physician #3 revealed he/she is currently performing medical and surgical procedures. The Surveyors requested verification of updated CPR/ACLS training and none was provided by 2/13/15. Center Manager #11 and Administrative Assistant #17 verified during an interview conducted on 2/9/15, that there is no expired or current CPR/ACLS documentation in the electronic credentialing file for physician #3.
Findings for: Citation 5 **Corrected Date:** 03/24/2015	**Rule/Statute:** Medications and Controlled Substances **Rule Text:** R9-10-1510. Medications and Controlled Substances A medical director shall ensure that: 7. A medication error or an adverse reaction, including any actions taken in response to the medication error or adverse reaction, is immediately reported to the medical director and licensee, and recorded in the patient's medical record;	**Survey Text:** **R9-10-1510.7**~ Based on a review of facility policy and procedures, medical records, adverse event/incident logs, and staff interviews, the Department determined the Administrator failed to ensure an adverse reaction to two (2) medications administered as moderate conscious sedation was reported to the medical director and licensee for 1 of 1 patient (patient #2). Findings include: Review of facility policy "COMPLICATIONS AND EMERGENCY PROTOCOLS" revealed: "...Affiliates must have written protocols for managing immediate, early, and late complications...." PATIENT #2 Review of the redacted medical record dated 10/18/14 provided on 2/13/15 revealed: "...Consent for Moderate Sedation Screening...Pre procedure... blood pressure (BP) 128/78... 3:19...Versed 1 mg (milligram)... 3:21...Fentanyl 50 mcg (microgram)... 3:24...BP 78/47...pulse 61... severe hypotension after receiving Versed and Fentanyl... Atropine 0.4 mg/ml (milligram per milliliter) and normal saline 500 ml administered... Atropine and fluids given with

		excellent results... Start time...3:29... 3:32 BP 94/63...pulse 81... Stop time...3:35... 3:46...To recovery room... PROCEDURE NOTE...Patient received uncomplicated sedation...." Medical record entries are signed by RN #7. Versed is a medication often used for its sedating properties. Fentanyl is a medication often used for its synthetic narcotic properties. Atropine is a medication used for its central nervous system stimulating and/or depressing properties. Review of the electronic personnel file nursing license for RN #7 revealed no advanced prescribing privileges have been granted to this licensee. The Surveyor requested the facility policy and procedure that identifies the blood pressure parameters of severe hypotension, none was provided. The Surveyor requested the facility policy and procedure delineating the care and treatment of a patient diagnosed with severe hypotension, none was provided. The Surveyor requested the facility standing orders for care and treatment of a patient having an adverse reaction to a medication/controlled substance, none was provided. The Surveyor requested documentation to identify physician notification and/or intervention, none was provided. The Surveyor requested documentation that the medication adverse reaction was reported to the medical director and licensee, none was provided. Center Manager #11, verified, during an interview conducted on 2/13/15, that there are no established blood pressure parameters for severe hypotension, standing orders, and/or facility policy that identifies the care and treatment of a patient experiencing severe hypotension after adversely reacting to a medication provided for conscious sedation. Center Manager #11, verified during an interview conducted on 2/13/15, that RN #7 gave the order to administer the Atropine and normal saline solution when patient #2's blood pressure decreased by 50 mmHg (millimeters of mercury), five (5) minutes after receiving the one (1) dose of Versed and three (3) minutes after receiving one (1) dose of Fentanyl.
Findings for: Citation 6 **Corrected Date:** 03/25/2015	**Rule/Statute:** Infection Control **Rule Text:** R9-10-1028. Infection Control An administrator shall ensure that: 3. Policies and procedures are established,	**Survey Text:** **R9-10-1028.3.a.iii**~ Based on review of facility policy and procedures (P&P), OSHA (Occupational Safety and Health Association) manual,

	documented, and implemented to protect the health and safety of a patient that cover: a. If applicable: iii. Sterilization and disinfection of medical equipment and supplies;	manufacturer's instructions for use, autoclave logs, and staff interviews, the Department determined the Administrator failed to implement the infection control program to: a. ensure the staff followed the facility P&P, and the manufacturer's instructions for use when performing the cleaning and maintenance of the Tuttnauer and/or Midmark autoclave unit; b. ensure the staff maintained the cleaning, spore checks, and preventive maintenance records of the Pelton & Crane, Ritter, and Midmark autoclave units when loaned to an affiliate clinic or sent out for repair; c. ensure the staff followed the facility P&P when cleaning and disinfecting the post procedure specimen bottles; and d. ensure the integrity and of the upholstered material covering the examination tables and the ability to sanitize the examination tables properly between patients. These failures have the potential for non sterile instruments or non disinfected supplies to be utilized on patients. Findings include: Review of facility policy "INFECTION CONTROL-OSHA manual revealed: "...Infection prevention program is managed by Risk Quality Management Manager...in conjunction with the Risk and Quality Management Committee...Reviewed annually in July or whenever mandates are required...Quality Assurance Team meets at least quarterly is instrumental in monitoring and reviewing all elements of the OSHA manual and reports to Risk and Quality Management Committee any emergency and crisis situations or when there is deemed to be a danger to patients or employees...." The Surveyors requested to speak with the designated Risk Quality Management Manager regarding the infection control program, none was available. Center Manager #11 verified, during an interview conducted on 2/12/15, that there is no designated infection control person assigned to the infection control position at this time. a. Review of the facility policy and procedure "STERILIZATION-AUTOCLAVE" revealed: "...Sterilization cycle...Quality control test are to be performed weekly and the result logged on the autoclave log...Spore test written results will be returned...The reports are to be filed on site and the results must be logged on the autoclave log...This log will be audited quarterly (affiliate wide)...." The Surveyor requested the quarterly audit of the autoclave logs, none was provided. Review of the facility policy and procedure

"STERILIZATION-AUTOCLAVE" revealed: "... Weekly cleaning instructions Tuttnauer autoclaves...Once per week, clean the air jet...To ensure that the temperature inside the chamber rises properly it is necessary...To keep the air jet clean...To ensure that the temperature inside the chamber rises...A dirty air jet will prevent indicator strips from changing color and cause spore tests to fail...once per week clean and descale the chamber, copper tubes and the reservoir using chamber brite...Reference per Tuttnauer Operation and Maintenance Manual Page 40...." Review of the manufacturer's instructions for use "TUTTNAUER...SERVICE AND MAINTENANCE INSTRUCTIONS" revealed: "...PREVENTIVE and SCHEDULED MAINTENANCE... The maintenance operations described in this chapter need to be followed as indicated to keep the device in good working condition... WEEKLY...Cleaning the air jet...(located in the water reservoir)...The air jet consists of a small orifice with a clean out wire inserted in it (wire is permanently installed and will not come out)...It is required that the air jet be cleaned once per week or more often if necessary, to remove any accumulated dirt and debris...It is preferred to clean the air jet when the unit is running a cycle and under pressure...This is so that any loosened debris will be blown away, however, it can be done while the unit is idle...Remove the water reservoir cover...Clean the hole of the jet by manipulating the air trap wire...back and forth 10 times...Checking the Safety Valve (Located in the water reservoir)...In order to prevent the safety valve from becoming blocked, it is necessary to allow the steam pressure to escape through the valve...This procedure should be done every month as follows...1. Run a sterilizer cycle with a sterilization temperature of 273 degrees Fahrenheit (F) according to the manual...2. Allow a pressure of approximately 30 psi (pressure per square inch) to build up in the chamber...3. Turn the timer back to 0 minutes...4. Remove the water reservoir cover...Caution...This next step will expose you to HOT STEAM...Caution...To avoid being burned, by hot steam, do not place your face over the safety valve...5. Pull the ring of the safety valve using a tool, i.e. screwdriver, hook etc. and open the safety valve for 2 seconds then release...Be careful

not to burn your hands...Verify that the valve releases steam and closes immediately...7. If the safety valve is stuck in the "open" position, let the pressure decrease to zero (atmospheric pressure)...8. After the pressure in the chamber decreases to zero, pull the valve ring to release the valve...9. Repeat operations 1 to 6...10. If the valve is stuck again in the open position, call for service...11. After a successful check, turn the multi-purpose valve to the Exh/Dry position ...12. Wait until the pressure decreases to zero, only then can the door be opened... "It is recommended that your autoclave be cleaned with CHAMBER BRITE once per week... CLEANING PROCEDURE: 1. Important-all steps in this procedure must be completed without interruption...2. When the autoclave chamber is cold, remove instruments and trays...3. Open the door and spread the contents of a packet in a straight even line along the bottom of the chamber, from back to front...4. Start a sterilization cycle with water and No Drying Cycle according to the manufacturer's instructions...When the cycle is finished, exhaust the unit...5. At the end of the exhaust cycle, drain the water from the reservoir...Fill the water reservoir with distilled water...7. Repeat a sterilization cycle without CHAMBER BRITE powder, to remove any excessive dirt in the pipes...Start a sterilization cycle with water and No Drying Cycle according to the manufacturer's instructions...When the cycle is finished, exhaust the unit ...8. At the end of the exhaust cycle, drain the water from the reservoir...9. Turn the autoclave off and allow chamber to cool...10. Remove the tray holder; wipe the interior of the chamber with a damp cloth...11. Fill the reservoir with distilled water only...13. Turn fill knob to fill position and allow a small amount of water (2-4 ounces) to fill the chamber...Remove water from chamber...14. The autoclave unit is ready to use.... " Review of facility policy "WEEKLY CLEANING MIDMARK ULTRACARE AUTOCLAVES" revealed: "... Flush the system to protect the intricate parts of the unit, the system must be flushed once a MONTH with speed clean sterilizer cleaner.a. through g. per manufacturer' s instructions: midmark installation and operation manual page 20-21...REMEMBER MUST LOG ALL CLEANING AND SPORE CHEK (sic) RESULTS ON THE AUTOCLAVE

LOG AND AUTOCLAVE INSTRUMENT CLEANING LOG...." Review of manufacturer's instructions for use a. through g. page 20-21 "OPERATOR MAINTENANCE-MONTHLY-MIDMARK" revealed: "...a. Drain reservoir and fill with clean, distilled water then add one ounce of Speed Clean Sterilizer Cleaner to a cool none chamber...b. Run one 30 minute cycle (PACKS)at 121 degrees C (250 degrees F)...Instruments must not be sterilized while cleaning the sterilizer...C. Drain reservoir fill with clean distilled...water and run one 3 minute cycle (UNWRAPPED) at 132 degrees C (270 degrees F)...d. Drain reservoir and allow sterilizer to cool to room temperature...Remove the trays, tray rack...and the tray plate...This is accomplished by grasping the tray rack on both sides in the front and gently pulling outward...The tray rack and tray plate should slide out of the chamber together...e. Wipe out the inside of the chamber being careful not to damage the heater element or the temperature and level sensor components...Wipe off the trays, tray rack, and tray plate...f. Re-install the tray rack...and tray plate...in the chamber as follows: Position the two rear posts of tray rack in rack holes...of tray plate...Then, hold front end of tray rack at approximately a 30 degree angle from the tray plate...Then, insert rear end of tray rack and tray plate as an assembly in chamber...Push tray rack and tray plate into chamber completely...Re-install the trays...g. Refill the reservoir with clean distilled or demineralized water...." none Review of facility WEEKLY CLEANING-AUTOCLAVE LOGS 4/8/14 through 1/28/15 revealed: "...PELTON & CRANE/TUTTNAUER ...4/8/14 replaced autoclave with Tuttnauer ...4/8/14 cleaning...Comments...drained and omni cleaner ...4/15/14 not in use due to power issues ...4/22/14 cleaning...Comments omni cleaner and drained-passed...." The staff failed to identify which unit was in use on 4/8/14 and not in use on 4/15/14. Review of preventive maintenance records revealed a "...Tuttnauer unit received in facility...7/1/14...." Center Manager #11 and HCA #6 verified, during an interview conducted on 2/9/15, that the Pelton & Crane autoclave unit was only used one (1) time. Center Manager #11 verified, during an interview conducted on 2/12/15, that the current and permanent Tuttnauer unit was

received into the facility on or about 7/1/14. The staff failed to identify which unit was being cleaned and if the correct cleaner was being used per manufacturer's IFU on 4/8/14 and 4/22/14. The entries on 3/19/14, 4/8/14, and 4/22/14 were initialed by Center Manager #15. Review of facility "WEEKLY AUTOCLAVE LOGS" for 4/30/14, 5/7, 5/14, 5/21, 5/28/14 revealed the same entry as 4/22/14 by Center Manager #15. Review of facility WEEKLY AUTOCLAVE LOGS from 6/4/14 through 7/30/14 revealed "...6/4/14...6/11...cleaning...Comments... cleaning product used ...6/18/14...6/25...7/3...cleaning...Comments... product used ...7/9/14...cleaning...Comments___ ...7/22/14...cleaning...Comments-detergent used ...7/30/14...cleaning...perform spore test___...." Review of the facility "MONTHLY AUTOCLAVE LOGS" identified under the MIDMARK unit from 11/11/13 through 7/30/14 revealed no documentation of monthly cleaning, and running 30 minute and 3 minutes cycles per facility policy and manufacturer's instructions for use. The staff failed to identify which unit was being used 4/22/14 through 7/30/14. The staff failed to document and/or provide documentation of monthly cleaning of either of the autoclave units identified above. The staff failed to document monthly cleaning of the Midmark unit 6/4/14 through 10/17/14. The staff failed to identify what cleaning product was used to perform the weekly autoclave cleaning. The HCA #5 verified, during an interview conducted on 2/13/15, that he/she does not know where the air jet apparatus is located on the Tuttnauer autoclave unit; he/she has not cleaned this part of the autoclave unit, particularly while it is hot; and when he/she uses the Chamber Brite cleaner, he/she sprinkles a package of it down the middle of the chamber (front to back) turns the autoclave unit on and lets it go through the required cycle then it is ready for use. Center Manager #11, verified during an interview conducted on 2/13/15, that the staff is probably cleaning the air jet, but just not documenting it. Center Manager #11, verified during an interview conducted on 2/13/15, that the facility policy does not delineate the full cleaning and maintenance procedure recommended by the Tuttnauer manufacturer. Center Manager #11, verified during an interview conducted on 2/13/15,

that the staff is not performing the specified cleaning and maintenance per policy and manufacturer's instructions for use. b. Review of the autoclave logs for the PELTON & CRANE unit revealed: "...1/31/14-2/21/14...Autoclave broken not used...LM...." The LM initials identify Center Manager #15. The Pelton & Crane autoclave unit was out of use 20 days. The Surveyor requested the maintenance records related to repair of this unit, none was provided. Review of the autoclave logs for the RITTER unit revealed: "... 10/30/14___11/6/14 left building...." The staff failed to document why the unit was out of the assigned clinic for 7 days. The Surveyor requested documentation of the cleaning, spore checks, and maintenance records related to this unit, none was provided. Review of the autoclave logs for the MIDMARK unit revealed: "...11/11/13...Midmark autoclave unit sent to Tempe...LM ...2/3/14...Autoclave back from Tempe...LM...." The Midmark autoclave unit was on loan to an affiliate clinic for 81 days. The Surveyor requested documentation of the cleaning, maintenance, and spore checks performed at the affiliate clinic from 11/11/13 through 2/3/14, none was provided. Review of the autoclave logs for the Midmark unit revealed: "...4/10/14 Midmark sent to Tempe ...4/22/14...unit returned...." The Midmark autoclave unit was on loan to an affiliate clinic for 11 days. The Surveyor requested documentation of the cleaning, maintenance, and spore checks performed at the affiliate clinic from 4/11/14 through 4/22/14, none was provided. sl276 slmult1 c. Review of facility policy and procedure "...SPECIMEN BOTTLES PROCEDURE" revealed: "...Specimen bottles must be changed, cleaned, disinfected, and dried between patients...." The facility policy does not identify the specific cleaning and disinfecting solution to use for this procedure. HCA #5 verified, during an interview conducted on 2/13/15, that the specimen bottles are cleaned and disinfected with Metriclean 2. Review of the manufacturer's IFU on the container of Metriclean 2 revealed: "...mix one (1) ounce to one (1) gallon...." The Surveyor requested the measuring tools used to prepare the cleaning solution, none was provided. HCA #5 verified, during an interview conducted on 2/13/15, that he/she uses three (3) capfuls of Metriclean 2 and adds it to an eyeball estimate, of three (3)

		gallons, of water in the sink. Center Manager #11 verified, during an interview conducted on 2/13/15, that the Metriclean 2 is not being prepared per manufacturer's IFU.sl276 slmult1 d. During tour of the entire facility, accompanied by the HCA #6 the Surveyors observed the following: Exam room 2: the examination table has five (5) tears in the upholstered material and material is missing out of the upholstered surface exposing the internal stuffing material in multiply areas of the table. Exam room 6: the procedure/exam table contained multiple tears and eight (8) small puncture marks in the upholstered surfaces, where a patient would be positioned. Upholstery tears in multiple areas vary in size from 1/4 to 1 inch and puncture marks vary in size from 1/2 inch to 1/3 inch. The Surveyors requested documentation that a repair order has been placed to repair the tables upholstery identified above, none was provided. HCA #6 verified, during an interview conducted on 2/9/15, that the integrity of the upholstered material on the current examination and procedure tables prevents proper sanitation and cleaning of these tables between patients.
Findings for: Citation 7 **Corrected Date:** 03/23/2015	**Rule/Statute:** Environmental and Safety Standards **Rule Text:** R9-10-1512. Environmental and Safety Standards A licensee shall ensure that: 6. An evacuation drill is conducted at least once every six months that includes all personnel in the physical facilities the day of the evacuation drill. Documentation of the evacuation drill is maintained in the physical facilities for one year after the date of the evacuation drill and includes:	**Survey Text:** **R9-10-1512.6**~ sl276 slmult1 Based on a review of the facility fire and evacuation drill records, and staff interviews, the Department determined the licensee failed to ensure that an evacuation drill was conducted every six (6) months. Findings include: The Surveyor requested the fire and disaster evacuation drills for 2014 and 2015. Review of the facility "FIRE DRILL/DISASTER SCHEDULE AND EVALUATION" form of 2015 revealed: "...January 30, 2015...Fire Drill...Discussed where to go and to help/ensure all patients, staff, and others are out and accounted for...." The Fire Drill/Disaster Schedule and Evaluation form dated 1/30/15 did not identify who conducted the drill and it was unsigned. rdrbrdrdotrdrw60rsp20 sl276 slmult1 The Center Manager verified, during an interview conducted on 2/9/15, that there is no evidence of an evacuation drill conducted in 2014; and the drill conducted on 1/30/15 was only a discussion of how to evacuate the premises during a fire.