State of Virginia

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 _____	05/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD SOUTH ATLANTIC - ROANOKE	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	12VAC5-412 Initial Comments An unannounced First Trimester Abortion Facility (FTAF) Biennial Licensure inspection was conducted 05/18/2016 through 05/21/2016 by two (2) Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. The facility was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 06/20/2013). Deficiencies follow in this report.	T 000		
T 025	12VAC5-412-150 D Governing Body The governing body shall have a formal organizational plan with written bylaws. These shall clearly set forth organization, duties and responsibilities, accountability, and relationships of professional staff and other personnel. The bylaws shall identify the person or organizational body responsible for formulating policies. This RULE: is not met as evidenced by: Based on interview and document review it was determined the governing body failed to ensure the responsibilities of resident physicians were delineated in writing for three of four resident physicians allowed to perform abortions at the facility (Identified as Staff #17, Staff #18, and Staff #19); and The findings included: During the entrance conference on 05/18/2016 at approximately 11:30 a.m., with Staff #1 the surveyor requested a list of all employed or under contract personnel. The surveyor explained the	T 025	The governing body has a formal organizational plan with written bylaws that clearly set forth organization, duties, and responsibilities, accountability, and relationships of professional staff and other personnel. The bylaws identify the person or organizational body responsible for formulating policies. (Bylaws are attached as Exhibit A for review.) A formal policy has been developed in accordance with the governing body bylaws that delineates the responsibilities of resident physicians and addresses the findings in the report. (Policy is attached as Exhibit B for review.) All residents who provide services at the health center are trained and onboarded using the Students and Trainees Abbreviated Resources Training (START) Manual. Residents do not function independently within the clinic and are not considered members of the clinical staff. All care they provide is under the direct supervision of a fully trained, onboarded and credentialed physician, which the resident policy addresses.	7.12.16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	President and CEO	7.12.16

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T 025	Continued From Page 1 list was to include all physicians performing abortions at the facility. Review of the employee list included three physicians. The surveyor inquired if any other physicians performed abortions at the facility; Staff #1, stated, "No." Review of the facility's governing body by-laws titled "[Name of entity] Governing Authority Oversight of Professional Staff" read in part: "Policy: [Name of entity] ensures all professional staff meets the [Name of oversight entity] medical protocols, MS&G [medical standards and guidelines]'s administrative standards. The procedures outlined in this policy are followed for all professional staff ... Procedures: each professional staff applicant will be screened and evaluated appropriate to his/her credentials and requirements of the position ..." The governing body by-laws contained information regarding the responsibilities for "On-Boarding" physicians including a "proctoring program" by the medical director or designee. The governing body by-laws did not list the requirements needed for resident physicians. A review of the facility's complaint log on 05/20/2016 at approximately 4:20 p.m. documented the facility utilized resident physicians to perform abortions. Staff #1 reported Staff #9 trained resident physicians regarding termination of pregnancies. The surveyor requested the names and credentialing/privileges for each resident. On 05/20/2016 at approximately 4:45 p.m. Staff #1 presented two file folders for Staff #18 and Staff #19. The folders only included the facility based on-line training completed.	T 025		

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T 025	Continued From Page 2 An interview was conducted on 05/20/2016 at 5:16 p.m., with Staff #1 in the presence of Staff #6 and another surveyor. The surveyor informed Staff #1 the folders presented for Staff #18 and Staff #19 only contained facility based training, but did not contain their delineation of privileges. Staff #1 reported he/she would contact Staff #9 regarding where the delineation of privileges for Staff #18 and Staff #19 was documented. Staff #1 reported that Staff #9 would bring the information to the facility on 05/21/2016. The surveyor inquired if Staff #1 could determine the number of abortions performed by Staff #18 and Staff #19. Staff #1 stated, "I'm not sure but I will try to run a report." Staff #1 did not present further information prior to the end of the day (6:15 p.m.) on 05/20/2016. An interview was conducted on 05/21/2016 at 8:35 a.m., with Staff #6. The surveyor made a second request for information related to the number of abortions performed by Staff #18 and Staff #19. An interview was conducted on 05/21/2016 at 2:18 p.m., with Staff #9. Staff #9 reported he/she had nothing in writing, which specified what the resident physicians were permitted to perform or written expectations. Staff #9 discussed the steps he/she took with the resident physicians he/she trained. Staff #9 stated, "I let them observe two to three procedures. Then they perform a hands-on early (gestation) procedure. From that point depending on their skill level I allow them to perform the procedures." Staff #9 reported the resident physician performed procedures under direct supervision. Staff #9 verified the governing body did not have a written process for the credentialing and provision of privileges for resident physician training. Staff #9 reported that Staff #10 also trained resident physicians.	T 025		

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T 025	Continued From Page 3 An interview was conducted on 05/21/2016 at approximately 2:40 p.m., with Staff #6 a third request was made regarding the number of cases that involved resident physicians performing abortions. At approximately 3:47 p.m., on 05/21/2016 Staff #9 stated,"[Name of Staff #17] performed ten abortions in March [2016] and four in April [2016]" The surveyor informed Staff #6 that Staff #17's name had not been on the list of resident physicians. The surveyor inquired regarding the number of cases for Staff #18 and Staff #19. Staff #6 stated, "We are not able to determine the number of cases [Names of Staff #18 and Staff #19]. They were here in 2015." The surveyor requested a list of patients that Staff #17 had performed their procedure. Staff #6 explained the resident physicians were not listed in the patient's medical records and only the facility staff's signature was listed as performing the procedure; "so, there is no way to determine which procedures were performed by the residents." On 05/21/2016 at 3:52 p.m., Staff #5 approached the surveyors and stated, "There is no other information, you have all that we have."	T 025		
T 035	12VAC5-412-160 A Policies and Procedures Each abortion facility shall develop, implement and maintain documented policy and procedures, which shall be readily available on the premises and shall be reviewed annually and updated as necessary by the governing body. The policies and procedures shall include but not limited to the following: 1. Personnel; 2. Types of elective services performed in the abortion facility;	T 035		

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T 035	Continued From Page 4 3. Types of anesthesia that may be used; 4. Admissions and discharges, including criteria for evaluating the patient before admission and before discharge; 5. Obtaining informed written consent of the patient pursuant to § 18.2-76 of the Code of Virginia prior to the initiation of any procedures; 6. When to use sonography to assess patient risk; 7. Infection prevention; 8. Quality an risk management; 9. Management and effective response to medical and/or surgical emergency; 10. Management and effective response to fire; 11. Ensuring compliance with all applicable federal, state, and local laws; 12. Abortion facility security; 13. Disaster preparedness; 14. Patient rights; 15. Functional safety and abortion facility maintenance; and 16. Identification of the administrator and methods established by the governing body for holding the administrator responsible and accountable.	T 035		

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T 035	Continued From Page 5 This RULE: Is not met as evidenced by: Based on observations, interviews and document review it was determined the facility staff failed to ensure the following policies and procedures were consistently implemented: 1. Emergency drills; 2. Emergency training; 3. Performing preventative maintenance; and The findings included: 1. On 05/18/2016 at 3:33 p.m. Staff #1 presented the facility's emergency drills for 2016. Review of the 01/20/2016 drill for "Hemorrhage and Hypovolemic Shock or Hypertension" indicated fourteen items which documented nursing and clinical staff "Demonstrates Knowledge." Review of the facility's staff roster did not reveal that licensed nursing staff attended the drill. Review of the "Emergency Drill- Anaphylaxis" conducted on 03/20/2016 documented eighteen (18) items that nursing and clinical staff had been recorded as "Demonstrates Knowledge." Review of the facility's staff roster did not reveal that licensed nursing staff attended the drill. Review of the "Armed Intruder /Active Shooter Training Drill" conducted on 01/20/2016 documented only the facility's health care assistants (HCA) and one nurse attended. The "Armed Intruder /Active Shooter Training Drill" was listed as a mandatory drill for all staff. An interview was conducted on 05/18/2016 at 4:43 p.m., with Staff #1. The surveyor asked about the process to include all staff in required training.	T 035	All employees will complete all required trainings by 7/26/16, or if not, he or she will not be allowed to work until such time as required training is completed. In order to ensure that appropriate training is performed for all staff going forward, the Health Center Manager will follow the affiliate-wide monthly training schedule for emergency and security drills (attached as Exhibit C for review). The Health Center Manager will ensure that any staff who are not present at the time of the scheduled training review all pertinent materials and complete the drills prior to their next scheduled shift. The Regional Director will audit and document ongoing compliance quarterly for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, the Regional Director will perform audits biannually.	7.26.16

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T 035	Continued From Page 6 Staff #1 reported the majority of the trainings were held during the week and the licensed nursing staff only worked weekends. Staff #1 stated, "So, it is hard to include them in the training." Staff #1 and the surveyor reviewed the sign-in sheets for the 01/20/2016 drill for "Hemorrhage and Hypovolemic Shock or Hypertension" and the 03/20/2016 "Emergency Drill- Anaphylaxis" training both indicated that licensed nursing staff attended and demonstrated the correct knowledge. Staff #1 reviewed the sign-in sheets and stated, "It documents the nurses demonstrated knowledge, but no nurses are listed on the sign-in sheets." Staff #1 stated, "The presenter should have only checked the first three items that pertained to the HCAs." On 05/21/2016 at 3:52 p.m., Staff #5 approached the surveyors and stated, "There is no other information, you have all that we have." 2. Nine (9) of ten (10) staff whose records were reviewed did not include documentation of annual training for disaster preparedness and fire and safety or emergency preparedness. At 3:35PM. on 5/21/2015 Staff #5 presented the surveyor with a new hire orientation checklist which included safety and security training, but had no documentation available to review for ongoing training, and stated "There is no other information for fire and emergency training, you have all that we have". 3. There was no inspection record for one of four vacuum suction machines. The vacuum suction machine in the physicians office had a PM (preventative maintenance) sticker dated 2/8/2016; however, there was no inspection record available for review for that piece of equipment. The pulse oximeter on the emergency cart in the	T 035	All vacuum suction machines have been inspected and have updated inspection stickers and accurate updated inspection records as of 7/1/16. The pulse oximeter on the emergency cart has received preventive maintenance and has a current PM sticker. The Regional Director will audit and document proper completion, as well as inspection and preventive maintenance of equipment quarterly for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, the Regional Director will perform audits biannually.	7.1.16

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T 035	Continued From Page 7 recovery room lacked a PM sticker. The pulse oximeter uses light to measure how much oxygen is in the blood, which helps the health care provider decide if a person needs extra oxygen.	T 035		
T 045	12VAC5-412-170 A Administrator The governing body shall select an administrator who shall be responsible for the managerial, operational, financial, and reporting components of the abortion facility including but not limited to: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including patient rights; 2. Employing qualified personnel and ensuring appropriate personnel orientation, training, education, and evaluation; 3. Ensuring the accuracy of public information materials and activities; 4. Ensuring an effective budgeting and accounting system is implemented; and 5. Maintaining compliance with applicable laws and regulations and implementing corrective action. This RULE: is not met as evidenced by: Based on interview and document review, it was determined the administrator failed to ensure: 1. Policies were developed to delineate privileges for resident physicians training to perform termination of pregnancies; 2. Polices were implemented related to personnel	T 045	A formal policy has been developed in accordance with the governing body bylaws that delineate the responsibilities of resident physicians. (See Exhibit B.)	7.12.16

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T 045	Continued From Page 8 practices, emergency drills, and fire safety training The findings included: 1. A review of the facility's complaint log on 05/20/2016 at approximately 4:20 p.m. documented the facility utilized resident physicians to perform abortions. Staff #1 reported Staff #9 trained resident physicians regarding termination of pregnancies. The surveyor requested the names and credentialing/privileges for each resident. On 05/20/2016 at approximately 4:45 p.m. Staff #1 presented two file folders for Staff #18 and Staff #19. The folders only included the facility based on-line training completed. An interview was conducted on 05/20/2016 at 5:16 p.m., with Staff #1 in the presence of Staff #6 and another surveyor. The surveyor informed Staff #1 the folders presented for Staff #18 and Staff #19 only contained facility based training, but did not contain their delineation of privileges. Staff #1 reported he/she would contact Staff #9 regarding where the delineation of privileges for Staff #18 and Staff #19 was documented. Staff #1 reported that Staff #9 would bring the information to the facility on 05/21/2016. The surveyor inquired if Staff #1 could determine the number of abortions performed by Staff #18 and Staff #19. Staff #1 stated, "I'm not sure but I will try to run a report." Staff #1 did not present further information prior to the end of the day (6:15 p.m.) on 05/20/2016. An interview was conducted on 05/21/2016 at 2:18 p.m., with Staff #9. Staff #9 reported he/she had nothing in writing, which specified what the resident physicians were permitted to perform or written expectations. Staff #9 reported not being aware of a facility policy related to the training of resident physicians. Staff #9 reported the resident physician that he/she trained were in their "fourth	T 045		

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T 045	Continued From Page 9 year of residency and only four months from graduating." Staff #9 discussed the steps he/she took with the resident physicians he/she trained. Staff #9 stated, "I let them observe two to three procedures. Then they perform a hands-on early (gestation) procedure. From that point depending on their skill level I allow them to perform the procedures." Staff #9 reported the resident physician performed procedures under direct supervision. Staff #9 reported that Staff #10 also trained resident physicians. Staff #9 verified the facility did not have written delineation of privileges for resident physicians that were allowed to perform termination of pregnancies. The folders for Staff #18 and Staff #19 did not document their previous training, their residency year, or other details regarding their skills. The folder did not contain an evaluation of how the resident physician performed during training or the skills learned. An interview was conducted on 05/21/2016 at approximately 2:40 p.m., with Staff #6 a third request was made regarding the number of cases that involved resident physicians performing abortions. At approximately 3:47 p.m., on 05/21/2016 Staff #9 stated,"[Name of Staff #17] performed ten abortions in March [2016] and four in April [2016]." The surveyor informed Staff #6 that Staff #17's name had not been on the list of resident physicians. The surveyor inquired regarding the number of cases for Staff #18 and Staff #19. Staff #6 stated, "We are not able to determine the number of cases [Names of Staff #18 and Staff #19]. They were here in 2015." The surveyor requested a list of patients that Staff #17 had performed their procedure. Staff #6 explained the resident physicians were not listed in the patient's medical records and only the facility staff's signature was listed as performing the procedure; "so, there is no way to determine	T 045		

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T 045	Continued From Page 10 which procedures were performed by the residents." Staff #6 reported the facility did not have a policy related to the training of resident physicians. The Administrator failed to ensure the facility had a policy to follow regarding the training of resident physicians. 2 (a). A review was conducted on 05/18/2016 of the facility's "Quarterly VA Emergency Drill" TRAP (Virginia Targeted Regulations on Abortion Providers) performed by the facility staff on 02/16/2015, 05/18/2015, 08/17/2015, and 11/16/2015. Review of the forms revealed each signature was in the same place on each form, including a date different from the presentation date written after one of the signatures on the form. An interview was conducted on 05/18/2016 at 4:48 p.m., with Staff #1 and Staff #6. The facility staff was informed of the findings. Staff #6 reported the likelihood of staff signing a sheet in the same exact position and in the same manner was "highly unlikely." An interview was conducted on 05/19/2016 9:33 a.m., Staff #2 reported he/she had lost the original forms for the dates the VA TRAP drills were held. Staff #2 explained he/she had the staff sign a form and made copies then filled in the information. Staff #2 verified the documents were not marked as copies or replacements for the originals. On 05/18/2016 a surveyor reviewed the emergency drills conducted from January 2016 through March 2016 and noted no licensed nursing staff attended the drills. One (1) of three (3) licensed nursing staff had attended the	T 045	By July 26, 2016, staff will be retrained on the importance of clearly documenting all drills and training, and specifically on how to clearly and appropriately document prior training attendance in the unlikely event that documentation is lost again in the future. Staff are aware that photocopies are not an acceptable substitution for clear documentation and attestation of presence at drills and training. In order to ensure that appropriate training is performed for all staff going forward, the Health Center Manager will follow the affiliate-wide monthly training schedule for emergency and security drills. (Training schedule is attached as Exhibit C.) The Health Center Manager will also ensure that any staff who are not present at the time of the scheduled training review all pertinent materials and complete drills and training prior to their next scheduled shift. The Regional Director will audit and document ongoing compliance quarterly for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, the Regional Director will perform audits biannually.	7.26.16

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T 045	Continued From Page 11 mandatory training related to an armed intruder. The Administrator did not have a plan in place to implement the facility's policy regarding drills and training. 2. (b) Review of staff employment/training records revealed three (3) staff did not include documentation of annual training for disaster preparedness and fire and safety. A review by the surveyor of the personnel record for Staff #8, a physician, revealed that the performance evaluation dated and signed on 12/15/2015 by Staff #9, the medical director, included documentation under "comments" that "No direct clinical observation this evaluation period...Reviewed AB (abortion) chart audit findings, including BC counseling/Rx, minor consent". It was also noted by the surveyor that on the "clinical review:abortion services" section of the performance review "NR" (no report-skill not required or insufficient evidence to judge) had been marked for the following categories: "2. Provides counseling and education as needed, 3. Establishes effective rapport with staff and patients, 5. Utilizes correct abortion technique, 6. Demonstrates appropriate use of correct procedures and personal protective equipment, 7. Performs accurate assessment of POC" (products of conception). A review by the surveyor of the personnel record for Staff #10, a physician, revealed that the performance evaluation dated 12/15/2015 performed by Staff #9, the medical director, included documentation under "comments" that "Not observed-eval based on chart audit, manager and staff review and complication-date eval". The clinical review section of the evaluation "to be completed by medical director of designee" was blank under all columns which included ten items	T 045	All physicians had a clinical evaluation performed in December 2015 by the Medical Director. Clinical evaluation is based on multiple factors including chart review, audits and complication review, as well as direct observation of clinical skills at least every other year. All clinical evaluations were discussed with the physician, however, two of the three physicians did not sign the evaluation form. The Health Center Manager did not complete the administrative evaluation portion of these evaluations. However all administrative evaluation portions for all current physicians will be completed prior to 7/26/16. The Health Care Manager has been trained on the importance of completing the administrative portion of all physician evaluations. The Organizational Development department will audit and document ongoing compliance annually, auditing within one month following the completion of the physician evaluations, both clinical and administrative. *(continued on next page)*	7.26.16

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	AF-0011	A. BUILDING _____ B. WING _____	05/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD SOUTH ATLANTIC - ROANOKE	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 045	Continued From Page 12 under clinical review and "meets expectations/needs improvement/and comments". The physician reviewer section was signed by Staff #9, the medical director 12/15/2015. A review by the surveyor of the personnel record for Staff #12, an LPN (licensed practical nurse) who works in the recovery room, revealed documentation on the most recent annual review that "(employee's name) only works four hours a week therefore she has not been fully trained on medical standards and guidelines. She clearly understands all that pertains to her role".	T 045	All LPNs and RNs will have been trained as to Medical Standards and Guidelines as of 7/26/16, regardless of the number of hours working in the health center.	7.26.16
T 070	12VAC5-412-180 C Personnel Each abortion facility shall obtain a criminal history record check pursuant to § 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy, whose job duties provide access to controlled substances within the abortion facility. This RULE: is not met as evidenced by: Based on a review of personnel records, it was determined that facility staff failed to ensure that three (3) of eight (8) staff members who had access to controlled substances, had the required criminal history record check conducted by the Virginia State Police. Findings include: Three (3) of eight (8) staff whose job duties provided access to controlled substances within the facility did not have documentation of a criminal history record check performed by the Virginia State Police as required by § 32.1-126.02 of the Code of Virginia.	T 070	At initial hiring all staff underwent a national criminal background check. Requests for staff's criminal history record check with the Virginia State Police were submitted by July 5, 2016, and are awaiting the responses. The Organizational Development department will ensure that all newly hired staff will have the required state background checks within 60 days of employment. The Regional Director and the Organizational Development department will audit and document compliance quarterly for a minimum for three quarters, or until 100% compliance has been demonstrated. Thereafter, audits will be performed biannually.	7.5.16

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T 070	Continued From Page 13 When the surveyor asked about the missing criminal history record checks, on 5/20/16, Staff #1 and Staff #5 stated they were not aware that the criminal checks needed to be done through the Virginia State Police.	T 070		
T 080	12VAC5-412-180 D Personnel The abortion facility shall develop, implement and maintain policies and procedures to document that its staff participates in initial and ongoing training and education that is directly related to staff duties, and appropriate to the level, intensity and scope of services provided. This shall include documentation of annual participation in fire safety and infection prevention in-service training. This RULE: is not met as evidenced by: Based on a review of ten staff records, it was determined the facility staff failed to ensure that nine (9) staff received annual training in fire safety or emergency preparedness, and that there was documentation that an unlicensed staff administering IM (intramuscular) Depo-Provera injections demonstrated the ability to give the medication. Findings include: Nine (9) of ten staff whose personnel records were reviewed did not include documentation of annual training for disaster preparedness and fire and safety or emergency preparedness. At 3:52 PM on 5/21/2015 Staff #5 presented the surveyor with a new hire orientation checklist which included safety and security training, but had no documentation available to review for ongoing	T 080	All employees will complete all required training by 7/26/16, or if for any reason they do not, he or she will not be allowed to work until such time as required training is completed. In order to ensure that appropriate training is performed for all staff going forward, the Health Center Manager will follow the affiliate-wide monthly training schedule for emergency and security drills. (See Exhibit C.) Thereafter, the Health Center Manager will ensure that any staff members who are not present at the time of the scheduled training review all pertinent materials and complete drills prior to their next scheduled shift. The Regional Director will audit and document compliance quarterly for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, audits will be performed biannually.	7.26.16

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T 080	Continued From Page 14 training, and stated "There is no other information for fire and emergency training, you have all that we have". During an interview with Staff #1 on 5/18/2016 at 4:15 PM the surveyor was told that "Health Care Members (HCM's) give the Depo IM, there are five trained to do this. They go through our training and it is documented in their file". A review of the personnel record for Staff #20 revealed documentation for the clinical skill "IM injections". On the clinical skill check sheet there were five columns labeled "date, pt (patient) initials, observed, demo'd (demonstrated), and proctor initials". Staff #1 confirmed that Staff #20 had received IM injection training and that he/she was administering Depo. Staff #20's clinical skill check sheet documented five dates between 4/14/216 and 5/5/2016, there was a blank under pt. initials beside the date 4/28/2016. All areas to document demonstration of the IM administration (all the rows under the column "demo'd") were blank. Therefore, the check list lacked documentation that Staff #20 had demonstrated proficiency in the administration of IM injections.	T 080	All staff who perform IM injections have been fully trained to perform the procedure, ensuring that patient safety has not been compromised. In order to better document this training, by 7/26/16 (and ongoing with all new hires) all unlicensed staff will be formally privileged for administration of IM injections with criteria to include: • Taking the Center for Affiliate Learning course on IM injections; and • Documentation of direct observation by licensed staff of a minimum of five injections. Documentation of such privileging shall be signed by an appropriate licensed staff member and maintained in the personnel file.	7.26.16
T 090	12VAC5-412-180 F Personnel A personnel file shall be maintained for each staff member. The records shall be completely and accurately documented, readily available, including by electronic means and systematically organized to facilitate the compilation and retrieval of information. The file shall contain a current job description that reflects the individual's responsibilities and work assignments, and documentation of the person's in-service education, and professional licensure, if applicable.	T 090		

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T 090	Continued From Page 15 This RULE: is not met as evidenced by: Based on interviews and review of personnel records, it was determined the facility staff failed to ensure personnel files were readily available; that three (3) of ten (10) records included current annual performance evaluations; four (4) of ten (10) records included current job descriptions; and that two(2) records included documentation of current CPR (cardio-pulmonary resuscitation) certification. Findings include: The survey team provided a list of requested personnel files to Staff #1, for review on 5/19/2016. Staff #1 advised the surveyors that all personnel records were kept in human resources in North Carolina and would have to be emailed to the facility. A review of personnel records was conducted on 5/19/2016 and 5/20/2016, and it was noted by the surveyor that some records lacked the required information. A discussion related to missing documentation was held with Staff #1 and Staff #2 throughout the process of personnel file reviews. The human resource department was contacted by Staff #1 and all available information was emailed to the facility. The list of requested personnel files included the file for Staff #1. Staff #1's date of hire was 3/2/2016. On 5/20/16 at 10:15 AM, Staff #1 informed the surveyors that his/her personnel record was in the electronic files. The surveyor told Staff #6 that Staff #1's file could be reviewed electronically, and at 10:45 AM on 5/20/2016 Staff #2 stated "Human resources doesn't have employee files completely updated yet-they are	T 090	Personnel files are now electronically accessible on a secured, shared drive in the "Inspection Readiness Folder" and are readily available to the Health Center Manager and Regional Director. By 7/26/16, all personnel files will include current annual performance evaluations. Training with the Health Center Manager took place on 6/23/16 to ensure complete understanding of the requirements for Annual Evaluations. By 7/26/16, all staff will have current, signed Job Descriptions. During all AB days, a minimum of one person with current CPR certification shall be present at all times and all employees with CPR certification are documented as such in personnel files. At no time have AB services been provided without at least one CPR certified person being on site. Regional Director will audit personnel files quarterly for a minimum for three quarters, or until 100% compliance has been demonstrated. The audits will verify that all personnel files are current, including documentation of annual evaluations, Job Descriptions, and current CPR training as required. Thereafter, audits will be performed biannually.	7.26.16

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T 090	Continued From Page 16 just going to send it-it's not in the computer yet" A review of personnel records revealed that records for Staff # 5,10, and 21 did not include current annual evaluations. The review of personnel records revealed that records for Staff # 1, 12, 20, and 21 did not include a current job description that reflected responsibilities and work assignments. A review of personnel records revealed that records for Staff # 12 and 20 did not include documentation of current CPR certification. At 6:00 PM Staff #6 stated "you have everything that we have, I will say that if anything else is missing from the employee records, it's just not there".	T 090		
T 095	12VAC5-412-180 G Personnel Personnel policies and procedures shall include, but not be limited to: 1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification; 2. Process for verifying current professional licensing or certification and training of employees or independent contractors; 3. Process for annually evaluating employee performance and competency; 4. Process for verifying that contractors and their employees meet the personnel qualifications of the facility; and 5. Process for reporting licensed and certified	T 095		

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T 095	Continued From Page 17 health care practitioners for violations of their licensing or certification standards to the appropriate board within the Department of Health Professions. This RULE: is not met as evidenced by: Based on interviews and document review it was determined the facility did not have a process for verifying the qualifications of three (3) resident physicians allowed to perform abortions. (Staffs #17, #18 and #19) The findings included: Review of the facility's complaint log on 05/20/2016 at approximately 4:20 p.m. documented the facility utilized resident physicians to perform abortions. Staff #1 reported Staff #9 trained resident physicians. The surveyor requested the names and credentialing/privileges for each resident. On 05/20/2016 at approximately 4:45 p.m. Staff #1 presented two file folders, for Staff #18 and Staff #19. The folders only included the facility based on-line training completed. Review of the facility's governing body by-laws titled "[Name of entity] Governing Authority Oversight of Professional Staff" read in part: "Policy: [Name of entity] ensures all professional staff meets the [Name of oversight entity] medical protocols, MS&G [medical standards and guidelines]'s administrative standards. The procedures outlined in this policy are followed for all professional staff ... Procedures: each professional staff applicant will be screened and evaluated appropriate to his/her credentials and requirements of the position ..."	T 095	A formal policy has been developed in accordance with the governing body bylaws that describes the process for verifying the qualifications of all resident physicians. (See Exhibit A.) The Education Letter of Agreement between the Residency Program and the Health Center outlines the verification of qualifications of all residents and this information is available upon request. (Education Letter of Agreement is attached as Exhibit D.) Residents do not function independently within the clinic and are not considered members of the clinical staff. All care they provide is under the direct supervision of a fully trained, onboarded and credentialed physician.	7.12.16

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T 095	Continued From Page 18 An interview was conducted on 05/20/2016 at 5:16 p.m., with Staff #1 in the presence of Staff #6 and another surveyor. The surveyor asked Staff #1 about the folders presented for Staff #18 and Staff #19, as they contained facility based training, but did not contain verification of the resident physician's qualifications. Staff #1 reported the only information available regarding Staff #18 and Staff #19 was in the folders he/she presented. Staff #1 did not present further information prior to the end of the day (6:15 p.m.) on 05/20/2016. An interview was conducted on 05/21/2016 at 8:35 a.m., with Staff #6. The surveyor made a second request for information related to the number of cases and the verified qualifications of Staff #18 and Staff #19. An interview was conducted on 05/21/2016 at 2:18 p.m., with Staff #9. Staff #9 reported he/she had nothing in writing, which specified what the resident physicians were permitted to perform or written expectations. Staff #9 reported the resident physicians that he/she trained were in their "fourth year of residency and only four months from graduating." Staff #9 reported he/she did not have any other written documents to present. The surveyor informed Staff #9 the folders maintained by the facility on Staff #18 and Staff #19 did not document their previous training, their residency year, or other details regarding their skills and qualifications. An interview was conducted on 05/21/2016 at approximately 2:40 p.m., with Staff #6 a third request was made regarding the number of cases and qualifications of the resident physicians that had been allowed to perform abortions at the facility.	T 095		

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T 095	Continued From Page 19 At approximately 3:47 p.m., on 05/21/2016 Staff #9 stated,"[Name of Staff #17] performed ten abortions in March [2016] and four in April [2016]." The surveyor asked about Staff #17 as this was the first time the surveyors were made aware of this resident physician; he/she had not been included on the list of resident physicians previously given to the survey team. Staff #6 reported being unable to provide the number of cases performed by Staff #18 and Staff #19. Staff #6 reported the documents presented on 05/18/2016 were the only information on Staff #18 and Staff #19. On 05/21/2016 at 3:52 p.m., Staff #5 approached the surveyors and stated, "There is no other information, you have all that we have."	T 095		
T 105	12VAC5-412-190 A Clinical Staff Physicians and non-physician health care practitioners shall constitute the clinical staff. Clinical privileges of physician and non-physician health care practitioners shall be clearly defined. This RULE: is not met as evidenced by: Based on interviews and document review it was determined that three of four resident physicians were allowed to perform abortions without having written clinical privileges. (Identified as Staff #17, Staff #18, and Staff #19) The findings included: During the entrance conference on 05/18/2016 at approximately 11:30 a.m. with Staff #1, the surveyor requested a list of all employed or	T 105	A formal policy has been developed in accordance with the governing body bylaws that delineates responsibilities of resident physicians. (See Exhibit A.) The Residents do not function independently within the clinic and are not considered members of the clinical staff. All care they provide is under the direct supervision of a fully trained, onboarded and credentialed physician. *(continued on next page)*	7.12.16

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T 105	Continued From Page 20 contract personnel. The surveyor explained the list was to include all physicians performing abortions at the facility. Staff #1 provided a list that contained the names of three physicians. The list did not contain the names of resident physicians that had performed terminations of pregnancies. Review of the facility's complaint log on 05/20/2016 at approximately 4:20 p.m. documented the facility utilized resident physicians to perform abortions. Staff #1 reported Staff #9 trained resident physicians. The surveyor requested the names and credentialing/privileges for each resident. On 05/20/2016 at approximately 4:45 p.m. Staff #1 presented two file folders for Staff #18 and Staff #19. The folders only included the facility based on-line training completed. Review of the facility's governing body by-laws titled "[Name of entity] Governing Authority Oversight of Professional Staff" read in part: "Policy: [Name of entity] ensures all professional staff meets the [Name of oversight entity] medical protocols, MS&G [medical standards and guidelines]'s administrative standards. The procedures outlined in this policy are followed for all professional staff ... Procedures: each professional staff applicant will be screened and evaluated appropriate to his/her credentials and requirements of the position ..." An interview was conducted on 05/20/2016 at 5:16 p.m., with Staff #1 in the presence of Staff #6 and another surveyor. The surveyor informed Staff #1 the folders presented for Staff #18 and Staff #19 only contained facility based training, but did not contain their delineation of privileges. Staff #1 reported he/she would contact Staff #9 regarding	T 105	Resident physicians are evaluated by their supervising physician(s) at the end of their rotation using an evaluation tool provided by the Residency Program. Copies of these evaluations are maintained by the Residency Program and are available for review upon request. By 7/26/26, all physicians who work with residents will be retrained on the importance and process of documenting resident involvement in procedures (outlined in policy). During monthly AB chart completion audits, the Health Center Manager will review charts to confirm compliance with appropriate documentation of resident involvement. This oversight will continue monthly for a minimum of three months, or until 100% compliance has been demonstrated.	7.26.16

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T 105	Continued From Page 21 where the delineation of privileges for Staff #18 and Staff #19 was documented. Staff #1 reported that Staff #9 would bring the information to the facility on 05/21/2016. The surveyor inquired if Staff #1 could determine the number of abortions performed by Staff #18 and Staff #19. Staff #1 stated, "I'm not sure but I will try to run a report." Staff #1 did not present further information prior to the end of the day (6:15 p.m.) on 05/20/2016. An interview was conducted on 05/21/2016 at 8:35 a.m., with Staff #6. The surveyor made a second request for information related to the number of abortions performed by Staff #18 and Staff #19. An interview was conducted on 05/21/2016 at 2:18 p.m., with Staff #9. Staff #9 reported he/she had nothing in writing, which specified what the resident physicians were permitted to perform or written expectations. Staff #9 reported the resident physicians that he/she trained were in their "fourth year of residency and only four months from graduating." Staff #9 discussed the steps he/she took with the resident physicians he/she trained. Staff #9 stated, "I let them observe two to three procedures. Then they perform a hands-on early (gestation) procedure. From that point depending on their skill level I allow them to perform the procedures." Staff #9 reported the resident physicians performed procedures under direct supervision. Staff #9 reported that Staff #10 also trained resident physicians. Staff #9 verified the facility did not have written delineation of privileges for resident physicians that were allowed to perform termination of pregnancies. The surveyor informed Staff #9 the folders for Staff #18 and Staff #19 did not document their previous training, their residency year, or other details regarding their skills. The folders did not contain an evaluation of how the resident physicians performed during training or the skills learned.	T 105		

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T 105	Continued From Page 22 An interview was conducted on 05/21/2016 at approximately 2:40 p.m., with Staff #6 a third request was made regarding the number of cases that involved resident physicians performing abortions. At approximately 3:47 p.m., on 05/21/2016 Staff #9 stated,"[Name of Staff #17] performed ten abortions in March [2016] and four in April [2016]." The surveyor informed Staff #6 that Staff #17's name had not been on the list of resident physicians. The surveyor inquired regarding the number of cases for Staff #18 and Staff #19. Staff #6 stated, "We are not able to determine the number of cases [Names of Staff #18 and Staff #19]. They were here in 2015." The surveyor requested a list of patients that Staff #17 had performed their procedure. Staff #6 explained the resident physicians were not listed in the patient's medical records and only the facility staff's signature was listed as performing the procedure; "so, there is no way to determine which procedures were performed by the residents." On 05/21/2016 at 3:52 p.m., Staff #5 approached the surveyors and stated, "There is no other information, you have all that we have."	T 105		
T 140	12VAC5-412-200 B Patients' Rights The abortion facility shall establish and maintain complaint handling procedures which specify the: 1. System for logging receipt, investigation and resolution of complaints; and 2. Format of the written record of the findings of each complaint investigated.	T 140		

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PLANNED PARENTHOOD SOUTH ATLANTIC - ROANOKE	2207 PETERS CREEK ROAD ROANOKE, VA 24017

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T 140	Continued From Page 23 This RULE: is not met as evidenced by: Based on staff interviews and a review of facility records, it was determined the facility staff failed to ensure the facility had a system for logging receipt, investigation and resolution of complaints. The findings included: There were two documented complaints in the facility's complaint/adverse event book. When reviewing Patient #4's clinical record, on 5/20/16, the surveyor noted documentation of the patient being upset, though this was not documented as a complaint in the log book. Staff #22 documented in Patient #4's EHR (electronic health record) that on 5/7/2016 at 10:12 AM Patient #4 called and that "Patient was very upset stating that she thinks that she has a possible infection and can't get in touch with anyone and nobody will help her". Staff #22 also documented that Patient #4 stated "I should read the notes to know what's wrong with her. She can't get in touch with the Roanoke clinic and her ob-gyn refuses to see her". On 5/20/2016 at approximately 4:30 PM, Staff #1 told the surveyors he/she was unaware of Patient #4's complaints as they were not documented as a complaint by the facility, only as part of a progress note related to a phone call. Staff #1 and 6 were then asked how complaints received by the call center were logged and whether family planning and STI (sexually transmitted infection) related complaints were logged separately from complaints associated with the abortion clinic. Staff #1 stated "I am not sure how the call center handles complaints; we are still working on a process for the complaint log".	T 140	A written system for logging receipt, investigation and resolution of complaints has been developed and includes utilization of the Virginia state complaint log. Health Center Managers will train staff by 7/26/16 on the formalized patient complaint process. The Regional Director will audit quarterly for a minimum of three quarters or until 100% compliance has been demonstrated. Thereafter, audits will be performed biannually to ensure ongoing compliance with the implemented complaint handling procedures.	7.26.16

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T 140	Continued From Page 24 During a discussion with Staff #6 and 8 on 5/21/2016 at approximately 4:00 PM, Staff # 6, and 8 stated they did not recognize the name of Staff #22, the RN (registered nurse) who had written the patient's statements in the electronic health record.	T 140		
T 165	12VAC5-412-210 A Quality Management 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 interviews and document review it was determined the facility's quality committee failed to ensure the quality program was designed in a manner to collect and analyze data for improvement and to evaluate corrective action taken for identified problems. The findings included: An interview and review of quality improvement information was conducted on 05/20/2016 with Staff #1 and Staff #6. Staff #1 presented the facility's policies regarding quality and a form that listed required components according to state licensing law. Staff #1 was not able to provide the data collected for the documented conclusions listed on the form. Staff #1 reported that patient records were reviewed for completeness and	T 165	The 2015-2016 RQM Annual Plan identifies the clinical chart audit schedule. (A copy of the relevant portions of the Plan is attached as Exhibit E.) Data from chart audits are analyzed and reported to the Medical Director. Audit results and the Medical Director's recommendations for improvements are shared with staff. The Health Center Manager is required to develop audit action plans to implement improvements, which are reviewed by Regional Directors. Audits relevant to AB services are: Surgical Abortion, Medication Abortion, Pregnancy of Unknown location, and STI. The VA RQM Committee will review all action plans and correspondent data analysis for issues, and will submit plans to VP of Patient Services to assess if changes need to be made.	7.26.16

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T 165	Continued From Page 25 accuracy, but he/she did not have a written documentation of audits/reviews. During 2015 the facility identified staffing concerns, but the quality committee did not document an action plan or have proof of an evaluative process. Staff #1 reported the facility continued to have staffing pattern concerns in 2016. Staff #2 reported he/she had "plans to advertise and recruit" nursing staff, but did not have a written action plan formulated.	T 165		
T 170	12VAC5-412-210 B Quality Management 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 interviews and document review it was determined the quality committee failed to evaluate four (4) of the seven (7) required components to identify appropriateness of services and unacceptable trends.	T 170	The PPSAT VA Risk Quality Management (RQM) Committee will evaluate all areas as outlined in the regulation, will assure the adequacy and appropriateness of services, and will identify unacceptable or unexpected trends or occurrences. *(Continued on next page)*	7.26.16

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T 170	Continued From Page 26 The findings included: An interview and review of quality improvement information was conducted on 05/20/2016 at 12:40 p.m., with Staff #1 and Staff #6. Staff #1 presented the facility's policies regarding quality and a form that listed required components according to state licensing law. The form identified staffing pattern issues. The quality committee failed to document the action(s) taken in attempt to provide a directive or solution to the concerns. The quality committee did not review its resident physician training program or recognize the need to establish a system to verify resident physician's qualification and establish criteria for delineation of resident physician privileges. The committee did not review the training of resident physicians as part of its supervision and level of services. The form documented no complaints had been lodged by patients. Review of the facility's complaint log revealed a complaint. The quality committee failed to address the complaint and review the complaint data related to trends. A complaint filed by a patient that declined to have a resident physician perform her termination of a pregnancy had not been addressed for resolution. The quality committee failed to document consideration of infections, complications and the administration of expired medication to a patient. Staff #1 and Staff #6 both reported an event related to a patient being administered an expired medication occurred in 2015 prior to their hire date. Staff #1 and Staff #6 made several attempts to contact their corporate office for details and the follow through by the quality committee. Staff #1 and Staff #6 were unable to obtain further	T 170	The Medical Director and/or VP of Patient Services will attend quarterly VA RQM meetings for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, the Medical Director and/or VP of Patient Services will attend VA RQM meetings biannually. A formal policy has been developed (attached as Exhibit A) to address training of resident physicians and has been approved by the Administrator.	7.12.16

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T 170	Continued From Page 27 information prior to the end of the day on 05/20/2016.	T 170		
T 175	12VAC5-412-210 C Quality Management A quality improvement committee responsible for 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 interviews and document review it was determined the quality committee failed to designate a member to represent the rights and concerns of patients. The findings included: An interview and review of quality management information was conducted on 05/20/2016 at 12:40 p.m., with Staff #1 and Staff #6. Staff #1 presented the quality committee's membership. The surveyor inquired which of the five individuals	T 175	The VA RQM Committee meets quarterly. At the time of the last meeting (4/16/16), the individual designated to represent rights and concerns of patients was a health center assistant from our Charlottesville clinic. Since that meeting, this staff member has left our employ. A new representative of the rights and concerns of patients has been identified and designated and will attend the next meeting of the VA RQM Committee on July 14 2016. Although the post was technically not filled at the time of the inspection, a new member meeting these requirements had been designated. Therefore, all meetings of the Quality Management Committee have included and will continue to include a member who represents the rights and concerns of patients.	7.14.16

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T 175	Continued From Page 28 had been designated to represent the rights and concerns of the patients. Staff #1's initial response was that any and all of the staff on the quality committee had the ability to represent the rights and was sensitive to patients' concerns. Staff #1 reviewed the facility's documents regarding the quality committee. Staff #1 reported he/she was not able to determine which member was specifically designated to represent patient concerns. Staff #1 reported he/she would contact the corporation's quality representative to determine the name of the staff member. An interview was conducted on 05/21/2016 at 8:38 a.m., with Staff #6. The surveyor informed Staff #6 that Staff #1 had tried to obtain direction from their corporate entity regarding which member of the quality committee had been designated to represent patient concerns. On 05/21/2016 at 3:52 p.m., Staff #5 approached the surveyors and stated, "There is no other information, you have all that we have."	T 175		
T 185	12VAC5-412-210 E Quality Management 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:	T 185		

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T 185	Continued From Page 29 Based on interview and document review it was determined the quality committee failed to ensure corrective actions were documented and failed to have written documentation that the facility's identified concerns were reported to the governing body. The findings included: An interview and review of quality improvement information was conducted on 05/20/2016 at 12:40 p.m., with Staff #1 and Staff #6. Staff #1 presented the facility's policies regarding quality and a form, which listed required components according to state licensing law. Staff #6 and the surveyor reviewed a document which listed quality concerns for multiple facilities within the corporate structure. Staff #6 reported the document was combined by the corporate compliance personnel. Data within the document identified the facility had staffing pattern concerns in 2015. Staff #1 and Staff #6 reported the facility continues to have staffing pattern concerns. The document did not include a proposed or actual action plan to address the issue. The surveyor inquired regarding the direction and assistance from the governing body for improvement. The surveyor requested documentation that the facility's issues had been reviewed by the governing body in 2015 or the fiscal year 2016. Staff #1 stated, "I'll reach out to [the Name of the corporate Compliance Officer]. I'm not able to find specific documents that prove our issues were sent to the governing body or that there was a response specific to us." An interview was conducted on 05/20/2016 at approximately 3:00 p.m., with Staff #3. Staff #3 reported all of the facilities' quality information is combined in an aggregated report and sent to the	T 185	PPSAT RQM Committee meets quarterly. Discussion and review of deficiencies, including recommendations for corrections/improvements identified during quarterly VA RQM Committee meetings, will become a standing agenda item for PPSAT RQM Committee. Vice President (VP) of Compliance provides quarterly RQM Committee reports to the PPSAT Board Compliance Committee and will ensure deficiencies and recommendations for corrections/ improvements identified at VA RQM Committee are reviewed and acted upon as indicated. Minutes will be kept in all RQM and Board meetings in order to verify that any identified concerns have been reported and addressed to the governing body. The VP of Compliance for PPSAT will make this a standing item in Board Compliance Committee meetings going forward.	7.14.16

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T 185	Continued From Page 30 governing body from corporate compliance. The surveyor requested documentation the governing body developed a plan to assist the facility related to staffing pattern concerns identified in 2015. Staff #1 reported he/she would attempt to contact the corporate compliance for further documentation. The surveyors did not receive further documentation related to requested quality documents prior to the end of the day exit at 6:15 p.m. on 05/20/2016. On 05/21/2016 at 3:52 p.m., Staff #5 approached the surveyors and stated, "There is no other information, you have all that we have."	T 185		
T 195	12VAC5-412-220 B Infection Prevention Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community-acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-borne pathogen requirements of the U.S. Occupational Safety & Health Administration;	T 195		

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T 195	Continued From Page 31 6. Use of personal protective equipment; 7. Use of safe injection practices; 8. Plans for annual retraining of all personnel in infection prevention methods; 9. Procedures for monitoring staff adherence to recommended infection prevention practices; and 10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices. This RULE: is not met as evidenced by: Based on observations and interview, it was determined the facility staff failed to ensure that standard infection control precautions were followed, that personal protective equipment (PPE) was used, and that supplies available for patient use was properly cleaned. Findings include: On 5/19/2016 at 1:00 PM, during a tour of the facility, the surveyor observed four heating/cold packs in a drawer labeled "gloves". There was dried yellow debris circled in brown on one of the pads. The pads were made of a cloth like material which could not be wiped off and disinfected. Staff #5 stated "These are old school pads we don't use anymore, we just got new ones-I didn't know we even had these". Staff #5 took the hot/cold pads from the drawer and threw them into the trash.	T 195	All staff (as required by scope of role) will be retrained on appropriate use of personal protective equipment (PPE) prior to 7/26/16, to include specifically: 1. No patient sample (i.e. blood, urine) will be handled unless staff are wearing gloves. *(continued on next page)*	7.26.16

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T 195	Continued From Page 32 At 3:40 PM on 5/19/2016 while making observations in the laboratory, the surveyor observed Staff #5 perform a urine pregnancy test without wearing gloves. At 8:50 AM on 8/21/2015 the surveyor observed Staff #5 administer Ativan, Zithromax and Ibuprofen as pre-medication to Patient #14. After pouring the Ibuprofen into a medication cup along with the Ativan and Zithromax, Staff #5 picked the Ibuprofen out of the medication cup with ungloved hands then placed it back into the cup, and instructed Patient #14 to take the medications. At 8:55 the surveyor confirmed with Patient #14 that she did take three pills. On the same date, at 8:55 AM the surveyor observed Staff #5 place four misoprostel pills into a medication cup and instructed Patient #14 that approximately 2 hours prior to the surgical procedure the patient could either insert the pills Staff #5 would insert the pills for her. Staff #5 instructed Patient #14 that the purpose of the Misoprostel was to "soften the cervix to make the procedure more comfortable". Patient #14 chose to self administer the medication, and she was escorted to the sub-waiting room and told she would be called back before the procedure so that she could self administer the Misoprostel. Staff #5 left the pills in the unlabeled medication cup and sat them on top of a red folder placed on the corner of the desk in the recovery room where patients were pre-medicated for procedures. At 9:40 AM Patient #14 was called back to the recovery room and instructed to go into the bathroom to self administer the Misoprostel tablets. The surveyor observed the unlabeled medication cup sitting on the red folder at 9:05 AM and 9:25 AM, during which time the medication was	T 195	2. Staff who handle oral medications for patients will use either a no-touch technique or wear gloves when touching pills that will be administered to patients. Pills will not be prepared ahead of time so as to avoid any possibility for unattended medications. Instead, they will be prepared immediately prior to administration to the patient. If for any reason administration is delayed, the medication cup will be appropriately labeled. 3. Staff who examine POC must wear gloves. Additional PPE such as face shields is highly recommended, but not required as the risk of splash exposure from simply looking at a sample is minimal. Additional PPE such as face protection is required for staff when processing POC. Health Center Manager will monitor the correct use of PPE on at least three clinic days per week for a minimum of three months, or until 100% compliance has been demonstrated. Any observed lack of compliance will be responded to immediately with retraining and corrective action if necessary. Thereafter, compliance will be audited and documented biannually by the Regional Director.	

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T 195	Continued From Page 33 unattended, or other patients were being pre-medicated in the same room. On 5/21/2016 between 8:00 AM and 1:00 PM while observing procedures, two surveyors observed Staff #8 examining the products of conception without using PPE, other than gloves.	T 195		
T 210	12VAC5-412-220 E Infection Prevention The abortion facility shall develop, implement and maintain policies and procedures for the following patient education, follow up, and reporting activities: 1. A procedure for surveillance, documentation and tracking of reported infections; and 2. Policies and procedures for reporting conditions to the local health department in accordance with the Regulations for Disease Reporting and Control (12VAC5-90), including outbreaks of disease. This RULE: is not met as evidenced by: Based on interview and document review it was determined the facility staff responsible for infection prevention did not establish an infection log for surveillance, documentation and tracking of reported infections. The findings included: During the entrance conference conducted at approximately 11:30 a.m., on 05/18/2016 the surveyor requested the facility's infection prevention log. The surveyor explained to Staff #1 if the facility documented and tracked reported infections electronically, the surveyor would view the electronic version.	T 210	The organization keeps comprehensive records of all complications, including infections, for all providers. Using our AB complication log, the Risk Quality Management Director creates a summary of complications, divided by complication type, including infections, and by provider, on a quarterly basis showing data for the prior year. This is reviewed quarterly by the Affiliate Medical Director and discussed at both Medical Safety Committee and at quarterly Risk Quality Management Committee meetings (at which the Administrator is in attendance). The Affiliate Medical Director reviews this complication data for trends in infections as well as other types of complications. Please see attached redacted spreadsheet (Exhibit F 2016 1st Quarter RNK Infection Summary) showing data for the last four quarters which demonstrated zero infections among abortion patients at the Roanoke facility.	7.12.16

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T 210	Continued From Page 34 After the second request for the facility's infection prevention documentation; Staff #1 presented the facility's infection control plan and complication log at 11:01 a.m. on 05/19/2016. Review of the complication log did not provide evidence of surveillance and tracking of reported infections. Staff #1 reported he/she would attempt to locate the requested documentation. A third request was made on 05/20/2016 at approximately 9:33 a.m. for the facility's surveillance and tracking of reported infections. At approximately 4:00 p.m. on 05/20/2016 Staff #1 and Staff #6 explained the facility did not have the requested information. Staff #1 reported he/she was not able to locate documentation on paper or an electronic version of reported infections, which had been collected, collated, analyzed, and tracked. An interview was conducted on 05/21/2016 at 8:35 a.m., with Staff #6. Staff #6 was informed of the outstanding information requested throughout the survey process. Staff #6 reported the facility did not have further documentation related to the surveillance, documentation and tracking of reported infections.	T 210		
T 245	12VAC5-412-240 A Medical Testing and Laboratory Services Prior to the initiation of any abortion, a medical history and physical examination, including a confirmation of pregnancy, and completion of all requirements of informed written consent pursuant to § 18.2-76 of the Code of Virginia, shall be completed for each patient. 1. Use of any additional medical testing shall be	T 245		

State of Virginia

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	AF-0011	A. BUILDING _____ B. WING _____	05/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD SOUTH ATLANTIC - ROANOKE	2207 PETERS CREEK ROAD ROANOKE, VA 24017

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T 245	Continued From Page 35 based on assessment of patient risk. The clinical criteria for such additional testing and the actions to be taken if abnormal results are found shall be documented. 2. Medical testing shall include a recognized method to confirm pregnancy and determination or documentation of Rh factor. 3. The abortion facility shall develop, implement and maintain policies and procedures for screening of sexually transmitted diseases consistent with current guidelines issued by the U.S. Centers for Disease Control and Prevention. The policies and procedures shall address appropriate responses to a positive screening test. 4. A written report of each laboratory test and examination shall be a part of the patient's record. This RULE: is not met as evidenced by: Based on observations and staff interviews, it was determined the facility staff failed to ensure the facility developed a policy and procedure regarding the screening of sexually transmitted infections (STI) consistent with current Centers for Disease Control and Prevention (CDC) guidelines. Findings include: On 5/19/2016 at 3:20 PM the surveyor observed Staff #4 reviewing and updating the history for Patient #8, at which time it was noted that STI testing was not offered, and the patient was not asked about STI history. At 3:35 PM, after Patient #8's interview/education was complete and she had left, the surveyor interviewed Staff #4 about the facility's policy for STI testing, and was told	T 245	Medical Standards and Guidelines that are followed by the Roanoke facility specifically state: "STI testing MUST be offered based on the CDC Guidelines to all patients at all visits." All staff have been re-trained on this policy as of June 22, 2016. The Health Center Manager will complete quarterly AB audits and will add "observed STI testing offered" and "STI history reviewed" to ten charts a quarter for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, audits will be performed biannually. In addition, the Regional Director will observe staff offering STI testing and completing STI history during in-person visits.	6.22.16

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T 245	Continued From Page 36 "We don't run STI checks for any of the abortion patients unless they pay out of pocket or if using insurance. We wait until follow up to do two separate appointments because the grant that pays for that doesn't have anything to do with abortion services. A lot of times with the first appointment we don't offer STI testing because the first appointment can be so overwhelming". On 5/21/2016, the surveyor accompanied Patient #14 throughout the process of a surgical procedure. At 7:45 AM, Staff #4 reviewed Patient #14's health history, provided information, and gave Patient #14 the opportunity to ask any questions. Staff #4 asked if Patient #14 had a plan for birth control after the procedure and advised her that she could return in seven to ten days for a visit, and through a grant, get birth control and STI testing at that time. STI testing was not offered as an option as related to the abortion procedure.	T 245		
T 305	12VAC5-412-260 A Administration, Storage, Dispensing of Drugs Controlled substances, as defined in § 54.1-3401 of the Code of Virginia, shall be stored, administered and dispensed in accordance with federal and state laws. The dispensing of drugs, excluding manufacturers' samples, shall be in accordance with Chapter 33 (§54.1-3300 et seq.) of Title 54. 1 of the Code of Virginia, Regulations Governing the Practice of Pharmacy (18 VAC 110-20), and Regulations for Practitioners of the Healing Arts to Sell Controlled Substances (18 VAC 110-30). This RULE: is not met as evidenced by: Based on observation and interview it was	T 305		

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T 305	Continued From Page 37 determined the facility staff failed to maintain secure storage for Schedule IV medications (Ativan and Valium). The findings included: Observations and interviews during the initial tour on 05/18/2016 at 12:56 p.m., with Staff #1 revealed a patient could receive Ativan 1 mg (milligram) tablet as a pre-procedure medication. Staff #1 verbally reviewed the facility's process for storage and dispensing Ativan. Staff #1 reported the Ativan was stored in a locked box within a locked cabinet in a specific room in the facility. Staff #1 reported the Ativan used on the day of procedures was recorded in a log. Staff #1 reported the facility required two staff to perform a count and verify the amount used with the amount left. Staff #1 retrieved the keys for the locked cabinet and the lock box from Staff #5. During the observation it was determined nursing staff failed to count and record the amount of Ativan administered. The locked box also contained two multidose ten (10) mL (milliliter) vials of Valium. One of the vials was missing the protective flip top. Staff #1 and the surveyors were unable to tell if the vial had been accessed. An interview was conducted on 05/20/2016 at 10:09 a. m., with Staff #1 regarding the multidose vial of Valium, which did not have a flip top covering the septum of the vial and the medication log book. Staff #1 offered to observe the multidose vial again with the surveyor. At 10:15 a.m. Staff #1 and the surveyor entered the unlocked clinician's office. Staff #1 opened the unlocked drawer of Staff #5's desk. Staff #1 retrieved the keys from the unlocked drawer. Staff #1 and the surveyor entered the room where the medication was kept and utilized the keys to unlock the cabinet and unlock the lock box that	T 305	As of 5/20/16, all controlled substances are maintained in a locked cabinet inside a separate locked box (i.e. double-locked), and the keys to both are placed in a separate locked box with a coded key pad, the code to which is only known to Health Center Manager and licensed staff members. The current documentation log for controlled substances is up to date. A count was completed by the Health Center Manager and a licensed staff member and documented appropriately as of 5/21/16. Health Center Manager will monitor the log with a licensed staff member every Saturday when completing the Lorazepam 1mg count. A Controlled Substances Training was conducted for all licensed staff and Health Center Managers on 5/20/16, which discussed maintaining appropriate counts of controlled substances. Health Center Manager performs a daily audit to ensure that medication counts are completed and recorded per policy. The Regional Director will review these audits for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, audits will be performed biannually.	5.20.16 5.21.16 5.20.16

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T 305	Continued From Page 38 contained the Ativan 1 mg tablets and the two multidose vials of Valium. The surveyor informed Staff #1 of the current issue. The facility's Schedule IV medications were not securely stored. The keys for both locks, which were to provide a double lock system, were kept in an unlocked drawer in an unlocked office. Staff #1 verified that the keys were readily assessable to any staff with knowledge that the medication keys were in Staff #5's unlocked office. Review of the facility's policy titled "Controlled Substances Policy" read in part: "Security Procedures: Physical facilities: Schedule II and IV controlled substances will be stored in a securely locked, substantially constructed cabinet at all times. Only licensed health care staff and health center manager or designee will have access to storage cabinets containing controlled substances ..." According to www.drugs.com: "Ativan (lorazepam) belongs to a group of drugs called benzodiazepines. Lorazepam affects chemicals in the brain that may be unbalanced in people with anxiety. Lorazepam may be habit-forming and should be used only by the person it was prescribed for. Misuse of habit-forming medicine can cause addiction, overdose, or death. Ativan should never be shared with another person, especially someone who has a history of drug abuse or addiction. Keep the medication in a secure place where others cannot get to it." According to www.drugs.com: "Valium (diazepam) is a benzodiazepine. Diazepam affects chemicals in the brain that may be unbalanced in people with anxiety." According to the American Heart Association Valium is one of the required emergency medications, which should be available.	T 305		

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T 325	12VAC5-412-260 E Administration, Storage, Dispensing of Drugs Records of all drugs in Schedules I-V received, sold, administered, dispensed or otherwise disposed of shall be maintained in accordance with federal and state laws, to include the inventory and reporting requirements of a theft or loss of drugs found in § 54.1-3404 of the Code of Virginia. This RULE: is not met as evidenced by: Based on observation, interview and document review it was determined the facility nursing staff failed to follow the facility's guidelines to record the number of Ativan 1 mg (milligram) tablets utilized as a pre-procedure medication and to keep the medication log current. The findings included: Observations and interviews during the initial tour on 05/18/2016 at 12:56 p.m., with Staff #1 revealed Ativan 1 mg tablets were used as a pre-procedure medication if the patient decided to purchase the medication. Staff #1 verbally reviewed the facility's process for storage and dispensing Ativan. Staff #1 reported the Ativan was stored in a locked box within a locked cabinet in a specific room in the facility. Staff #1 reported the Ativan used on the day of procedures was recorded in a log. Staff #1 reported the facility required two staff to perform a count and verify the amount used with the amount remaining. Staff #1 obtained the keys for the locked cabinet and the lock box from the licensed staff on duty. Staff #1 presented the binder, which contained the documented count for the Ativan 1 mg (milligram) tablets. Review of the log sheet within the binder documented the last count was performed on	T 325	The current documentation log for controlled substances is up to date. A count was completed by the Health Center Manager and a licensed staff member and documented appropriately as of 5/21/16. The Health Center Manager will monitor the log with a licensed staff member every Saturday when completing the Lorazepam 1mg count. A Controlled Substances Training was rolled out for all licensed staff and Health Center Managers on 05/20/16 which discussed maintaining appropriate counts of controlled substances. Regional Director will review these audits for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, audits will be performed biannually.	5.21.16 5.20.16

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T 325	Continued From Page 40 05/02/2016 for a final tally of "271." The surveyor inquired whether procedures were performed on 05/07/2016 and 05/14/2016. Staff #1 stated, ""We had procedures on both days." Staff #1 reported the nurse failed to enter the amount used for both days and the final tally. Staff #1 retrieved the procedure sheets for 05/07/2016 and 05/14/2016 and counted the number of Ativan 1 mg doses administered on 05/07/2016 and 05/14/2016. Staff #1 reported a total of sixteen (16) doses were administered. The surveyor observed Staff #1 count the Ativan 1 mg tablets. Although the count was correct for a total of 256 tablets; Staff #1 verified the nurse failed to follow the facility's procedure for two staff to count and record all Schedule IV medications. The surveyor requested the facility's policy related to controlled substances. Review of the facility's policy titled "Controlled Substances Policy" read in part: "Working Inventory Procedures (controlled substances used in day-to-day clinical services) ... staff must use Controlled Substance Log: Working Inventory ... at the beginning and end of each business day in which clinical services were provided. A single log page must be used for each drug per date ..." The facility's policy listed eighteen (18) items that must be included on the controlled substance log sheet. The policy listed "1. Date inventory is performed, 2. Recovery Room RN (Registered Nurse) name, 3. Exact drug name, 4. Strength ... 5. Size ... 6. Lot # (number), 7. Expiration date, 8. Starting count," 9. [reconciliation with the previous clinic ending total], "... 12. MR (medical record) #, 13. Patient full name (Sic), ... 15. Amount given to client, 16. Amount remaining, 17. RN name and signature, and 18. Signature of witness." According to www.drugs.com: "Ativan (lorazepam) belongs to a group of drugs called	T 325		

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T 325	Continued From Page 41 benzodiazepines. Lorazepam affects chemicals in the brain that may be unbalanced in people with anxiety. Lorazepam may be habit-forming and should be used only by the person it was prescribed for. Misuse of habit-forming medicine can cause addiction, overdose, or death. Ativan should never be shared with another person, especially someone who has a history of drug abuse or addiction. Keep the medication in a secure place where others cannot get to it."	T 325		
T 330	12VAC5-412-270 Equipment and Supplies An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include, as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator	T 330		

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T 330	Continued From Page 42 This RULE: is not met as evidenced by: Based on observations, staff interviews and document review, it was determined the facility staff failed to ensure that medical equipment to care for patients based on the scope and intensity of services provided were available and not expired. Findings include: A review of the facility's emergency cart, located in the recovery area was conducted on 5/19/2016 at 1:00 PM. The surveyor noted that two packs of defibrillator pads available for use with the AED (automated external defibrillator) expired 10/2015. An AED is a portable device that checks the heart rhythm and can send an electric shock to the heart to try to restore a normal rhythm. AED's are used to treat sudden cardiac arrest. If AED pads are used beyond their expiration date, they may not adhere to the skin as well, particularly when cardiopulmonary resuscitation (CPR) is done. The facility's monthly emergency box inventory form included a check mark documenting that the AED was checked by Staff #5 in January, February, and March of 2016; there was no notation for April or May 2016. Staff #1 told the surveyor at 1:15 PM on 5/19/2016 that the facility had recognized that the defibrillator pads were expired on 5/17/2016, and had been ordered at the time of that discovery; Staff #5 concurred. On 5/21/2016 when procedures were performed at the facility, there were no AED defibrillator pads available for use that were not expired. The surveyor observed that there was no Vasopressin available for use on the emergency	T 330	As of 6/1/16, the emergency cart and supplies were all current and did not contain any expired medications or supplies. Foley catheters, suction machines, and AED pads have been added to current emergency supply checklist and are present on the emergency cart. Although Vasopressin is an option for treatment of cervical laceration, there are other more readily available options since vasopressin is currently on national shortage. A revised Emergency Care Manual will be sent out to Virginia sites on or before 7/26/16 reflecting the various options available for management of different emergency situations. Patient safety has not been compromised by Vasopressin shortage as other effective treatment options are available, as outlined in the Emergency Care Manual. Licensed personnel will check emergency cart by the last day of each month and fill out corresponding inventory checklist. Any missing, expired or otherwise unusable items will be replaced immediately via notification to the Health Center Manager. Throughout the month, any time an item is used from the emergency cart, the Health Center Manager is notified at that time. *(continued on next page)*	6.1.16 7.26.16

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T 330	Continued From Page 43 cart. The facility's policy and procedure for management of a cervical laceration states "consider dilute Vasopressin 2-4 units intracervical". The surveyor observed that there was no Foley catheter available for emergency use. The facility's policy and procedure for management of a cervical laceration states "For severe bleeding and suspected high cervical tear, consider insertion of 30 ml Foley catheter into cervix...". There was no documentation that the facility's monthly emergency box inventory form had been checked for the months of April and May of 2016.	T 330	Emergency cart check has been added to the Health Center Manager's Monthly RQM-003 checklist to ensure compliance with this requirement. The Regional Director will also audit and document compliance quarterly for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, audits by the Regional Director will be performed biannually.	7.12.16
T 415	12VAC5-412-350 B Maintenance When patient monitoring equipment is utilized, a written preventive maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, not less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. This RULE: is not met as evidenced by: Based on observations,interviews, and document review, it was determined the facility staff failed to ensure that equipment was checked for preventative maintenance (PM) at least annually and that records were maintained on each piece	T 415	As of 7/26/16, all patient monitoring equipment will receive preventive maintenance, including being checked and/or tested in accordance with manufacturer's specifications. All such inspections will be appropriately documented. *(continued on next page)*	7.26.16

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T 415	Continued From Page 44 of equipment to indicate its history of testing and maintenance. Findings include: On 5/18/2016 at 1:00 PM, the surveyor observed that the pulse oximeter (used to measure oxygen in the blood and helps the health care provider decide if a person needs extra oxygen) on the emergency cart did not have a PM sticker. At approximately 2:00 PM on 5/18/2016, Staff #1 stated "he probably just didn't know that was in there when he checked the equipment". On 5/20/2016 at 1:15 PM the surveyor observed a vacuum suction machine in the physicians' office that had a PM sticker dated 2/8/2016; however, there was no inspection record associated with that piece of equipment available for review.	T 415	The Director of Facilities and Security, or his/her designee, is responsible for implementation, oversight and compliance of the preventive maintenance program. The Health Center Manager maintains records documenting the history of testing and maintenance of each piece of equipment. The Regional Director will audit preventive maintenance documentation quarterly for a minimum of three quarters, or until 100% compliance has been demonstrated. Thereafter, audits will be performed biannually.	

Exhibit A

PLANNED PARENTHOOD SOUTH ATLANTIC

BYLAWS

Dated as of January 1, 2015
Revised June 27, 2015

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Exhibit A

PLANNED PARENTHOOD SOUTH ATLANTIC

BYLAWS

Dated as of January 1, 2015
Revised June 27, 2015

ARTICLE I
NAME

1.1 Corporate Name. The name of this organization is Planned Parenthood South Atlantic, hereinafter referred to as the "Organization" or "PPSA."

ARTICLE II
ORGANIZATION

2.1 Organization. The Organization has been formed under the laws of the State of North Carolina as contained in Chapter 55A of the General Statutes of North Carolina (the "North Carolina Nonprofit Corporation Act") and has received designation under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provisions of any future United States internal revenue law) (the "Code") as a tax-exempt nonprofit organization.

2.2 Affiliation. The Organization shall be an affiliate of Planned Parenthood Federation of America ("PPFA").

ARTICLE III
PURPOSES AND MISSION STATEMENT

The Organization believes in the fundamental right of all persons to control their own sexuality and reproductive life, regardless of their gender (as defined below), race, color, national origin, age, religion, sexual orientation (as defined below), gender identity (as defined below), sexual identity (as defined below), gender expression (as defined below), disability, income, marital status or any other characteristic or status protected by applicable federal, state, or local law

The Organization believes that respect and value for diversity in all aspects of the Organization is essential to the well-being of the Organization. As such, it is PPSA's policy to provide equal employment opportunity and service access to all qualified employees, applicants for employment, volunteers, and clients without regard to unlawful consideration of gender, race, color, national origin, age, religion, sexual orientation, gender identity, sexual identity, gender expression, disability, income, marital status, or any other characteristic or status protected by applicable federal, state, or local law.

Based on these beliefs, the mission and purposes of the Organization are to:

Exhibit A

(a) Provide comprehensive reproductive and sexual health care services in settings that preserve and protect the individual's right to privacy and informed decisions;

(b) Advocate public policies which advance these rights and expand access to these services to the extent allowed consistent with the Organization's IRC 501(c)(3) tax-exempt status;

(c) Provide educational programming that fosters a culture of healthy sexuality;

(d) Work with and meet the needs of diverse communities and the underserved; and

(e) Lead broad-based strategies that further these fundamental rights.

For purposes of these Bylaws, "gender" means one's biological, social, and legal status as a male or female; "sexual orientation" means one's sexual identity in relation to the gender to which one is attracted (i.e., the fact of being heterosexual, homosexual, or bisexual);"gender identity" means one's inner sense of being female or male or a mixture of both (which sense may not be consistent with one's biological, social, or legal gender); "sexual identity" means how one labels oneself (which label is a part of one's overall conception of oneself and may not be consistent with one's behavior or orientation); and "gender expression" means the ways in which one manifests or communicates one's masculinity or femininity.

ARTICLE IV
OFFICE AND REGISTERED AGENT

4.1 Principal Office. The principal office of the Organization shall be located and maintained in Raleigh, North Carolina. The Organization may have such additional offices as may be designated by the Board.

4.2 Registered Office and Registered Agent. The registered office and registered agent of the Organization shall be determined by the Board

4.3 Changes. Any change to the Organization's registered office or registered agent shall be accomplished in compliance with the North Carolina Nonprofit Corporation Act.

ARTICLE V
MEMBERSHIP

5.1 Membership. The Organization shall have no members.

Exhibit A

ARTICLE VI
BOARD OF DIRECTORS

6.1 Powers.

(a) General Powers. The business and affairs of the Organization shall be managed by the CEO of the Organization under the direction and supervision of the Board of Directors (collectively, the "Board," and each member, a "Director"), taking into account the standards of affiliation of PPFA and subject to any limitation set forth in the Organization's Articles of Incorporation, these Bylaws, or as otherwise provided by law.

(b) Specific Powers.

(i) The Board shall:

(1) Hire, evaluate, determine the compensation of, and dismiss the CEO (in each case taking into consideration the recommendation of the Executive Committee);

(2) Ensure that the Organization does not engage in any activity that would jeopardize the Organization's federal tax exemption (specifically ensuring that the Organization (1) does not attempt to influence legislation, except to the extent permitted by law, and (2) does not participate or intervene in any political campaign of any candidate for public office);

(3) Ensure that these Bylaws are reviewed periodically by legal counsel (selected and appointed as set forth in ARTICLE XII) to ensure compliance with applicable laws, and annually file a compliance form with PPFA to that effect; and

(4) Have oversight responsibility for the financial well-being of the Organization, including:

(A) developing financial policies and programs,

(B) considering the annual operating and capital budgets presented by the Finance and Investment Committee and, after making any revisions it deems advisable, adopting and monitoring the same,

(C) appointing the Organization's independent public accountant (the "Auditor") (taking into consideration the recommendation of the Finance and Investment Committee with respect to such appointment) (ensuring that at least every five years, the lead audit partner or concurring audit reviewer is rotated),

(D) ensuring that the Auditor completes an annual audit of the books and financial statements of the Organization,

(E) meeting annually with the Auditor without staff present, and

(F) reviewing the audit letter and other communications from the Auditor.

(ii) To the extent that the Organization has the authority to appoint the members of the board of directors of another entity, it shall be the responsibility of the Board to make such appointments.

6.2 Number. The number of Directors shall be determined by the Board and shall be not less than 18 or more than 23 persons.

6.3 Honorary Directors. The Board may invite members of the PPFA Board of Directors and members of the PPFA Leadership Council, in each case who live in the area served by PPSA, to be honorary directors (provided that they are and continue to be members in good standing of the PPFA Board or the PPFA Leadership Council, as applicable). At the discretion of the Chair of the Board, honorary directors may be present at and participate in Board meetings (except executive sessions) and receive Board materials; provided, however, that they shall not have the authority to vote, shall not count towards quorum or diversity requirements or recommendations, and shall not be included for purposes of determining the minimum or maximum number of Directors of the Organization.

6.4 Eligibility to Serve as a Director. The Board should reflect the diversity of the communities and states served by the Organization. No individual shall be disqualified from serving as a Director because of gender, race, color, national origin, age, religion, sexual orientation, gender identity, sexual identity, gender expression, disability, income, marital status, or any other characteristic or status protected by applicable federal, state, or local law. No employee of PPFA or any affiliate of PPFA may serve on the Board or have voting privileges with respect thereto.

6.5 Election. Directors shall be elected prior to July 1 of each year. The Board Governance Committee shall present a slate of individuals for consideration by the Board, and current Directors may nominate additional individuals during the meeting at which new Directors are to be elected, provided that the nominees have consented to such nomination.

6.6 Terms. Except as set forth in this Section 6.6 and in Section 6.8, Directors shall serve three-year terms that begin on July 1 of the year in which they were elected and that end at such Director's death, resignation, or removal or when his or her successor is elected and qualified. The terms of the Directors shall be staggered so that as nearly as possible one-third of the Board shall be elected each year.

The Board may provide for shorter or longer terms of office as follows:

(a) In unusual circumstances, the Board may extend a Director's term of office in one-year increments.

(b) The Board may elect a Director to a term of office that is shorter or longer than three years in order to maintain an approximately equal number of Directors in each of the three classes of Directors.

A Director who has served for two full terms shall be ineligible for re-election for one full year, with the exception that each past Chair of the Board shall be eligible, immediately following the year in which such individual served as Chair, to be elected as a Director of the Board and may serve up to two one-year terms as a Director in order to provide the Board with the experience and perspective of the Past Chair.

6.7 Removal. Any Director may be removed, with or without cause, by a vote of two-thirds of the Directors.

6.8 Vacancies. Vacancies occurring on the Board between annual elections may be filled by the remaining Directors. Directors so elected shall hold office until the next annual election, at which time they shall be eligible for re-election. For purposes of clarity, a Director who is initially elected to fill a partial year of a former Director's term shall be eligible to serve two three-year terms following the end of his or her initial partial-year term.

6.9 Compensation and Expenses. No Director shall be entitled to, or shall receive any, direct or indirect compensation for attendance at meetings of the Board or for other services rendered to the Organization as a Director or member of a committee of the Board. A Director may, however, be reimbursed for any out-of-pocket expenses incurred on behalf of the Organization or in connection with the transaction of the Organization's affairs and approved for reimbursement by the Board.

ARTICLE VII
MEETINGS OF THE BOARD OF DIRECTORS

7.1 Annual and Regular Meetings. An annual meeting of the Board (for the purpose of electing directors and officers, appointing committees, and carrying on such other business as may properly come before the meeting) shall be held on such day as is designated by the Board. The Board shall also schedule three additional regular meetings during each fiscal year.

7.2 Special Meetings. Special meetings of the Board may be called at any time by the Chair or by any five Directors. Such meetings shall be held at such times as the person or persons calling the meetings shall designate.

7.3 Locations of Meetings. Meetings of the Board shall generally be held at the principal office of the Organization or at a place within the area served by the Organization;

however, meetings may also be held at such places, within or without the Organization's service area (and within or without the State of North Carolina), as the Board shall designate from time to time. If no place is designated, meetings shall be held at the principal office of the Organization.

7.4 Notice of Meetings. Notices of regular meetings of the Board shall be given to each Director not less than five days before such meetings, and notices of special meetings of the Board shall be given to each Director not less than 48 hours before such meetings, in either case by any usual means of communication, including, without limitation, in person, by telephone, by facsimile, by email, or by mail. Oral notice of a meeting is effective when actually communicated to the Director. Written notice is effective at the earliest of the following:

(a) When received;

(b) Three days after deposit in the United States mail, as evidenced by the postmark, if mailed with postage thereon prepaid and correctly addressed to the address of the Director last known to the Organization; or

(c) On the date shown by the confirmation of delivery issued by a private carrier, if sent by private carrier to the address of the Director last known to the Organization.

Any such notice shall set forth the time of the meeting.

7.5 Waiver of Notice. A Director may waive any notice required by law, the Articles of Incorporation, or these Bylaws before or after the date and time stated in the notice, and such waiver shall be equivalent to the giving of such notice. Except as provided in the next paragraph of this section, the waiver shall be in writing, signed by the Director entitled to the notice, and filed with the minutes or corporate records.

A Director's attendance at or participation in a meeting waives any required notice to the Director of the meeting unless the Director at the beginning of the meeting or promptly upon arrival objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting.

7.6 Quorum. One-half of the Directors shall constitute a quorum for the transaction of business at a meeting of the Board.

7.7 Voting. If a quorum is present when a vote is taken, the act of a majority of the Directors present shall be the act of the Board, unless otherwise provided in these Bylaws. A Director who is present at a meeting of the Board or a committee of the Board when corporate action is taken is deemed to have assented to the action taken unless the Director (a) objects at the beginning of the meeting, or promptly upon arrival, to holding it or transacting specified business at the meeting, (b) votes against, or abstains from, the action taken, and such dissent or abstention is entered in the minutes of the meeting, or (c) files written notice of his or her dissent or abstention with the presiding officer of the meeting before its adjournment or with the Organization immediately after adjournment of the meeting. The right of dissent or abstention is not available to a Director who votes in favor of the action taken.

7.8 Attendance. Any Director who is absent from two consecutive meetings without giving prior notice of such absences to the Secretary shall be deemed to have resigned from the Board.

7.9 Action Without Meeting. Any action required to be taken or which may be taken at a meeting of the Board or any committee created by the Board may be taken without a meeting if each of the members of the Board or each of the members of such committee, as the case may be, approves such action by either (a) signing one or more written consents setting forth the action to be taken or (b) consenting to such action in electronic form and delivering such consent by electronic means. A consent provided under this section has the effect of a meeting vote and will be included in the minutes or filed within the corporate records reflecting the action. The action taken must be reported at the next regular meeting of the Board.

7.10 Participation in Meetings by Electronic Communications. The Chair of the Board may permit any or all Directors to participate in a regular or special meeting by, or conduct the meeting through the use of, any means of communication by which all Directors participating may simultaneously hear each other during the meeting. A Director participating in a meeting by this means is deemed to be present in person at the meeting. Likewise, with the permission of the chair of a committee, any one or more members of a committee may participate in a committee meeting by means of a conference telephone or similar device which allows all persons participating in the meeting to hear each other, and such participation in a meeting shall be deemed presence at such meeting.

ARTICLE VIII
OFFICERS

8.1 Officers. The officers of the Organization shall be a Chair, a Vice Chair, a CEO, a Secretary, a Treasurer, and other officers and assistant officers as may be deemed by the Board to be necessary or advisable to carry on the business of the Organization. The Chair, Vice Chair, Secretary, and Treasurer shall be Directors. The Assistant Treasurer and other officers are not required to be Directors.

8.2 Appointment and Eligibility. Except as otherwise provided in this ARTICLE VIII, the Board shall, taking into consideration the recommendation of the Board Governance Committee, appoint the officers of the Organization. No employee of PPFA or any affiliate of PPFA may serve as Chair, Vice Chair, Secretary, or Treasurer.

8.3 Resignation and Removal of Officers. Any officer may resign at any time upon written notice to the Board, and no acceptance of a resignation shall be necessary to make it effective. The Board may remove any officer at any time, with or without cause.

8.4 Terms. The officers shall be appointed prior to July 1 of a given year. With the exception of the CEO, whose term of office shall be within the Board's discretion, the officers shall serve one-year terms that begin on July 1 of the year in which they were elected and that end at such officer's death, resignation, or removal or when his or her successor is appointed and

qualified. An officer may be elected for a maximum of three consecutive one-year terms. In unusual circumstances, the Board may extend an officer's term of office for up to six months.

8.5 Vacancies. Officer vacancies may be filled by the Directors. Officers so appointed shall hold office until the next annual election, at which time they shall be eligible for re-election. For purposes of clarity, an officer who is initially elected to fill a partial year of a former officer's term shall be eligible to serve three one-year terms following the end of his or her initial partial-year term.

8.6 Duties of Officers.

(a) Chair. The Chair shall (i) preside at all meetings of the Board and (ii) be an ex-officio member of all Standing Committees of the Board (including being counted towards the presence of a quorum of such committees and having the right to vote on any matter before such committees). The Chair shall also perform such other duties as are properly required by the Board.

(b) Vice Chair. The Vice Chair shall act as the Chair in the event of the absence or inability of the Chair to act, or in the event of a vacancy in that office. Upon completion of the Chair's term(s) of office, the Vice Chair shall assume the office of Chair. The Vice Chair shall also perform such other duties as are properly required by the Board or by the Chair.

(c) CEO.

(i) Appointment. The Board shall, taking into consideration the recommendation of the Executive Committee, appoint the President and Chief Executive Officer ("CEO"). The Board shall also be responsible for the dismissal of the CEO.

(ii) Responsibilities. The CEO shall:

(1) Implement the policies of the Board;

(2) Manage the Organization's day-to-day operations;

(3) Ensure that the mission, goals, and objectives (as defined by the Board) are carried out; and

(4) Hire, supervise (directly or indirectly), review the performance of, and discharge all employees of the Organization.

(iii) Limitations. The CEO shall not perform any act (or allow or cause to be performed any act) that is unlawful, inconsistent with commonly accepted business and professional standards, in violation of contractual standards or requirements set forth by funding sources or regulatory bodies, or contrary to explicit limitations set forth by the Board.

(iv) Relationship with the Board. The Board and the CEO shall work together in a mutually supportive manner, within the context of their respective

roles, in full recognition that their joint contributions are the key to PPSA's continuing success.

(d) Secretary. The Secretary shall (i) attend all of the meetings of the Board and the Executive Committee, (ii) keep or cause to be kept minutes of all meetings of the Board and the Executive Committee and timely distribute them as appropriate, (iii) ensure the accurate documentation of the policies and resolutions of the Organization, and (iv) make such reports and perform such other duties as are incident to the office or properly required by the Board.

(e) Treasurer. The Treasurer shall (i) keep or cause to be kept such accounts and records as may be necessary to show receipts, expenditures, and the financial condition of the Organization from time to time; (ii) represent the Board in all matters related to the financial affairs of the Organization; (iii) chair the Finance and Investments Committee; and (iv) perform all other duties as are incident to the office or properly required by the Board.

(f) Assistant Treasurer. The Assistant Treasurer shall act as the Treasurer in the event of the absence or inability of the Treasurer to act, or in the event of a vacancy in that office.

8.7 Limitation on Authority. No officer may bind the Organization to obligations beyond the limit of items in the approved budget without specific authority in writing from the Board.

8.8 Reliance on Others. In discharging their duties, officers may rely upon information, opinions, reports, or statements, including financial statements and other financial data, if prepared by or presented by (a) one or more officers or employees of PPSA that is or are reasonably believed to be reliable and competent in the matters presented, or (b) legal counsel, public accountants, or other qualified persons as to matters the officer reasonably believes are within the person's professional or expert competence. Reliance is not permitted if an officer has actual knowledge concerning the matter in question.

ARTICLE IX
COMMITTEES OF THE BOARD

9.1 Committees. The Board shall have the standing committees set forth in these Bylaws (the "Standing Committees"). The Chair of the Board may also, with the approval of the Board, create one or more ad hoc advisory committees as he or she sees fit, provided that the purpose and operation of any such ad hoc advisory may not be inconsistent with the standards of affiliation of PPFA.

9.2 Authority of Committees. A Standing Committee may exercise the authority of the Board if such authority is (a) specified in these Bylaws or (b) delegated by the Board at a meeting called and held in accordance with ARTICLE VII or pursuant to a written consent satisfying the requirements of Section 7.9. Notwithstanding the generality of the foregoing (or

any authorization of the Board to the contrary), no committee may (i) fill vacancies on the Board or on any of its committees; (ii) amend the Articles of Incorporation; (iii) adopt, amend, or repeal these Bylaws; (iv) amend or repeal any resolution of the Board; (v) approve dissolution, merger, or the sale, lease, exchange, pledge, mortgage, or transfer of all or substantially all of the Organization's property or assets; (vi) except for the Executive Committee and unless specifically authorized to do so by the Board, enter into any contracts; (vii) authorize the voluntary dissolution of the Organization or revoke any proceedings for voluntary dissolution of the Organization; or (vii) take any action prohibited by law.

9.3 Appointment of Committee Chairs and Members. The Board shall, taking into consideration the recommendation of the Board Governance Committee, appoint the members and chairs of the Standing Committees (provided, however, that the chairs of the Executive Committee and the Finance and Investment Committee shall be as set forth in Section 9.7).

9.4 Composition of Committees. Each Standing Committee shall consist of a Committee Chair and at least two more members. All chairs of the Standing Committees must be Directors, and, with the exception of the members of the Finance and Investments Committee and the Development Committee (which committees may have members who are not Directors, provided that a majority of the members of such committees are Directors), all members of the Standing Committees must be Directors.

9.5 Terms. Chairs and members of the Standing Committees shall serve in such capacity for a term of one year, unless otherwise provided in this ARTICLE IX.

9.6 Committee Meetings; Miscellaneous. Unless otherwise provided in this ARTICLE IX, the provisions of these Bylaws governing meetings, action without meetings, notice and waiver of notice, and voting requirements of the Board shall apply to the Standing Committees and their members as well.

Each Standing Committee shall meet a minimum of two times per year and at such other times as it deems necessary and appropriate. Each Standing Committee shall keep minutes of its meetings and shall report its actions and recommendations to the Board at its next meeting. With the exception of the Executive Committee (the quorum requirements for which are set forth in Section 9.7(a) below), a quorum at all Standing Committee meetings shall consist of the greater of (a) one-third of the members of such committee who are Directors or (b) two members of the committee who are Directors. If a quorum is present when a vote is taken, the act of a majority of the members of the committee present shall be the act of such committee.

Any committee member who is absent from two consecutive committee meetings without giving prior notice of such absences to the chair of the committee shall be deemed to have resigned from such committee.

Exhibit A

9.7 Standing Committees. The Board shall have the following Standing Committees:

(a) Executive Committee.

(i) Composition. The Executive Committee will consist of at least three Directors, including the Chair of the Board (who shall also chair the committee), appointed in accordance with Section 9.3. It is anticipated, but not required, that the Executive Committee will also consist of the Directors then serving as officers of the Organization, the chair of each of the other Standing Committees, and the immediate Past Chair of the Board.

(ii) Functions. The Executive Committee shall (1) have the full authority of the Board during the intervals between meetings of the Board, (2) make policy recommendations to the Board, (3) supervise and review the actions of the other Standing Committees, (4) oversee the long-range planning of the Board, (5) recommend, as applicable, the hiring, compensation, and dismissal of the CEO, and (6) prepare and present to the Board an annual evaluation of the CEO.

(iii) Quorum. A quorum of the Executive Committee shall be a majority of the members of the Executive Committee. If a quorum is present when a vote is taken, the act of a majority of the members of the Executive Committee present shall be the act of the Executive Committee.

(b) Finance and Investments Committee.

(i) Composition. The Finance and Investments Committee shall consist of the Treasurer, and at least two other persons, at least one of whom has substantial financial expertise. The Treasurer shall chair the committee.

(ii) Functions. The Finance and Investments Committee shall:

(1) With respect to financial matters: (A) have oversight responsibility for the quality and integrity of the Organization's financial statements, (B) ensure compliance with legal and regulatory requirements relating to financial matters, (C) regularly (and no less than annually) review the adequacy of the Organization's internal financial controls and financial policies, (D) review and submit to the Board for approval the annual operating and capital budgets of the Organization, and (E) monitor (at least quarterly) the Organization's financial operations through review of its actual performance relative to the approved operating and capital budgets;

(2) With respect to audit-related matters: (A) after approving its fees and ensuring its independence, recommend to the Board the selection of the Auditor, (B) review with the Auditor the annual audit program, (C) review the audit letter and other communications from the

Auditor, and (D) have oversight responsibility over such Auditor, including ensuring its ongoing independence from the Organization; and

(3) With respect to investment-related matters: (A) review (at least biannually) the performance of all of the Organization's investments, and (B) develop guidelines for the efficient management of such investments.

(c) Board Governance Committee.

(i) Composition. The Board Governance Committee shall consist of at least 3 Directors, at least one of whom is a person of color. The CEO shall be an ex-officio member of the committee, with voice but without vote.

(ii) Terms. The chair and members of the Board Governance Committee shall serve up to three one-year terms in such capacity. The membership of the Board Governance Committee should reflect PPSA's commitment to diversity.

(iii) Functions. The Board Governance Committee shall (1) conduct an annual assessment of the Board to determine priorities for characteristics and skills of incoming Board members consistent with the Organization's commitment to diversity; (2) develop programs and other resources to increase the leadership skills of the Directors and the effectiveness of the Board; (3) plan Board orientations and retreats; (4) plan educational presentations for the Board; (5) annually recommend to the Board (A) a slate of individuals nominated for election to the Board, (B) a slate of individuals nominated to be appointed as officers, and (C) a slate of Directors nominated to be members of each of the Standing Committees; (6) monitor the performance of the Board and each of the Standing Committees; and (7) annually conduct a performance evaluation of Directors.

d) Compliance Committee

(i) Composition. The Compliance Committee shall consist of at least 3 Directors. The Chief Executive Officer and the Compliance Officer shall serve as ex-officio members of the Compliance Committee.

(ii) Functions. The Board Compliance Committee shall (1) oversee the implementation of the Compliance Program, (2) monitor implementation of the Compliance Program, and evaluate its effectiveness (3) review reports and recommendations of the Compliance Officer regarding Compliance Program activities, including data regarding compliance generated through audit, monitoring and individual reporting, and (4) based on these reports, make recommendations to the Board of Directors.

(e) Development Committee.

(i) Composition. The Development Committee shall consist of at least three Directors.

(ii) Functions. The Development Committee shall (1) develop and recommend to the Board policies and strategic plans for fundraising; (2) ensure the implementation of such policies and strategic plans; (3) support staff in implementing major campaigns, plans for donor cultivation and retention, special events, and planned giving campaigns; and (4) ensure that 100% of the Directors make personal gifts to the Organization.

Exhibit A

ARTICLE X
INDEMNIFICATION

10.1 Extent. In addition to the indemnification otherwise provided by law, the Organization shall indemnify and hold harmless its Directors and officers, former Directors and officers, employees and those persons who were serving at the request of the Organization in any capacity in another corporation, partnership, joint venture, trust or other enterprise (collectively, the "Indemnified Persons" and individually, the "Indemnified Person"), against (a) reasonable litigation expenses, including attorneys' fees, actually and necessarily incurred by such Indemnified Person in connection with any threatened, pending or completed action, suit or proceeding, whether civil, criminal, administrative or investigative and whether or not brought by or on behalf of the Organization, seeking to hold such Indemnified Person liable by reason of the fact that he or she is or was acting in such capacity and (b) reasonable payments made by such Indemnified Person in satisfaction of any judgment, money decree, fine, penalty or settlement for which he or she may have become liable in any such action, suit or proceeding; provided, in either case, that it is determined in accordance with Section 10.2 of this ARTICLE X that he or she is entitled to indemnification hereunder. Notwithstanding the above, the Organization shall not indemnify the Indemnified Person in relation to matters as to which such Indemnified Person has been adjudged to have acted in bad faith or to have been liable or guilty by reason of willful misconduct in the performance of duty.

10.2 Determination. Any indemnification under Section 10.1 of this ARTICLE X shall be paid by the Organization in any specific case only after a determination that the Indemnified Person did not act in bad faith or was not liable or guilty by reason of willful misconduct in the performance of duty. Such determination shall be made (a) by the affirmative vote of a majority of a quorum of those Directors who are not or were not parties to the action, suit or proceeding out of which the liability or expense for which indemnification is to be determined arose, or against whom the claim out of which such liability or expense arose is not asserted ("Disinterested Directors"), (b) if a quorum cannot be obtained under clause (a) of this sentence, by the affirmative vote of a majority of a special committee duly designated by the Board and consisting solely of two or more Disinterested Directors (the "Determination Committee") or (c) by independent legal counsel selected by (i) the Board, in the manner prescribed in clause (a) of this sentence, (ii) the Determination Committee, in the manner prescribed in clause (b) of this sentence or (iii) the majority vote of all Directors, if a quorum of the Disinterested Directors cannot be obtained under clause (a) of this sentence and a Determination Committee cannot be designated under clause (b) of this sentence. The Board shall take all such action as may be necessary and appropriate to authorize the Organization to pay the indemnification required by this ARTICLE X, including without limitation, to the extent needed, making a good faith evaluation of the reasonable amount of indemnity due to such Indemnified Person.

10.3 Advanced Expenses. Expenses incurred by an Indemnified Person in defending a civil or criminal claim, action, suit or proceeding may, upon approval of a majority of the Disinterested Directors, even though less than a quorum, be paid by the Organization in advance of the final disposition of such claim, action, suit or proceeding, provided, however, that prior to such payment such Indemnified Person shall agree in writing to repay such amount to the Organization unless it is ultimately determined that he or she is entitled to be indemnified against such expenses by the Organization.

10.4 Reliance and Consideration. Any person who serves or has served in any of the capacities set forth in Section 10.1 of this Article X for or on behalf of the Organization shall be deemed to be doing or to have done so in reliance upon, and as consideration for, the right of indemnification provided herein. Such right shall inure to the benefit of the legal representatives of such person and shall not be exclusive of any other rights to which such person may be entitled apart from the provision of this Section 10.4. No amendment, modification or repeal of this Article XIII shall adversely affect the right of any Director or officer to indemnification hereunder with respect to any activities occurring prior to the time of such amendment, modification or repeal.

10.5 Insurance. The Organization may purchase and maintain insurance on behalf of its Directors and officers, former Directors and officers, employees and those persons who were serving at the request of the Organization in any capacity in another corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against such person and incurred by such person in any such capacity, or arising out of the person's status as such, whether or not the Organization would have the power to indemnify such person against such liability under the provisions of this ARTICLE X or otherwise. Any full or partial payment made by an insurance company under any insurance policy covering and made to or on behalf of an Indemnified Person will relieve the Organization of its liability for indemnification provided for in this ARTICLE X or otherwise to the extent of such payment, and no insurer will have a right of subrogation against the Organization with respect to such payment.

10.6 The indemnification provided in this ARTICLE X shall not be exclusive to or in lieu of any right to reimbursement for legal expenses and associated fees to which any Director, officer or agent is entitled under these Bylaws or under any other agreement.

ARTICLE XI
FISCAL YEAR

11.1 Fiscal Year. The fiscal year of the Organization shall begin on July 1 and end on June 30.

ARTICLE XII
SPECIAL CORPORATE ACTS

12.1 Execution of Written Instruments. Contracts, deeds, documents, and instruments shall be executed by the Chair, Vice Chair, or CEO, unless otherwise stipulated by the Board.

12.2 Legal Counsel. Legal counsel shall be selected and appointed by the Chair with the approval of the Board.

12.3 Voting Shares Held in Other Corporations. Unless otherwise directed by the Board, the CEO can vote, in person or by proxy, shares of stock issued by another corporation that are owned or otherwise controlled by the Organization.

12.4 Gifts. The Board may accept or decline on behalf of the Organization any contribution, gift, bequest, donation, or devise for the general purposes or for any qualified special purpose of the Organization.

12.5 Voting Delegates. The voting delegates to meetings of PPFA shall be the Chair, the Vice Chair, and the CEO, except as otherwise provided by the Board.

12.6 Confidentiality of Contributors List. The Organization may not, nor may it permit any employee, Director, or volunteer of the Organization to, lend, give, share or sell the Organization's contributors list to any other organization or person without the prior authorization of the Board; provided, however, that, with the approval of the CEO, the Organization may license the use of such lists to any nonprofit entity that it controls that has received tax-exempt designation under Section 501(c)(4) of the Code.

12.7 Sale of Investments. Any one of the Chair, Vice Chair, Secretary, Treasurer, or CEO is authorized to sell, assign, or transfer any and all stocks, bonds, evidences of interest and/or indebtedness, rights, and options to acquire or to sell the same, and all other securities, corporate or otherwise, listed in the name of or owned by PPSA (the "Investments") and to make, execute, and deliver any and all written instruments of assignment and transfer necessary or proper to effectuate the authority hereby conferred. The sale of any Investment must first be approved by the Board; provided, however that the sale of any Investment that the Organization receives as a gift shall not require prior approval of the Board so long as the sale of that Investment takes place within thirty days of the Organization's initial receipt of the Investment as a gift.

ARTICLE XIII
BOOKS AND RECORDS

13.1 The Organization shall keep correct and complete books and records of account and shall also keep minutes of the proceedings of the Board and committees having any of the authority of the Board. All books and records of the Organization may be inspected by any Director for any proper purpose at any reasonable time upon reasonable notice and request thereof.

ARTICLE XIV
DISSOLUTION/DISAFFILIATION

14.1 Upon the dissolution of the Corporation, and after all of its liabilities and obligations have been paid, satisfied, and discharged, or adequate provisions made therefor, all of the Corporation's remaining assets shall be distributed (a) to one or more organizations that are organized and operated exclusively for religious, charitable, scientific, or educational purposes within the meaning of section 501(c)(3) of the Code and that have purposes that are substantially similar to those of PPSA, or (b) if such an organization does not exist, to one or

more organizations that are organized and operated exclusively for religious, charitable, scientific, or educational purposes within the meaning of section 501(c)(3) of the Code.

14.2 In the event of disaffiliation with PPFA or a successor organization for any reason whatsoever, all requirements of the PPFA standards of affiliation in force at that time shall be complied with as to the disposition of medical records of health center patients, notification of patients, and discontinuation of the use of the name "Planned Parenthood."

ARTICLE XV
AMENDMENTS AND PROCEDURES

15.1 Amendments. These Bylaws may be amended only by the affirmative vote of two-thirds of the Directors at any regular or special meeting of the Board. A copy or summary of the proposed amendment(s) shall be provided to the Directors at least ten days prior to the meeting at which such amendment will be voted upon. The notice shall clearly state that the purpose, or one of the purposes, of the meeting is to consider an amendment to these Bylaws.

15.2 Procedures. For purposes of procedure, all meetings shall be governed by Roberts' Rules of Order (rev.). However, no action taken by the Board shall be deemed invalid, void or voidable because Roberts' Rules of Order were not followed when the action was taken.

ARTICLE XVI
REGULATORY REQUIREMENTS

16.1 Application. This ARTICLE XVI shall apply to all facilities wholly owned by PPSA in Virginia that are regulated as abortion facilities under Virginia law, including under 12 VA. ADMIN. CODE § 5-412-150 (2014) (hereinafter referred to as "Regulated Facilities").

16.2 Licensee. PPSA is the licensee for the Virginia facility licenses.

16.3 Governing Body. The Board shall be the governing body of each Regulated Facility and shall be responsible for the management and control of the operation of each Regulated Facility. The Board shall provide facilities, personnel, and other resources necessary to meet patient and program needs at the Regulated Facilities. The Board shall have such functions and duties as are set forth in this ARTICLE XVI or elsewhere in these Bylaws. The Board, as governing body, supervises the Administrator, who will ensure that proper policies directly related to the Regulated Facilities are in place and adhered to, including, but not limited to, Medical Standards and Guidelines, Personnel Policies, and Infection Control Policies and Procedures. The Board, as governing body, will inform the Office of Licensure and Certification (the "OLC") for the Virginia Department of Health of any change in the ownership of any of the Regulated Facilities.

16.4 Organizational Plan. These Bylaws constitute the formal organizational plan for the Regulated Facilities. The Board shall be responsible for formulating policies with respect to the Regulated Facilities, except to the extent that the authority to formulate such policies has been delegated to the CEO in these Bylaws or by resolutions adopted by the Board.

16.5 Administrator. The CEO shall serve as the administrator of each of the Regulated Facilities (the "Administrator"). The Vice President for Operations of PPSA shall be appointed to carry out the duties and responsibilities of the Administrator in the absence of the CEO. If at any time there shall be no person serving as the Vice President for Operations, such duties and responsibilities shall be carried out in the CEO's absence by an individual appointed in writing by the CEO, and approved by the Board, to carry out such responsibilities in the CEO's absence. Any reference to the CEO in this ARTICLE XVI shall be deemed to include any person serving as the CEO on an interim basis pursuant to a resolution adopted by the Board or a writing executed by the Chair or the Vice Chair. The Board shall promptly notify the OLC of any change in Administrator. Any other person appointed to serve as acting Administrator shall be approved by the Board, and the OLC shall be notified thereof. The Administrator shall have the duties and responsibilities set forth below and may delegate such duties to clinical staff members, including physicians and non-physician health care practitioners of the Regulated Facilities (collectively, the "Staff"):

(a) to hire, discharge, and supervise all employees of PPSA engaged in the operation of a Regulated Facility;

(b) to select and appoint the Staff;

(c) to determine the authority, duties, and responsibilities of the Staff;

(d) to develop, implement, and maintain an appropriate policy and procedures manual for the Regulated Facilities satisfying regulations promulgated by the Commonwealth of Virginia for the regulation of abortion facilities (the "Facilities Regulations"), which policies and procedures (i) shall be based upon standards and guidelines of PPFA and, where appropriate, other standards and guidelines recognized in the health care industry, and (ii) shall be reviewed annually and updated as necessary;

(e) to maintain Staff for each Regulated Facility that is adequately trained and capable of providing appropriate services and supervision to patients, which Staff shall be selected and supervised in accordance with the requirements of the Facilities Regulations; and

(f)) to ensure that the Regulated Facilities comply with the Facilities Regulations.

16.6 Qualifications of Administrator. The Administrator shall be an individual who is competent, in the determination of the Board, by reason of experience and talent, to (a) supervise the operation of the Regulated Facilities and the employees and Staff engaged in such operation, (b) produce appropriate policies and procedures regulating such operation, and (c) appropriately advise the Board with respect to the foregoing.

Exhibit B **Planned Parenthood South Atlantic**

POLICY CATEGORY	Patient Services	**EFFECTIVE DATE:**	7.12.16
SOP TITLE	Resident Policy and Procedures	**NUMBER OF PAGES:**	3
REPLACES POLICY(IES):			

I. Purpose

Planned Parenthood South Atlantic (PPSAT) supports the training of future abortion providers to ensure that women will continue to have access to quality, compassionate abortion care.

To that end, PPSAT enters into agreements with institutions that provide graduate medical education programs, hereinafter referred to as "home institution(s)". Through these arrangements, PPSAT works with home institutions to afford residents opportunities for hands-on training in family planning and elective abortion care at PPSAT health centers.

II. Definitions

III. Procedures

A. Summary of the Residency Experience at PPSAT

Residents are typically employees of the home institution and are not employees of PPSAT. Their general scope of practice is established by the home institution. As part of the home institution's residency program, residents are given the opportunity to do a short-term clinical rotation at PPSAT. The length of the PPSAT clinical rotation may vary, but typically lasts one month. In their training capacity, the residents are not a part of PPSAT's clinical staff or subject to PPSAT's policies and procedures on clinical staff selection, appointment and clinical privileges. Residents do not function independently within the clinic; all care they provide is under the direct supervision of a fully trained, onboarded, and credentialed physician.

B. Resident Qualifications and Evaluations

Residents' credentials are validated by the home institution prior to residents' arrival at PPSAT. Background checks and health requirements are also completed and maintained by the home institution and all such credentialing and background check information is made available to and reviewed by PPSAT on an as-needed basis. The home institution is responsible for verifying that all residents meet all necessary credentialing and licensure requirements throughout their clinical rotation at PPSAT.

POLICY CATEGORY	Patient Services	EFFECTIVE DATE:	7.12.16
SOP TITLE	Resident Policy and Procedures	NUMBER OF PAGES:	3
REPLACES POLICY(IES):			

The home institution is also responsible for maintaining a file for each resident that includes credentialing and privileging information. PPSAT has access to each resident's file on an as-needed basis. The home institution will promptly notify PPSAT of any issues pertaining to a resident's credentialing status or other eligibility to participate in the clinical rotation that arise while the resident is completing a clinical rotation at PPSAT.

The home institution is responsible for reviewing the clinical competence of each resident on a systematic basis and rating them on the milestones promulgated by the Accreditation Council for Graduate Medical Education. Prior to starting a clinical rotation at PPSAT, most residents are PGY2 or later in their training and possess an established skill set prior to arrival at PPSAT. Generally, they have experience in, and may be privileged to perform, colposcopy; IUD and implant insertion and removal; ultrasound for pregnancy dating; and D&C/D&E procedures. PPSAT does not have a minimum prior experience requirement for starting a rotation at one of our health centers. Rather, the individual supervising physician(s) will assess the skills of the resident and determine the appropriate level of involvement they may have in performing procedures.

All residents complete required PPFA onboarding activities for medical trainees via the Students' & Trainees' Abbreviated Resources Training (START) Manual. PPSAT keeps copies of START Verification and HIPAA Security and Compliance training in each resident's file on site.

At the end of a clinical rotation, the supervising physician completes an evaluation of the resident's performance at the request of the residency program. This evaluation is maintained as part of the residents training file at the home institution, but is available to PPSAT upon request/as necessary.

C. Supervision of Residents

All residents work under the direct supervision and license of a supervising physician. The supervising physician is present in the room, directly supervising all abortion care provided by the resident physician. PPSAT shall comply with applicable state and federal requirements in providing appropriate supervision of residents.

D. Resident Responsibilities and Expectations

During clinical rotations, the residents must meet certain learning objectives with regard to patient care and medical knowledge, professionalism and communication skills, practice-based learning and improvement, and systems-based practice. Under the supervision of a PPSAT physician, residents' responsibilities may include:

- Counseling patients on reversible and permanent contraceptive methods appropriate to their medical and social circumstances;

POLICY CATEGORY	Patient Services	**EFFECTIVE DATE:**	7.12.16
SOP TITLE	Resident Policy and Procedures	**NUMBER OF PAGES:**	3
REPLACES POLICY(IES):			

- Counseling women with unwanted pregnancies, STD risk behavior, and sexual complaints;
- Counseling for and providing medication abortion;
- Exposure to and/or performance of family planning office procedures, including outpatient surgical abortion and LARC insertion/removal;
- Assessing gestational age using pelvic exam and ultrasound;
- Identifying products of conception;
- Routine abortion aftercare including contraceptive provision;
- Assessing and managing emergency situations and complications related to out-patient termination of pregnancy;

Residents must meet the following expectations during their clinical rotation at PPSAT:

- Attend and be punctual for all sessions, except for excused absences of which PPSAT is notified;
- Maintain professional behavior at all times;
- Complete the residency program's learning and education objectives;
- Document hours worked and procedures performed as required by home institution.

E. Patient Consent

PPSAT's standard medical and surgical consent forms contain language informing clients that it is a teaching facility and that medical trainees may be involved in the provision of care. Additionally, when residents are on site, patients are verbally informed of their presence and provided the option to allow or decline a resident's participation in their procedure.

F. Documentation

Resident involvement in abortion services is recorded in the patient's medical record as follows and as indicated:

- when resident performs limited portions of the service: "assisted by resident physician Dr. Smith"
- when resident performs significant portions or all of the service: "procedure performed by resident physician Dr. Smith under my direct supervision"

G. Billing

Services performed by a resident are billed in accordance with the terms of applicable third party payer contracts. Otherwise, as a general rule, PPSAT follows CMS guidelines, which provide for the billing of services under the teaching/supervising physician when that provider is physically

POLICY CATEGORY	Patient Services	**EFFECTIVE DATE:**	7.12.16
SOP TITLE	Resident Policy and Procedures	**NUMBER OF PAGES:**	3
REPLACES POLICY(IES):			

present during the critical or key portions of the services that are furnished by the resident.

Related Policies: PPSAT Resident Onboarding Policy

Prepared by: Amanda Ohira

Approved by: Chief Executive Officer: Jenny Black

Affiliate Medical Director: Katherine Farris, MD

Vice President of Patient Services

Original Date: 7.12.16

Reviewed Date:

Revised Date:

Exhibit C

PPSAT AFFILIATE REQUIRED TRAINING CALENDAR 2016-17

Month	Training Topic	Training Audience
July	Annual OSHA/Infection Prevention Shock Armed Intruder*every 60 days	Anyone who works in the Health Center Health Center Staff All Staff
August	TB Screening and Health Assessment Annual Competencies Hemorrhage, Hypovolemic Shock, Hypotension Chemical Attack	Anyone who works in the Health Center Health Center Staff All Staff
September	Seizure Fire Drills: VA quarterly; SC AB sites quarterly; all other sites 2x/year	Health Center Staff All Staff
October	Annual HIPAA Security & Privacy Annual Compliance/Code of Conduct Training Health Center Case Study Robbery	All Job Functions All Staff Health Center Staff All Staff
November	Annual Performance Evaluations Annual Job Descriptions Annual Clinical Assessments CPR Certification Syncopy, client collapse Invasion/blockage	All Job Functions Anyone who works in the Health Center Health Center Staff All Staff
December	Annual Performance Evaluations Annual Job Descriptions Annual Clinical Assessments Health Center Case Study Power Failure	All Job Functions Health Center Staff All Staff
January	Training Catch Up Month Vagal response Disaster Recovery Plan	All Job Functions Health Center Staff All Staff
February	TB Screening and Health Assessment Annual Competencies Health Center Case Study Confidentiality Policies, Suspicious Encounters, telephone precautions	Anyone who works in the Health Center Health Center Staff All Staff
March	Respiratory Depression Fire Drills: VA quarterly; SC AB sites quarterly; all other sites 2x/year	Health Center Staff All Staff
April	Anaphylaxix Review of Evacuation Plan	Health Center Staff All Staff
May	Training Catch Up Month Allergic Reaction Bomb Threat	All Job Functions Health Center Staff All Staff
June	Annual Mandatory Reporting MS&Gs Protocol Changes	All Job Functions Health Center Staff

Exhibit C

	Cardiopulmonary Arrest Hostile Intruder	All Staff

Exhibit D

Educational Letter of Agreement between Carilion Clinic – Virginia Tech Carilion School of Medicine Ob/Gyn Residency Program and Planned Parenthood Health Systems, Inc. at the Roanoke Health Center – GYN Rotation

Preamble:

This Educational Letter of Agreement between Carilion Clinic – Virginia Tech Carilion School of Medicine (also called Carilion Medical Center) and Planned Parenthood Health Systems, Inc. exists to delineate the roles and responsibilities of each party for the provision of resident education in the OB/GYN Residency Program sponsored by Carilion Medical Center.

Accreditation:

All sponsoring and participating hospitals must be accredited by the Joint Commission or accredited by another entity with reasonably equivalent standards as determined by the ACGME Institutional Review Committee (IRC). Non-hospital settings, such as nursing homes, institutions of higher learning, etc. must be recognized or accredited by appropriate regulatory bodies with reasonably equivalent standards, as determined by the IRC. Planned Parenthood Health Systems, Inc. agrees to have accreditation documentation on file and available.

Carilion Medical Center assures compliance with the institutional requirements outlined in the Essentials of Accredited Residencies required by the Accreditation Council for Graduate Medical Education (ACGME). Carilion Medical Center has received and maintains full institutional accreditation from the ACGME. A copy of the letter of accreditation is available in the Carilion Medical Center Office of Medical Education. The OB/GYN Residency Program is fully accredited by the ACGME. Letters of accreditation are available in the Carilion Medical Center's Office of Academic Affairs.

Responsible Officials:

The Carilion Medical Center and Planned Parenthood Health Systems, Inc. must identify faculty who will assume administrative, educational and supervisory responsibilities for the Carilion Medical Center residents while participating in an assigned educational rotation at the Planned Parenthood Roanoke Health Center. The following Carilion Medical Center officials are responsible for oversight of this Agreement:

Exhibit D

CCVTC OB/GYN Residency ELA with Planned Parenthood Health Systems, Inc.

Carilion Medical Center P.O. Box 13367 Roanoke, VA 24033		
Name	**Title**	**Telephone Number**
Donald W. Kees, M.D.	DIO	540-981-8385
Richard Butler, D.O.	Director, Osteopathic Medical Education	540-981-8385
Patrice Weiss, M.D.	Chair of OB/GYN, OB/GYN Residency	540-853-0417
Eduardo Lara-Torre, M.D.	Program Director, OB/GYN Residency	540-266-6349

The following faculty are responsible for the education, supervision, and evaluation of the residents/fellows while assigned to the educational rotation at the Planned Parenthood Roanoke Health Center:

Planned Parenthood Health Systems, Inc. Roanoke Health Center Roanoke, VA 24017		
Name	**Title**	**Telephone Number**
Christopher Marengo, MD	Clinic Director	540-562-3457
Elizabeth Swallow, MD	Faculty	540-562-3457
Randall Falls, MD	Supervising Faculty Responsible to Program	540-562-3457
Ann Logan Bass, NP	Advanced Clinical Practitioner	540-562-3457
Noelani Hall	Site Coordinator	540-562-3457

Responsibilities of Carilion Medical Center:

1. Program Director: Carilion Medical Center will appoint a single Program Director who is responsible for the development, coordination and administration of all phases of the OB/GYN Residency Program as outlined in the ACGME Requirements for Residency. The Program Director will ensure integrity of the educational program at Planned Parenthood Roanoke Health Center.

2. Carilion Medical Center will continue to pay the resident's salary and fringe benefits while the resident is assigned to the Planned Parenthood Roanoke Health Center.

3. The Carilion Medical Center shall maintain in effect, during the term of this Agreement and any extension, limits: (i) the per claim limit shall be equal to or greater than the damage cap for medical malpractice claims against physicians in the Commonwealth of Virginia, as increased from time to time by Va. Code § professional liability insurance coverage for residents assigned to work at the Facility with the following 8.01-581.15; (ii) the annual aggregate limit shall be equal to or greater than three (3) times the damage cap for medical malpractice claims against physicians in the Commonwealth of Virginia, as increased from time to time by Va. Code § 8.01-581.15. If Carilion Medical Center maintains professional liability coverage under a claims made policy of insurance, Carilion Medical Center shall also provide "tail" insurance coverage upon termination of this Agreement extending to all periods during which residents were assigned to Facility pursuant to this Agreement. The Carilion Medical Center shall also

maintain, during the term of this Agreement and any extension, general liability coverage in the amount of one million dollars.

4. Evaluation:

   a. The Program Director will provide Planned Parenthood Health Systems, Inc. with forms to be utilized by the supervising faculty to evaluate residents'/fellows' performance and competency.
   b. The Program Director will provide Planned Parenthood Health Systems, Inc. with results of residents'/fellows' evaluation of the faculty at the Roanoke Health Center.

5. Content of the Educational Experience:

   a. The Program Director, in collaboration with the Planned Parenthood faculty and site director, will define the educational content of the educational experience consistent with ACGME Program, Common Program and Institutional Requirements.
   b. The goals and objectives for the rotation (See Attachment 1) will be sent to the site director who will be responsible for distribution to the faculty at the site.
   c. The residents will be provided copies of the goals and objectives for the educational experience prior to the start of the rotation.

6. Policies and Procedures governing resident/fellow education at the Planned Parenthood Roanoke Health Center:

   a. Residents' credentials and appointments will have been validated by the OB/GYN Residency Program through the Resident Credentials Verification Letter (RCLV) or Trainee Qualifications and Credentials Verification Letter (TQCVL).
   b. Residents and faculty at the Planned Parenthood Roanoke Health Center are under the general direction of the Carilion Clinic Graduate Medical Education Committee (GMEC). Residents and faculty must adhere to the policies and procedures in the Medical Education Policy and Procedure Manual and the OB/GYN Residency Program's Policy and Procedure.
   c. Residents assigned to the Planned Parenthood Roanoke Health Center must strictly adhere to the Duty Hours Policy (Attachment 2). Residents will be required to log all duty hours while at the Planned Parenthood Roanoke Health Center.
   d. The Program Director is responsible for communicating the GMEC policy and procedures to the Planned Parenthood site director and faculty.
   e. The Program Director is responsible for annual site visits to assure the educational program and rules and regulations are adhered to.
   f. Additionally, residents must comply with all rules and regulations required by Planned Parenthood Health Systems, Inc.

7. Duration of the Assignment:

   a. The OB/GYN residents are currently scheduled to attend the Planned Parenthood GYN rotation for one month. Residents assigned to these activities may change based on the needs of the program and the Administrative Chief resident, in communication with the program director who makes final assignments for each training block.
   b. Planned Parenthood Health Systems, Inc. must approve the assignment of all residents and has the right to refuse any assignment.

Responsibilities of Planned Parenthood Health Systems, Inc.

1. Teaching:
   a Curriculum – The goals and objectives of the educational experience have been developed by the Program Director and the residency education committee in accordance with the ACGME OB/GYN Residency Program Requirements.
   b In cooperation with the Program Director, the Site Director and faculty at the Planned Parenthood Roanoke Health Center are responsible for the day to day activities of the residents/fellows to ensure that the stated goals and objectives are met during the course of the educational experiences at the Planned Parenthood Roanoke Health Center.

2. Supervision:

   a The faculty must provide appropriate supervision of the residents in patient care activities and will maintain a learning environment conducive to educating the residents in the ACGME six areas of competency.
   b The Program Director of the residency supervises the activities of the faculty in carrying out the mission of the residency and will coordinate all activities with the Planned Parenthood Site Director and will report to the OB/GYN Residency Education Committee.

3. Responsibilities of Educational Site Director at Planned Parenthood Roanoke Health Center:

   a The Site Director is responsible for day-to-day supervision and oversight of resident/fellow activities, and ensuring adequate number of approved teaching staff (attendings). This includes such activities as daily and team scheduling, evaluations, conflict resolution, conferences, sick leave, etc.
   b The Site Director will also ensure ACGME based curriculum objectives are met during the training period.

4. Evaluation:

   a. Faculty physicians who have had direct supervisory contact with the assigned residents/fellows will complete a written evaluation at the completion of the educational assignment.

b. The residents/fellows will complete a written evaluation on the teaching physician(s) who has provided direct supervision over the course of the educational assignment.
c. Evaluations will be completed in a timely fashion.
d. Written evaluations will become part of the permanent educational record of the resident/fellow.

5. Patient Care: Planned Parenthood Health Systems, Inc. retains full responsibility for the care of patients, including all administrative and professional functions pertaining hereto.

6. Orientation: Planned Parenthood Health Systems, Inc. will provide the assigned residents/fellows with an orientation to the facility and pertinent clinical policies and procedures.

Term and Termination

1. This Letter of Agreement is effective March 10, 2014 and shall remain in effect for a period of five (5) years unless updated, appended, or terminated by either party upon ninety (90) days written notice. If Planned Parenthood Health Systems, Inc. terminates this Agreement, the termination will not be effective until the later of the assigned resident(s) completion of the clinical rotation or the expiration of the ninety (90) days written notice. This agreement will be reviewed annually by all parties. The assignment of residents will be updated on an annual basis.

2. Any notice provided pursuant to this Agreement will be hand delivered or mailed to the respective party at the address listed in this Agreement.

3. This Agreement will be governed and interpreted by the laws of the Commonwealth of Virginia.

4. The parties agree to comply with applicable laws, regulations, rulings, and standards and amendments thereto, of all entities that regulate, license, govern and/or accredit the parties, including, but not limited to, federal, state and local governmental entities.

Indemnification

Each party hereto (as the "Indemnifying Party") agrees to indemnify and hold harmless the other party (as the "Indemnified Party") and its directors, officers, employees and agents from and against any losses, judgments, claims, costs, expenses (including reasonable attorney's fees), liabilities, or damages (collectively "Losses") asserted against the Indemnified Party by a third party and resulting from the Indemnifying Party's breach of its obligations under this Agreement or the negligent act or omission of the Indemnifying Party or its directors, offices, employees or agents in connection with this Agreement.

Exhibit D

CCVTC OB/GYN Residency ELA with Planned Parenthood Health Systems, Inc.

Donald W. Kees, M.D. 3-7-14 Date
Designated Institutional Official
Carilion Clinic

Eduardo Lara-Torre, M.D. 3/7/14 Date
Program Director, OB/GYN
Residency
Carilion Medical Center

Elaine Pleasants, M.D. Date
Vice President
Planned Parenthood Health Systems, Inc.

Katherine Farris, M.D. 3/7/14 Date
Interim Affiliate Medical Director
Planned Parenthood Health Systems, Inc.

September 16, 2013

ATTACHMENT 1

Planned Parenthood Goals and Objectives

Learning Objectives: This rotation is designed to teach you the fundamentals of providing comprehensive family planning and elective abortion services to patients. You will learn to serve as a consultant for incorporating caring behavior, skilled interviews and informed counseling. You will also improve your clinical skills in office procedures, pain management during office procedures and pelvic ultrasound.

Patient Care and Medical Knowledge
- Counsel for reversible and permanent contraceptive methods appropriate to patients' medical and social circumstances.
- Counsel women with unwanted pregnancies, STD risk behavior, and sexual complaints.
- Counsel for and provide medication abortion.
- Become competent in family planning office procedures including:
  - First trimester electric vacuum aspirations under local anesthesia.
- Consistently and accurately assess gestational age using pelvic exam and ultrasound.
- Consistently and accurately identify products of conception.
- Become competent at providing pain management for office procedures
- Provide routine abortion aftercare including contraceptive provision.
- Be able to assess and manage emergency situations and complications related to first trimester termination of pregnancy.

Professionalism and Communication Skills:
- Practice medicine guided by honesty and ethics.
- Provide compassionate care to address patients' and families' concerns respectfully and effectively.
- Maintain confidentiality
- Obtain appropriate informed consent for procedures.
- Interact professionally with all members of the health care team.

Practice-Based Learning and Improvement:
- Give non-directed alternatives counseling and identify women who are ready to make a decision and those who need more formal counseling.
- Demonstrate awareness of agencies in the community that can provide further assistance for help with prenatal care or adoption.

Systems-Based Practice:
- Practice cost-effective care with knowledge of practice systems and community support systems while advocating for your patients within the health system.
- Understand how legal, social, financial and ethical considerations effect the provision of care to women, especially relating to reproductive health care.
- Highlight systems to ensure patient safety.

How Learning Objectives are measured
End of block evaluation to be completed by site director and selected staff members

Expectations
Attendance and punctuality for all sessions which may include Saturdays
Professional behavior at all times
Completion of the learning and educational objectives listed above
Record all hours worked
Record all surgical procedures in Op Log

ATTACHMENT 2

CARILION CLINIC MEDICAL EDUCATION POLICY
DEPARTMENT OF OB/GYN

DUTY HOURS AND FATIGUE

EFFECTIVE DATE:	DATE REVISED:	REV. #:	PAGE:	OF:
JULY 1998	January 2014	3	1	3

Policy Statement

Duty hours and working conditions have a direct relationship to optimal resident education and quality patient care. Carilion Clinic supports working conditions that promote education and patient care and assure that undue stress and fatigue among residents are avoided.

Conditions

The Carilion OB/GYN Residency Program assures that duty hours and working conditions comply with requirements described by the RRCs for OB/GYN of the ACGME and the AOA:

1. Residents should have on average at least one day out of seven free of routine responsibilities during each four week rotation.

2. Residents are not to be on call more often than every fourth night averaged over four weeks.

3. Duties hours and on call schedules are based on educational rationale and continuity of care.

4. The GMEC will discuss duty hours and working conditions at least monthly.

5. This policy applies to Carilion OB/GYN residents when they are on rotations at Carilion Medical Center and at Planned parenthood.

6. Residents are not to work more than 80 hours per week averaged over four weeks.

7. Residents should have 10 hours between shifts and must have 8.

8. Interns cannot work more than a 16 hour shift without a shift break.

9. Any resident who moonlights will report all work hours to the OB/GYN program director. Moonlighting hours worked are added to residency hours and may not be more than 80 hours per week.

10. The program monitors all rotations to be sure each rotation is in compliance.

11. Any resident physician who believes he or she is too fatigued (see appendix A) to safely and appropriately evaluate and treat patients will contact the OB/GYN Chief Medical Residents, the attending faculty or the Program Director. If the program director or the senior staff attending agrees that this resident should be removed from service, he or she will make arrangements for alternative coverage of duties (ward, clinic or call).

12. There will be no academic repercussions for taking time out due to fatigue if agreed by the program director or attending faculty.

13. OB/GYN residents and faculty will undergo yearly training aimed at helping them recognize the signs of fatigue as well as learning measures to combat fatigue and procedures to remove themselves from patient care duties if necessary. Faculty, staff and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract the potential negative effects.

14. If a resident feels that he or she may be at risk when operating a motor vehicle because of fatigue or sleep deprivation, he/she should obtain sleep at the on site call room before departing the premises, ask for a cab voucher from GME, or ask someone to take them home.

15. All other duty hours from the GMEC Duty hours apply to our program as well.

Monitoring

The residents complete a weekly log in MedHub detailing their hours of work, on call hours and any moonlighting hours. This is reviewed and monitored by the program director and the DIO weekly.

Review

The policy will be discussed in faculty meetings on a regular basis and the Program Director will report to the GMEC. The GMEC will review compliance with policies related to duty hours on a regular basis.

Appendix A:

Fatigue: Temporary loss of strength or energy resulting from hard work or mental work

Signs:
Impaired ability to function
Increased sensitivity to light and noise
Difficulty concentrating
Irritability

Confusion
Loss of patience
Deteriorating interpersonal skills

Preventing and Reducing Fatigue:
Good night rest the night before taking call
Try taking a brief nap before taking evening call
Try to take a micro nap during the night
Drink cold water frequently while awake
Take frequent breaks while awake during the night and get some fresh air
Avoid over-socializing with colleagues when on-call in the middle of the night – get your work done and go back to bed.

Exhibit E

PPSAT 2016 Annual Compliance and Risk /Quality Management Work Plan

Department	Reference/ Source*	Time Frame	Responsible Staff	Due Date	Completion Date
Medical chart audits related to AB services					
PUL (Inconclusive Ultrasound) audit	PPFA; ARMS	Annually, or as indicated	RLC	Jan-March 2016	completed 4-6-16
STI Management audit	ARMS	Annually, or as indicated	RLC	5/16 **Re-Audit**	Re-audit completed 6-16-16.
SAB audit	ARMS	Annually, or as indicated	RLC	10/16 (review charts from 1/1/16)	completed 11/2015
MAB audit	ARMS	Annually, or as indicated	RLC	10/16 (review charts from 1/1/16)	completed 11/2015

Exhibit F

2015 2-4th & 2016 1st quaraters

Procedure/Type of Complication

SAB

	RKE Physician A total	%
Total SAB	254	
Minor Infection	0	0.00%
Serious Infection	0	0.00%

MAB

	RKE Physician A total	%
Total MAB	232	
Serious Infection	0	0.00%
Minor Infection	0	0.00%