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		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	ER:		IPLE CONSTRUCTION	(PC) DATE S COMPL	
AF-06*?			E. WING		05/	31/2014	
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ROANOKE	PLANHED PARENTHO	OD HEALTH SYSTEMS, !	ž.	RS CREEK : . VA. 24017	CAO		
(X4) D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			D FREFIX TAG	PROVIDERS PLAN OF CORRECTS (EACH CORRECTIVE ACTION SHOUL CROSS-REFER INDEA TO THE AFPROVIDERCY)	DBE	(X6) COMPLETE DATE
An unannounced Bienniai Licensurs Inspection was conducted 5/27/14 through 5/28/14 and 5/31/14 by three Medicai 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.		s from	T eco		en e		
		ules A					
Angel dibladen water take	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 mat as evidenced by: Based on agency document review and staff interview, the agency falled to implement an on-going, comprehensive Quality Assurance program specific to the agency.		T315	As per out Pian of Correct dated August 23, 2012, the was to be a separate Qual Assurance Program implemented. A previous President then interpreted regulation as the Quality Assurance Program we had our entire affiliate would be more appropriate than indifference and a separate Quality Assurance Program is in program is in program of the Roanoke site.	ere lity Vice this ad for e ividual ite.	06.24.14	
	regarding the Quality is program. The Agency which evidenced the a program and listed the	m., the survey team on provided by the age mprovement/Assurance had a policy and processency would have the required elements to be information presented.	s sdura		RECEIV JUN 2 4 20 VDH/OL		

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(X6) DATE

PRINTED: 06/12/2014 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING AF-0011 B. WING 05/31/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER ROANOKE PLANNED PARENTHOOD HEALTH SYSTEMS, I 2207 PETERS CREEK ROAD ROANOKE, VA 24017 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) Continued From Page 1 T 315 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 320 12 VAC 5-412-300 B Quality assurance T 320 This has now been corrected as 06.24.14 stated in the T 315 response. B. The following shall be evaluated to assure The first Roanoke QRM meeting adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or will be held June 24, 2014, as occurrences: evidenced by the attached 1. Staffing patterns and performance; agenda, and will be site specific 2. Supervision appropriate to the level of and address the seven (7) service; 3. Patient records; elements as identified under 12 4. Patient satisfaction; VAC 5-412-300 B. 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 RECEIVED to assure adequacy of services and identification

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of unacceptable or unexpected trends or

On 5/28/14 at 12:00 p.m., the survey team reviewed the information provided by the agency regarding the Quality Improvement/Assurance

occurrences.

The findings included:

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If continuation sheet 2 of 5

PRINTED: 06/12/2014 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING AF-0011 B. WING 05/31/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER ROANOKE PLANNED PARENTHOOD HEALTH SYSTEMS, I 2207 PETERS CREEK ROAD **ROANOKE, VA 24017** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) T 320 Continued From Page 2 T 320 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 12 VAC 5-412-300 C Quality assurance As per 12 VAC 5-412-300 C. 06.24.14 T 325 this committee has now been C. A quality improvement committee responsible established and at the sitefor the oversight and supervision of the program specific meeting, the committee shall be established and at a minimum shall consist of: members will meet the 1. A physician requirement for this section.

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:

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		AF-0011	B. WING _		05/31/2014
	ROVIDER OR SUPPLIER E PLANNED PARENTHO	OD HEALTH SYSTEMS, I 2207	EET ADDRESS, CITY, ST 7 PETERS CREEK F ANOKE, VA 24017	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
	reviewed the informating regarding the Quality program. The Agend which evidenced the program and listed the evaluated, however the survey team for rinformation for all the specific agency was areas were not identified. Staff #2 stated on 5/2 he/she was not involving stated the meetings viewel. 2 VAC 5-412-300 E C E. Results of the quashall be reported to the and shall include the recommendations for improvements. The ripy the governing bodic corrective actions shall dentified deficiencies safety shall be reported the licensee by the quantities. This RULE: is not me Based on staff interviewely, the agency fa Improvement Program which identified, corrected deficiencies/unaccept deficiencies/unaccept.	p.m., the survey team tion provided by the agency Improvement/Assurance by had a policy and procedure agency would have the the required elements to be the information presented to eview was a compilation of facilities in the region. This not identified and the required fied or evaluated. 18/14 at 1:03 p.m., that we din the committee. He/she were all held at the corporate Itality improvement program the licensee at least annually deficiencies identified and corrections and the facility. All that jeopardize patient that jeopardize patient and immediately in writing to that jeopardize patient and in the facility. The provided and reported able trends/occurrences to and licensee at least annually	d T 335	Relative to 12 VAC 5-412-E, now that the proper committee with required members has been establifor the Roanoke site. This Quality Assurance Program now site specific, will ident correct, and report deficiencies/unacceptable trends/occurrences to the Governing Body annually a will document any correctivactions.	ished n, ify,
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	AF-0011		B. WING		05/3	31/2014	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE			
ROANOKE PLANNED PARENTHOO	D HEALTH SYSTEMS, II	2207 PETE ROANOKE	RS CREEK RO , VA 24017	AD			
PREFIX (EACH DEFICIENCY	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
T 335 Continued From Page	T 335 Continued From Page 4						
On 5/28/14 at 12:00 p reviewed the informati regarding the Quality I program. The Agency which evidenced the a program and listed the evaluated, however the the survey team for reinformation for all the specific agency was mareas were not identification. Staff #2 stated on 5/28 he/she was not involved.	Tag REGULATORY OR LSC IDENTIFYING INFORMATION) 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			Common Co	EIVED 4 2014 OLC		

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 performanc es				
Supervision and level of service				
Patient records				
Patient Satisfaction				
Complaint resolution	·			
Infections, complicatio ns, adverse events				
Staff concerns- quality of care				

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PLAN OF CORRECTION REVIEW AND ACCEPTANCE DOCUMENTATION

Medical Facility	Inspector:	Debbie	Marion, RN
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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)	Biennial Licensure		
Complaints – enter complaint number(s)			
POC Review date	6/26/24		
POC Accepted/Denied	6/26/14- ACCEPTED		
Date Administrator notified of	6/26/14 11:00 a.m.		
Acceptance/Denial	Linda Riddle Facilities Coordinator		
(Document who was given information)			
Corrections needed and specify	none		
Date Administrator was notified of needed	NA		
corrections			
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 <u>how</u> corrective action will be accomplished for those patients/areas found to have been affected by the deficient practice.
- 2. Address how the facility will <u>indentify</u> other patients/areas having the potential to be affected by the same deficient practice.
- 3. Address what <u>measures</u> will be put into place or <u>systemic changes</u> 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 <u>dates</u> when the corrective action will be completed.