STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

January 12, 2016

Judy Tabar, Chief Executive Officer
Planned Parenthood Of Connecticut Inc - Norwich
12 Case Street
Norwich, CT 06360

Dear Ms. Tabar:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Norwich on December 22, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensure inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by January 26, 2016 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Maureen H Klett RN

Maureen H. Klett, R.N.,C., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

MHK:lsl

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DATE OF VISIT: December 22, 2015

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D48 (b)(1).

1. Based on observations and interviews, the facility failed to ensure that credentialed staff had completed the credentialing process and/or that documents were maintained in the clinicians personnel file. The findings include:
    a. Upon surveyor inquiry on 12/22/15, the facility provided documents dated 1/6/16 identifying that credentialed staff was privileged to provide care at the center without specific dates that they are credentialed until. Review of facility policy identified that applications and documentation of privileges are to be maintained in the clinician's personnel file.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D54.

2. Based on review of the clinical record and interviews with facility personnel, the facility failed to ensure that the clinical record was accurate. The findings include:
    a. Patients #1-#5 were admitted to the clinic from 9/17/15-12/17/15 for a surgical procedure. Review of the history and physical and pre-anesthesia assessments failed to indicate that a comprehensive assessment was completed. Review of facility policy identified that a complete assessment of the patient needs were to be completed prior to the procedure being performed. Interview with the Office Manager on 12/22/15 identified that they have a new computer system and some of the patient information was not documented.
    b. Patients #1-#5 were admitted to the clinic from 9/17/15-12/7/15 for a surgical procedure. Review of the consent for a surgical procedure identified that the consent was signed by a medical assistant and not a physician. Review of facility policy identified that the clinician performing a procedure must ascertain that informed consent has been obtained and that all client questions have been answered before providing that procedure. Interview with the Office Manager on 12/22/15 identified that the consent is reviewed with the patient by the medical assistant.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D52.

3. Based on observations and interviews with facility personnel, the facility failed to ensure that infection control practices were maintained. The findings include:
    a. During tour of the post anesthesia care area on 12/22/15, it was observed that two bags of soiled laundry were being stored until it could be picked up by an outside vendor. Interview with the Office Manager on 12/22/15 identified that the laundry bags have been there since the last surgery day, which was 5 days ago.
    b. During tour of the sterile processing area on 12/22/15, it was observed that sterile instruments were being stored in the dirty decontamination area. In addition, multiple

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

boxes, supplies and equipment were being stored in the dirty decontamination area.

c. Review of the sterilization logs dated 11/2015-12/2015 failed to identify the load with patient/pertinent information for each load for tracking purposes.

The following are violations of the Regulations of Connecticut State Agencies Section's 19-13-D46 (a)(b)(c) and/or (d) and/or 19-13-D54 and/or 19a-116-1.

4. On 12/22/15 at 9:30 AM the surveyor, while accompanied by the Center Manager, the Clinical Assistant or the Property Manager observed that :
   a. The battery-powered, emergency light fixture located at the staff restroom within the recovery (PACU) area did not work, as required by "*CT Fire Prevention Code*"; i.e. lamps did nothing when test button was depressed;
   b. The battery-powered, emergency light fixture located at the staff restroom within the waiting area just outside the clinic did not work, as required by "*CT Fire Prevention Code*"; i.e. lamps did nothing when test button was depressed.

5. On 12/22/15 at 11:00 AM the surveyor was not provided with documentation from the Center Manager, the Clinical Assistant or the Property Manager to indicate that:
   a. The facility fire alarm and facility smoke detectors are being tested & inspected semi-annually, as required by "*CT Fire Prevention Code*"; i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;
   b. The smoke detectors that are connected to the facility fire alarm system had had sensitivity testing conducted on them, as required by "*CT Fire Prevention Code*"; i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;
   c. The facility fire extinguishers are being inspected at least monthly, as required by "*CT Fire Prevention Code*";
   d. The battery-powered, emergency lights at the facility are being inspected at least monthly, as required by "*CT Fire Prevention Code*";
   e. The battery-powered, emergency lights at the facility are being tested at least annually, as required by "*CT Fire Prevention Code*";

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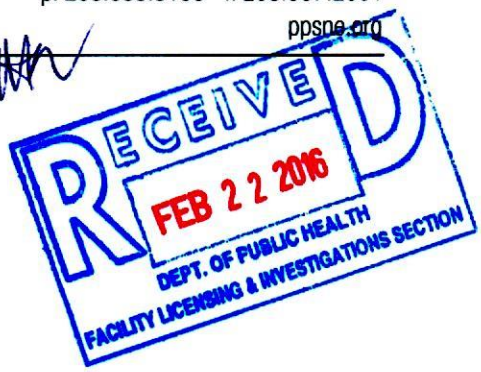
POC accepted 2/23/16 MMH



FACILITY: Planned Parenthood of Southern New England – Norwich

DATE OF VISIT: December 22, 2015

February 19, 2016

Maureen Klett, R.N., C., M.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section
State of CT Department of Health
410 Capitol Avenue –MS #12 HSR
PO Box 340308
Hartford, CT 06134

Dear Ms.Klett

Below please find the listing of violations and plan of correction from the December 22, 2016 visit to the Planned Parenthood of Southern New England Norwich location. Thank you very much for speaking with us to clarify the violations. We also very much appreciate the extension given us to prepare our response.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D48 (b)(1)

1. *Based on the observations and interviews, the facility failed to ensure that credentialed staff had completed the credentialing process and/or that documents were maintained in the clinicians personnel file. The findings include:*
   a. *Upon surveyor inquiry on 12/22/15, the facility provided documents dates 1/6/16 identifying that credentialed staff was privileged to provide care at the center without specific dates that they are credentialed until. Review of facility policy identified that applications and documentation of privileges are to be maintained in the clinician's personnel file.*

Response:
Credentialing files are kept at the administrative office in New Haven with personnel files. Files in centers are shadow files. PPSNE has set up a shared folder and is starting to upload the credentialing documents to the folder for each provider. This process will be added to the credentialing policy. Center managers will have access to the system when surveyor is on site for inspection. This will completed by March 31, 2016. Responsibility for monitoring this will be assumed by Sally Hellerman, APRN, MS, FNP-BC, Director of Medical Services.

The following violation of the Regulations of Connecticut State Agencies Section 19-13-D54

2. *Based on review of the clinical record and interviews with facility personnel, the facility failed to ensure that the clinical record was accurate. The findings include:*

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a. *Patients #1-#5 were admitted to the clinic from 9/7/15-12/17/15 for a surgical procedure. Review of the history and physical and pre-anesthesia assessments failed to indicate that a comprehensive assessment was completed. Review of facility policy identified that a complete assessment of the patient needs were to be completed prior to procedure being performed. Interview with the Office Manager on 12/22/15 identified that they have a new computer system and some of the patient information was not documented.*

Response:
The PPSNE electronic health record has been modified to better ensure that the comprehensive assessment is completed. Additional training has also been provided to the Norwich staff. An audit will be conducted to ensure compliance in June 2016. Additionally the abortion service is audited annually. This plan of correction will be monitored by [redacted], APRN, MS, FNP-BC, Director of Quality Management.

b. *Patient #1-#5 were admitted to the clinic from 9/17/15-12/7/15 for a surgical procedure. Review of the consent for the surgical procedure identified that the consent was signed by a medical assistant and not a physician. Review of facility policy identified that the clinician performing a procedure must ascertain that informed consent has been obtained and that all client questions have been answered before providing that procedure. Interview with the Office Manager on 12/22/15 identified that the consent is reviewed with the patient by the medical assistant.*

Response:
We are modifying our consent process to require that the physician sign the consent form. Signature lines are being added to the consents. Physicians will be notified of this change. Charts for each physician will be audited by the end of March. This change will be in place by March 15. This plan of correction will be monitored by [redacted], APRN, MS, FNP-BC, Director of Quality Management.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D52

3. *Based on observations and interviews with facility personnel, the facility failed to ensure that infection control practices were maintained. The findings include:*
   a. *During tour of the post anesthesia care on 12/22/15, it was observed that two bags of soiled laundry were being stored until it could be picked up by an outside vendor. Interview with the Office Manager on 12/22/15 identified that the laundry bags have been there since the last surgery day which was 5 days ago.*

Response:
The Center Manager has arranged for the laundry will be removed by the laundry service on the day of the procedure. If laundry is left onsite, the soiled laundry will be kept in the dirty area of the back lab. This procedure is in effect as of February 1,

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2016. The Infection Control Manual will be update to reflect this by March 30th. Responsibility for monitoring this will be assumed by [redacted]an, APRN, MS, FNP-BC, Director of Medical Services.

b. *During tour of the sterile processing area on 12/22/15, it was observed that sterile instruments were being stored in the dirty decontamination area. In addition, multiple boxes, supplies and equipment were being stored in the dirty decontamination area.*

Response:
Sterile instruments, supplies and equipment are no longer stored in a dirty decontamination area. Staff education has been provided. This will be monitored by [redacted]an, APRN, MS, FNP-BC

c. *Review of the sterilization logs dates 11/2015-12/2015 failed to identify the load with patient/pertinent information for each load for tracking purposes.*

Response:
After telephone conversation of February 4, 2016, PPSNE will be contracting with an infection control nurse consultant to learn how to operationalize this tracking requirement. This will be implemented by April 30, 2016. In the interim, the abortion patient log will be used to track infectious outbreaks. This will be monitored by [redacted]n, APRN, MS, FNP-BC

The following are violations of the Regulations of Connecticut State Agencies Section's 19-13-D46 (a)(b)(c) and/or (d) and/or 19-13-D54 and/or 19a-116-1

4. *On 12/22/15 at 9:30 AM the surveyor, while accompanied by the Center Manager, the Clinical Assistant or the Property Manager observed that:*
   a. *The battery-powered, emergency light fixture located at the staff restroom within the recovery (PACU) area did not work, as required by the "CT Fire Prevention Code", i.e. lamps did nothing when test button was depressed;*

Response:
The repair to the battery powered emergency light fixture was completed February 17, 2016.

b. *The battery-powered, emergency light fixture located at the staff restroom within the waiting area just outside the clinic did not work, as required by the "CT Fire Prevention Code", i.e. lamps did nothing when test button was depressed.*

Response:
The repair to the battery powered emergency light fixture was completed February 17, 2016.

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5. *On 12/22/15 at 11:00 AM the surveyor was not provided with documentation from the Center Manager, the Clinical Assistant or the Property Manager to indicate that:*
   a. *The facility fire alarm and facility smoke detectors are being tested and inspected semi-annually, as required by "CT Fire Prevention Code", i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;*
   b. *The smoke detectors that are connected to the facility fire alarm system had had sensitivity testing conducted on them, as required by "CT Fire Prevention Code", i.e. property manager only has receipts/invoices for fire alarm inspections-no nfpa 72-style report forms;*
   c. *The facility fire extinguishers are being inspected at least monthly, as required by "CT Fire Prevention Code";*
   d. *The battery-powered, emergency lights at the facility are being inspected at least monthly, as required by "CT Fire Prevention Code",*
   e. *The battery-powered, emergency lights at the facility are being tested at least annually, as requires by "CT Fire Prevention Code";*

Response:
According the Property Manager Annually 100% functional test & inspection of the fire alarm system is performed, including all devices including smoke detector, fire extinguishers, heat detectors, pull stations, load test of all batteries and door holders with a NFPA report. In addition, a visual test is performed semiannually as well as testing of all batteries. The system is also centrally monitored 24/7. The 17 fire extinguishers in the common areas are inspected and tagged monthly by the Property Management Company. The extinguishers, battery powered emergency lights in the suite will be inspected monthly by the Center Manager, [redacted]. The testing will be recorded in the log. This will begin March 1, 2016. The battery powered emergency lights will be tested annually and recorded in a log. The first test will be conducted June 1, 2016. This will also be monitored by [redacted], center Manager.

Please do not hesitate to contact me if you have questions.

Best regards,

Mary Bawza
COO

CC: Sally Hellerman, APRN
Tim Spurrell, MD
Janeen Otiz, center Manager