


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  008137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/17/2011
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NAME OF PROVIDER OR SUPPLIER  WHOLE WOMANS HEALTH OF BEAUMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 440 18TH ST STE A BEAUMONT, TX 77703
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A 000	<p>TAC 139 Initial Comments</p> <p>Note: The State Form is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be referred to the Office of the Texas Attorney General (OAG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.</p> <p>An on-site unannounced survey was conducted on 11/15/2011 to determine the facility's compliance with the requirements of the Abortion Facility Reporting and Licensing Rules. An entrance conference was conducted with the Administrator on 11/15/2011 at 2:00 PM in the Administrator's office. The purpose and process of the survey was explained and an opportunity was provided for questions and discussion.</p> <p>An exit conference was held in the waiting area of the clinic on 11/17/2010 at 9:00 AM with the Administrator. The preliminary findings of the survey and the next steps in the survey process were explained. An opportunity was provided for questions and discussion.</p>	A 000		
A 12		A 12		

S00 - State Form

LABORATORY DIRECTOR OF MEDICAL SERVICES  
STATE FORM



TITLE: DIRECTOR OF MEDICAL SERVICES

OU7011

(X6) DATE

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A 125	Continued From page 1 	A 125	A125 	



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A 247	<p>139.44(c) Orientation, Training, Competency</p> <p>(c) The facility shall ensure that staff responsible for sterilization of critical surgical instruments are trained by the facility to meet the requirements of §139.49(d) of this title (relating to Infection Control Standards) and demonstrate competency in performing the sterilization procedures at the facility.</p> <p>This Requirement is not met as evidenced by: Based on demonstration and interview the facility failed to ensure the staff was trained in sterilization process of surgical instruments.</p> <p>During the demonstration by staff #2 when using peel pouches (a type of package used for sterile instruments that is sealed with a peel away adhesive seal) revealed staff #2 did not know the proper technique for the use of the peel pouch. When staff #2 sealed the sterile package she left a open area in the package.</p> <p>On touring the sterilization area where sterile instruments are kept, found eight (8) peel pouches sealed and sterilized with open areas still present in the sterile package. Opened a wrapped sterilized instrument and found no sterilization indicator in the package. Staff #2 did not know what a sterilization indicator was or what it is used for in the sterilization process.</p> <p>An interview with staff # 2 on 11/16/2011 at 4:00 PM, asked the surveyor to demonstrate the proper technique on how to seal the packages. An interview with the Administrator on 11/16/2011 at 4:30 PM, confirmed there were no sterilization indicators in the facility.</p>	A 247	<p>The Clinic Administrator will be responsible for ensuring all personnel involved in Decontamination and Sterilization Processes will complete the Orientation and Training Checklists, as well as demonstrate accurate competency. (See procedure attached)</p> <p>A staff Re-Training and Re-Orientation of all personnel involved in infection control practices will be facilitated by 02-10-12. This training will include a thorough review of WWH Sterilization and Decontamination practices, and explanation of the importance of sterilization indicators in all surgical pack and instruments. All instruments will be re-sterilized following the proper methods of Decontamination and sterilization.</p> <p>The Clinic Administrator will be responsible for ensuring all Decontamination and Sterilization practices are being followed accurately by inspecting all surgical packs and pouches on a weekly basis for a period of 90 days if no deviations are found during this evaluation period. The Director of Medical Services will assess competency of the Administrator as well as all staff involved in Infection Control Practices during QA Visits.</p>	02-10-12

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A 252 Continued From page 3



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		A 253	A261 The Clinic Administrator will ensure all staffing requirements are met, including an LVN or RN as part of Direct Patient Care Staff.  As outlined in the Texas Administrative Code, Title 25, Chapter 139, Subchapter D, and Section 139.46 (3) Direct Patient Care (B) Nursing Staff. Whole Woman's Health has always been compliant with our staffing and nursing coverage. During the time in question WWH contracted the services of a nursing agency in order to satisfy the nursing requirements by having an LVN at the facility during direct patient care hrs. In addition to having a contract with a nursing agency, An LVN was hired on 11-18-11, her Orientation documents, Trainings, Competencies, and Vaccinations have been initiated and are been kept in her personnel file.	02-10-12
A 261	139.46(3)(B) Staffing Requirements  (3) Direct patient care staff. (B) Nursing staff. The nursing staff shall include a registered nurse(s) or a licensed vocational nurse(s).  This Requirement is not met as evidenced by: Based on record review and interview the facility failed to staff the clinic with a registered nurse(s) or a licensed vocational nurse(s).  Review of staffing record and personnel records revealed no full time licensed nurse in the facility. Record review revealed a contract agency nurse	A 261	The Administrator will monitor the completion of nursing staff hiring and training process. Including orientation and training of agency nurses.	

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A 261	Continued From page 5 was being staffed part time in the facility. In reviewing agency nurse's personnel file it was revealed the facility failed to orientate the agency nurse to the abortion facility.  An interview with the agency nurse on 11/16/2011 at 5:00 PM, confirmed she worked there part time. She stated "I work for a hospital in Houston thru the agency".  An interview with staff #1 (Administrator) on 11/16/2011 at 5:30 PM, confirmed the full time nurse last day worked in the facility was November 3, 2011.	A 261		
A 274	139.47(b)(6) Facility Administration  (b) The administrator shall: (6) ensure that staff receive training, education, and orientation to their specific job description, facility personnel policies, philosophy, and emergency procedures in accordance with this section;  This Requirement is not met as evidenced by: Based on record review and interview the facility administration failed to ensure staff received training, education, and orientation to their specific job description.  A review of the agency nurse's personnel file revealed no documentation the facility administration had orientated the agency nurse to the abortion facility.  An interview with staff #1 (Administrator) on 11/16/2011 at 5:30 PM, confirmed the personnel file of the agency nurse contained no documentation the facility had oriented the	A 274	A274  The Administrator will be responsible for ensuring all staff receives training, education, and orientation to their specific job description, facility personnel policies, philosophy, and emergency procedures.  The Director of Medical Services has reviewed Administrative responsibilities with the Clinic Administrator to ensure proper follow through of Company Policies. All personnel records, orientation, and proof of follow through of company policies regarding Personnel Records will be completed by 02-10-12, this procedure will also be followed for per diem, agency, and temporary staff.  The Administrator will monitor all personnel records in a monthly basis in order to ensure proper maintenance.	02-10-12



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A 274	Continued From page 8 agency nurse to the Abortion facility.	A 274		
A 283	139.48(1)(A) Physical & Environmental Requirements  The physical and environmental requirements for a licensed abortion facility are as follows: (1) A facility shall: (A) have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients and staff at all times;  This Requirement is not met as evidenced by: Based on observation and interview the facility failed to provide a safe and sanitary environment.  Findings Included:  During the tour of the facility on 11/15/2011 at 3:00 PM observed in exam room #1 there was a sign on the bed written it was broken. The bed remained broken during the survey. When questioned the Administrator, she stated someone was to suppose to come fix the bed.  During the tour of the facility on 11/15/2011 at 3:20 PM observed in the procedure room #2 there was a drain in the middle of the room, but the cover was loose and caused a hole to be in the floor right in front of the patient's bed.  During the tour of the facility on 11/15/2011 at 3:20 PM observed in the procedure room #2 there was numerous rusty spots on the suction machine used on the patient for evacuation of the products of conception.  During the tour of the facility on 11/15/2011 at	A 283	A283  The Clinic Administrator will ensure the facility's physical and environmental requirements are followed.  It is not unusual for office and medical equipment to suffer damage due to the wear and tear of regular use and repairs are undertaken promptly at WWH. The broken exam table found on exam room #1 was not available for patients until completely repaired and did not affect patient safety in the clinic. The clinic had 2 other exam rooms available for patient care, without hindering the patient's safety at any point. At this point, the exam table has been completely repaired and it is now available for patient care.  The loose cover on the drain on Procedure room #2 will be repaired, as well as the rusted spots on the suction machines. These repairs will be completed by 02-10-12. The Administrator will contract with a medical cleaning company to clean, and buff the floors to address the rust stains that are a natural result of metal equipment seating	



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A 283	Continued From page 7 3:00 PM observed the facility's floor were stained and discolored which gives the appearance of being dirty.  During the tour of the facility on 11/15/2011 at 3:00 PM observed the three facility's fire extinguishes were last inspection on March of 2010.  During the tour of the facility on 11/15/2011 at 3:00 PM observed no postings of a plan to evacuate the building in case of a disaster.  An interview with the administrator on 11/15/2011 at 4:00 PM confirmed the bed was broken in room #1, there was a hole in the In procedure room #2, the floors were stained, and the evacuation plan of the building was not posted for the safety of the patients and employees.	A 283	on vinyl floors throughout the clinic. A fire extinguisher company will be contacted in order to inspect all fire extinguishers for proper functioning.  The Administrator will post the emergency evacuation plan throughout the clinic, and will offer a staff training to ensure all personnel is aware of proper emergency evacuation procedure.  The Administrator will ensure all equipment it's in optimal functioning and complaint with physical and environmental requirements in order to provide a safe environment for patients.	02-10-12
A 284	139.48(1)(B) Physical & Environmental Requirements  The physical and environmental requirements for a licensed abortion facility are as follows: (1) A facility shall: (B) equip each procedure room so that procedures can be performed in a manner that assures the physical safety of all individuals in the area;  This Requirement is not met as evidenced by: Based on observation and interview the facility failed to provide safe equipment in the patient's procedure rooms.  Findings included:  During the tour of the facility on 11/15/2011 at	A 284	A284  See correction for A283	



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A 284	Continued From page 8  3:00 PM observed in exam room #1 there was a sign on the bed written it was broken. The bed remained broken during the survey. When questioned the Administrator, she stated "someone was to suppose to come fix the bed".  During the tour of the facility on 11/15/2011 at 3:20 PM observed in the procedure room #2 there was numerous rusty spots on the suction machine used on the patient for evacuation of the products of conception.  An interview with the administrator on 11/15/2011 at 4:00 PM confirmed the bed was broken in room #1, and there were numerous rusty spots on the suction machine used on patients for evacuation of the products of conception.	A 284		
A 286	139.48(1)(D) Physical & Environmental Requirements  The physical and environmental requirements for a licensed abortion facility are as follows. (1) A facility shall: (D) have a written protocol for emergency evacuation for fire and other disasters tailored to the facility's geographic location. Each staff member employed by or under contract with the facility shall be able to demonstrate their role or responsibility to implement the facility's emergency evacuation protocol required by this subparagraph;  This Requirement is not met as evidenced by: Based on record review and interview the facility failed to conduct and follow the facility's policy on fire and/or disaster drills for evacuation of patients and staff in the facility.	A 286	A286  The Clinic Administrator will be responsible for ensuring all staff is properly trained on the facilities emergency evacuation plan (See Attached)  A staff in service will be facilitated by 02-10-12 in order to train the staff on the Facility's Emergency evacuation plan (Fire, and Natural Disasters)  The Clinic Administrator will ensure an annual Emergency Evacuation Drill has been completed, and documented.	02-10-12



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A 286	<p>Continued From page 9</p> <p>Review of record titled "Fire Safety" revealed "It is the policy of this facility to conduct a fire drill or handle a fire in such a manners to preserve lives, prevent undue panic, and control the spread of fire. Each employee will be aware of fire exits, fire extinguishes, the proper procedure for ensuring fire safety, and the steps to be taken in case of fire. It is not the intent of this policy that any staff member endangers him/herself; rather, the intent is to ensure the safety both staff and patients."</p> <p>Review of facility records found no evidence of that fire and/or disaster drills had been conducted.</p> <p>An interview with staff #1 (Administrator) on 11/16/2011 at 5:00 PM, confirmed no drills had been conducted in the facility in the last year.</p>	A 286		
A 306	<p>139.49(d) Infection Control Standards</p> <p>(d) Policies and procedures for decontamination, disinfection, sterilization, and storage of sterile supplies. A licensed abortion facility shall have written policies covering the procedures for the decontamination and sterilization activities performed. Policies shall include, but not be limited to, the receiving, cleaning, decontaminating, disinfecting, preparing and sterilization of critical items (reusable items), as well as those for the assembly, wrapping, storage, distribution, and the monitoring and control of sterile items and equipment.</p> <p>This Requirement is not met as evidenced by: Based on observation and interview the facility's staff failed to monitor the expiration dates on sterile supplies.</p>	A 306	<p>A306</p> <p>The Clinic Administrator will be responsible for the accurate follow through of the company's infection control policies (Cleaning, Decontamination, and Sterillization)</p> <p>All expired supplies were removed from the facility. The Clinic Administrator will inspect supplies inventory to check for expiration dates on a monthly basis, to ensure patient safety. The findings will be submitted to the Director of Medical Services to address any deviations and training needs. Competency of the Administrator and all staff involved in Infection Control Practices will be addresses during QA visits.</p>	02-10-12



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A 308	Continued From page 10  During a tour of the facility on 11/15/2011 at 4:00 PM found in the procedure room #1 and #2, and the supply closet were expired sterile supplies.  Size #8 Straight curettes, expired 2011-04 X 46 Size #7 Straight curettes, expired 2011-02 X 1 Size #7 Straight curettes, expired 2011-03 X 8 Size #7 Straight curettes, expired 2011-03 X 8 Size #11 Straight curettes, expired 2011-08 X 15 Size #11 Straight curettes, expired 2011-09 X 8 Size #14 Straight curettes, expired 2011-07 X 28  An interview with staff #1 (Administrator) on 11/15/2011 at 4:00 PM confirmed the sterile supplies from the list above were expired.	A 308		
A 334	138.49(d)(5)(F)(iv) Infection Control Standards  (d) Policies and procedures for decontamination, disinfection, sterilization, and storage of sterile supplies. (5) Equipment and sterilization procedures. (F) Biological Indicators. (iv) If a test is positive, the sterilizer shall immediately be taken out of service. A malfunctioning sterilizer shall not be put back into use until it has been serviced and successfully tested according to the manufacturer's recommendations.  This Requirement is not met as evidenced by: Based on record review and interview the facility failed to read the biological indicators within the 24 hour incubation period on 14 of 54 readings over period of 3 months 8/4/2011-11/15/2011.  Manufacturer's recommendations revealed "ProSpore2 is ideal for in-office validation and	A 334		

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A 334	<p>Continued From page 11</p> <p>monitoring of steam sterilizers and has the same ease of use and indications as the ProSpore. It consists of a paper disc carrier containing <i>Geobacillus stercorophilus</i> spores. The disc is enclosed in a plastic tube along with a glass vial containing media for growing the bacterial spores. Bromocresol purple has been added to assist in detecting spore growth. The outgrowth of spores decreases pH, causing a color change from purple to yellow. A shorter incubation period allows a validated 24 hour result."</p> <p>Review of record titled "Biological Monitoring log for Prospore2 revealed 14 of 64 readings had been read either before the 24 hour period or over the 24 hour period.</p> <p>Biological Test Run Date—Biological Test Read Date</p> <table border="0"> <tr><td>8/5/2011</td><td>8/8/2011</td></tr> <tr><td>8/13/2011</td><td>8/13/2011</td></tr> <tr><td>8/13/2011</td><td>8/15/2011</td></tr> <tr><td>8/15/2011</td><td>8/15/2011</td></tr> <tr><td>8/20/2011</td><td>8/20/2011</td></tr> <tr><td>8/22/2011</td><td>8/22/2011</td></tr> <tr><td>8/27/2011</td><td>8/29/2011</td></tr> <tr><td>9/1/2011</td><td>9/1/2011</td></tr> <tr><td>9/10/2011</td><td>9/10/2011</td></tr> <tr><td>9/10/2011</td><td>9/12/2011</td></tr> <tr><td>9/24/2011</td><td>9/28/2011</td></tr> <tr><td>10/8/2011</td><td>10/10/2011</td></tr> <tr><td>10/22/2011</td><td>10/24/2011</td></tr> <tr><td>11/12/2011</td><td>11/15/2011</td></tr> </table> <p>Interview with staff #1 (Administrator) on 11/16/2011 4:00 PM, confirmed the readings were not read according to the manufacturer's recommendations.</p>	8/5/2011	8/8/2011	8/13/2011	8/13/2011	8/13/2011	8/15/2011	8/15/2011	8/15/2011	8/20/2011	8/20/2011	8/22/2011	8/22/2011	8/27/2011	8/29/2011	9/1/2011	9/1/2011	9/10/2011	9/10/2011	9/10/2011	9/12/2011	9/24/2011	9/28/2011	10/8/2011	10/10/2011	10/22/2011	10/24/2011	11/12/2011	11/15/2011	A 334	<p>A334</p> <p>The Clinic Administrator will be responsible for ensuring all Infection Control Standards are being followed</p> <p>A staff in Service will be facilitated by 02-10-12 to train the staff on Decontamination and Sterilization Procedures. The Clinic Administrator will ensure all instruments have been sterilized, and the Manufacturer's instructions regarding proper reading of bio indicators has been followed, as well as ensuring all sterilization packs and pouches are properly sealed including a Sterilization Indicator Strip on the inside of the packs.</p> <p>The Clinical Administrator will ensure proper follow through of Decontamination and Sterilization practices as well as all Infection Control Practices. The findings will be submitted to the Director of Medical Services for a period of 90 days in order to address competency, and further training needs.</p>	02-10-12
8/5/2011	8/8/2011																															
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11/12/2011	11/15/2011																															
A 340	139.48(d)(5)(H)(ii) Infection Control Standards	A 340																														



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  008137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  11/17/2011
NAME OF PROVIDER OR SUPPLIER  WHOLE WOMANS HEALTH OF BEAUMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 440 18TH ST STE A BEAUMONT, TX 77703		

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A 340	<p>Continued From page 12</p> <p>(d) Policies and procedures for decontamination, disinfection, sterilization, and storage of sterile supplies.</p> <p>(5) Equipment and sterilization procedures.</p> <p>(H) Maintenance of sterility.</p> <p>(II) All packages shall be inspected before use. If a package is torn, wet, discolored, has a broken seal, or is damaged, the item may not be used. The item shall be returned to sterile processing for reprocessing.</p> <p>This Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain the sterility of the surgical instruments.</p> <p>On touring the sterilization area where sterile instruments are kept, found eight (8) peel pouches sealed and sterilized with open areas still present in the sterile package. Opened a wrapped sterilized instrument and found no sterilization indicator in the package, continued to open all wrapped instruments and none of the wrapped instruments contained sterilization indicator for steam autoclaves.</p> <p>An interview with staff #2 confirmed she did not know what a sterilization indicator was or what it is used for in the sterilization process nor did she know how to properly seal the peel pouch. Staff # 2 on 11/16/2011 at 4:00 PM, asked the surveyor to demonstrate the proper technique on how to seal the packages.</p> <p>An interview with the Administrator on 11/16/2011 at 4:30 PM confirmed there were no sterilization indicators in the facility and observed that staff #2 did not know the proper technique for sealing peel pouches.</p>	A 340	<p>A340</p> <p>See Correction A334</p>	

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A 446	<p>139.58(c) Emergency Services</p> <p>(c) Personnel providing direct patient care shall be currently certified in basic life support by the American Heart Association, the American Red Cross, or the American Safety and Health Institute, or in accordance with their individual professional licensure requirements, and if required in their job description or job responsibilities.</p> <p>This Requirement is not met as evidenced by: Based on record review and interview the facility failed to ensure staff was trained in CPR (cardiopulmonary resuscitation) and follow the facility's policy on 1 (#3) of 4 staff members in the facility.</p> <p>Review of record titled "Job Description Patient Advocates" revealed "Required Continuing Education /Training: 1.) Basic Life Support Certification biannually 2.) Annual OSHA and PPE inservice training" per the facility's policy.</p> <p>A review of staff #3's personnel record revealed no documentation staff #3 had been trained in CPR.</p> <p>An interview with the Administrator on 11/16/2011 at approximately 11:00 AM, confirmed staff #3 does not have CPR training.</p>	A 446	<p>A446</p> <p>See Correction A254</p>	
A 476	<p>139.59(j)(1)(E) Anesthesia Services</p> <p>(j) Emergency equipment and supplies appropriate for the type of anesthesia services provided shall be maintained and accessible to staff at all times.</p> <p>(1) Functioning equipment and supplies which</p>	A 476		



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A 478	<p>Continued From page 14</p> <p>are required for all facilities include: (E) emergency medications specified by the medical staff and appropriate to the type of surgical procedures and anesthesia services provided by the facility.</p> <p>This Requirement is not met as evidenced by: Based on record review, observation, and interview the facility failed to have current emergency medication in the emergency crash cart and follow the facility's policy.</p> <p>An inventory of the crash cart revealed expired medication of 50% Dextrose 50 ml vial with expiration date of (September 2011).</p> <p>Review of policy titled "Medication Therapy Practices" revealed: "Medications Inventory and Audit" 1. Each month the Clinical Coordinator, Nurse or the Administrator will perform a detailed inventory of all medicines and medical supplies in the facility using WW11 inventory and tracking tools. (see medicines and medical supplies ordering inventory) 2. Each week the Clinical Coordinator, Nurse or Administrator will perform a detailed review and inventory of the crash cart in order to ensure all required medications are current and available. This will include all injectable, tablets and IV solutions, as well as supplies such as syringes, needles, bandages and airways. All expired medications and supplies will be disposed according to WWH wasting medications procedure. (See page 2) the crash cart inventory list will be updated</p>	A 478	<p>A476</p> <p>The Clinic Administrator will be responsible for ensuring all Anesthesia Services requirements are been properly followed.</p> <p>All expired medications have been properly disposed, and the crash cart has been re stocked with current required medications.</p> <p>The Clinic Administrator will be responsible for monitoring the inventory and expiration dates of all crash cart medications. A review of the inventory will be performed on a monthly basis; the findings will be submitted to the Director of Medical Services in order to ensure accuracy. The Director of Medical Services will facilitate a retraining on this policy to the Clinic Administrator by 02-10-12</p>	02-10-12
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A 478	Continued From page 15 with the new medications lot numbers and expiration dates.  An interview with the Administrator on 11/15/2011 at approximately 5:00 PM, confirmed the medication was expired on the emergency crash cart and the facility had not followed their policy.	A 478		
A 478	139.56(j)(2)(B) Anesthesia Services  (2) In addition to the equipment and supplies required under paragraph (1) of this subsection, facilities which provide moderate sedation/analgesia, deep sedation/analgesia, regional analgesia and/or general anesthesia shall provide the following: (B) advanced airway management equipment, including laryngoscopes and an assortment of blades, endotracheal tubes and stylets in appropriate sizes for the population being served;  This Requirement is not met as evidenced by: Based on observation and interview the facility failed to provide emergency airway equipment. This facility provides moderate sedation/analgesia which requires advanced airway management equipment.  During the tour of the facility on 11/15/2011 at 5:00 PM it was seen on the emergency crash cart a laryngoscope blade, but no laryngoscope handle. When questioned the Administrator where the laryngoscope handle was located, she stated the batteries had eroded and ruined the handle, so the handle had been thrown away.  An interview with the Administrator on 11/15/2011 at 5:00 PM, confirmed the facility did not have	A 478	A478  The Clinic Administrator will be responsible for ensuring all Anesthesia Emergency Airway Equipment is in proper functioning.  The Administrator will purchase a Laryngoscope handle to be kept in the crash cart by 02-10-12. The Director of Medical Services will facilitate a Retraining of all Anesthesia Emergency Airway Equipment requirements to the Administrator in order to ensure accuracy.  The Clinic Administrator will ensure all required equipment its onsite and in proper use on a monthly basis.	02-10-12



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A 478	Continued From page 16 complete emergency airway equipment.	A 478		
A 495	<p>139.60(h)(8) State and Federal Requirements</p> <p>(h) A licensed abortion facility shall comply with the following federal Occupation Safety and Health Administration requirements: (8) 29 Code of Federal Regulations, Subpart L, §1910.157, concerning portable fire extinguishers;</p> <p>This Requirement is not met as evidenced by: Based on observation and interview the facility failed to follow the 29 Code of Federal Regulations, Subpart L, 1910.157 concerning portable fire extinguishers.</p> <p>During the tour of the facility on 11/15/2011 at 3:00 PM observed the three facility's fire extinguishes were last inspection on March of 2010.</p> <p>An interview with the administrator on 11/15/2011 at 4:00 PM confirmed the fire extinguishes were last inspection on March of 2010.</p>	A 495	<p>A495</p> <p>See Correction A283</p>	