STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AF-0011	A. BUILDING _____ B. WING _____	05/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE PLANNED PARENTHOOD HEALTH SYSTEMS, I	2207 PETERS CREEK ROAD ROANOKE, VA 24017

(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
T 000	12 VAC 5- 412 Initial comments An unannounced Biennial Licensure Inspection was conducted 5/27/14 through 5/28/14 and 5/31/14 by three Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. The facility was not in compliance with the Rules and Regulations for the Licensure of Abortion Facilities 12VAC5-412. Deficiencies are cited within this report.	T 000		
T 315	12 VAC 5-412-300 A Quality assurance A. The abortion facility shall implement an ongoing, comprehensive, integrated, self-assessment program of the quality and appropriateness of care or services provided, including services provided under contract or agreement. The program shall include process, design, data collection/analysis, assessment and improvement, and evaluation. The findings shall be used to correct identified problems and revise policies and practices, as necessary. This RULE: Is not met as evidenced by: Based on agency document review and staff interview, the agency failed to implement an on-going,comprehensive Quality Assurance program specific to the agency. The findings included: On 5/28/14 at 12:00 p.m., the survey team reviewed the information provided by the agency regarding the Quality Improvement/Assurance program. The Agency had a policy and procedure which evidenced the agency would have the program and listed the required elements to be evaluated, however the information presented to	T 315	As per out Plan of Correction dated August 23, 2012, there was to be a separate Quality Assurance Program implemented. A previous Vice President then interpreted this regulation as the Quality Assurance Program we had for our entire affiliate would be more appropriate than individual meetings specific to this site. This has now been corrected and a separate Quality Assurance Program is in place for the Roanoke site. RECEIVED JUN 24 2014 VDH/OLC	06.24.14

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

Elaine Pleasants, Alternate Administrator - 06.20.14

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T 315	Continued From Page 1 the survey team for review was a compilation of information for all the facilities in the region. This specific agency was not identified and the required areas were not identified. Staff #2 stated on 5/28/14 at 1:03 p.m., that he/she was not involved in the committee. He/she stated the meetings were all held at the corporate level.	T 315		
T 320	12 VAC 5-412-300 B Quality assurance B. The following shall be evaluated to assure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences: 1. Staffing patterns and performance; 2. Supervision appropriate to the level of service; 3. Patient records; 4. Patient satisfaction; 5. Complaint resolution; 6. Infections, complications and other adverse events; and 7. Staff concerns regarding patient care. This RULE: is not met as evidenced by: Based on agency document review and staff interview, the agency failed to ensure the Quality Improvement committee was specific for the agency and the required elements were evaluated to assure adequacy of services and identification of unacceptable or unexpected trends or occurrences. The findings included: On 5/28/14 at 12:00 p.m., the survey team reviewed the information provided by the agency regarding the Quality Improvement/Assurance	T 320	This has now been corrected as stated in the T 315 response. The first Roanoke QRM meeting will be held June 24, 2014, as evidenced by the attached agenda, and will be site specific and address the seven (7) elements as identified under 12 VAC 5-412-300 B. RECEIVED JUN 24 2014 VDH/OLC	06.24.14

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T 320	Continued From Page 2 program. The Agency had a policy and procedure which evidenced the agency would have the program and listed the required elements to be evaluated, however the information presented to the survey team for review was a compilation of information for all the facilities in the region. This specific agency was not identified and the required areas were not identified or evaluated. Staff #2 stated on 5/28/14 at 1:03 p.m., that he/she was not involved in the committee. He/she stated the meetings were all held at the corporate level.	T 320		
T 325	12 VAC 5-412-300 C Quality assurance C. A quality improvement committee responsible for the oversight and supervision of the program shall be established and at a minimum shall consist of: 1. A physician 2. A non-physician health care practitioner; 3. A member of the administrative staff; and 4. An individual with demonstrated ability to represent the rights and concerns of patients. The individual may be a member of the facility's staff. In selecting members of this committee, consideration shall be given to the candidate's abilities and sensitivity to issues relating to quality of care and services provided to patients. This RULE: is not met as evidenced by: Based on staff interview and agency document review, the agency staff failed to have an agency specific Quality improvement committee responsible for the oversight and supervision of the program. The findings included:	T 325	As per 12 VAC 5-412-300 C, this committee has now been established and at the site-specific meeting, the committee members will meet the requirement for this section. RECEIVED JUN 24 2014 VDH/OLC	06.24.14

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T 325	Continued From Page 3 On 5/28/14 at 12:00 p.m., the survey team reviewed the information provided by the agency regarding the Quality Improvement/Assurance program. The Agency had a policy and procedure which evidenced the agency would have the program and listed the required elements to be evaluated, however the information presented to the survey team for review was a compilation of information for all the facilities in the region. This specific agency was not identified and the required areas were not identified or evaluated. Staff #2 stated on 5/28/14 at 1:03 p.m., that he/she was not involved in the committee. He/she stated the meetings were all held at the corporate level.	T 325		
T 335	2 VAC 5-412-300 E Quality assurance E. Results of the quality improvement program shall be reported to the licensee at least annually and shall include the deficiencies identified and recommendations for corrections and improvements. The report shall be acted upon by the governing body and the facility. All corrective actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee. This RULE: is not met as evidenced by: Based on staff interview and agency document review, the agency failed to have a Quality Improvement Program specific for the agency which identified, corrected and reported deficiencies/unacceptable trends/occurrences to the Governing Body and licensee at least annually and documented the corrective actions.	T 335	Relative to 12 VAC 5-412-300 E, now that the proper committee with required members has been established for the Roanoke site. This Quality Assurance Program, now site specific, will identify, correct, and report deficiencies/unacceptable trends/occurrences to the Governing Body annually and will document any corrective actions.	06.24.14

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T 335	Continued From Page 4 The findings included: On 5/28/14 at 12:00 p.m., the survey team reviewed the information provided by the agency regarding the Quality Improvement/Assurance program. The Agency had a policy and procedure which evidenced the agency would have the program and listed the required elements to be evaluated, however the information presented to the survey team for review was a compilation of information for all the facilities in the region. This specific agency was not identified and the required areas were not identified or evaluated. Staff #2 stated on 5/28/14 at 1:03 p.m., that he/she was not involved in the committee. He/she stated the meetings were all held at the corporate level.	T 335		

Roanoke QRM Committee Meeting

6/24/14
10:00am
Chris Marengo, MD
Anne Logan Bass, RLC
Jeanine Harris, QRM
Linda Riddle, facilities
Shawn Capozzi, HCM
Samantha Woody, HCA

Item	Decisions/Discussion	Activities/Next Steps (include communication – who needs to know & how will it be communicated)	Person(s) Responsible	Date Due
Staffing patterns and performances				
Supervision and level of service				
Patient records				
Patient Satisfaction				
Complaint resolution				
Infections, complications, adverse events				
Staff concerns-quality of care				

PLAN OF CORRECTION REVIEW AND ACCEPTANCE DOCUMENTATION

Medical Facility Inspector: _____Debbie Marion, RN

Agency/Facility Name	Planned Parenthood Roanoke
Address/ City	2207 Peters Creek Road Roanoke VA 24017
Provider Number	AF-0011
Survey Dates	5/27-5/28 and 5/31/14
Type of survey(s) ***Complaints – enter complaint number(s)***	Biennial Licensure
POC Review date	6/26/24
POC Accepted/Denied	6/26/14- ACCEPTED
Date Administrator notified of Acceptance/Denial ***(Document who was given information)***	6/26/14 11:00 a.m. Linda Riddle Facilities Coordinator
Corrections needed and specify	none
Date Administrator was notified of needed corrections	NA
AOC date (45 days) (Allegation of correction)	6/24/14
Survey Report – Date sent to OLC Supervisor	6/2/14
Survey Package – Date mailed to OLC	6/3/14
Comments: Date administrator signed POC:	 6/20/14

PLAN OF CORRECTION REQUIREMENTS:

Effective January 14, 2000, CMS requires the following criteria for an **ACCEPTABLE** Plan of Correction.
An acceptable Plan of Correction must:

1. Address ***how*** corrective action will be accomplished for those patients/areas found to have been affected by the deficient practice.
2. Address how the facility will ***indentify*** other patients/areas having the potential to be affected by the same deficient practice.
3. Address what ***measures*** will be put into place or ***systemic changes*** made to ensure that the deficient practice would not recur.
4. Indicate how the facility plans to ***monitor*** it's corrective actions to make sure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.
5. Include ***dates*** when the corrective action will be completed.