Texas Department of State Health Services

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C                                     | 1 '  | (X3) DATE SURVEY<br>COMPLETED     |                          |
|--------------------------|---|---|---|--|-----------------------------------|--------------------------|
|                          |   | 008036  | B. WING   | >  | 09                                | /04/2013                 |
|                          | ROVIDER OR SUPPLIER   | CALLEN LP 802 SOL   | ADDRESS, CITY, STATE  JTH MAIN STREET  EN, TX 78501 | , ZIP CODE   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                                 | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| A 000                    | space. Any discrepa citation(s) will be refe Texas Attorney Gene If information is inadv provider/supplier, the should be notified imit An entrance conferer clinic Administrator of McAllen . the purpose survey (re-licensure) explained. An opportiquestions and discus A re-licensure survey 139.31 to determine to compliance with their (abortion facility licen report form.  An exit conference with Administrator of the apreliminary findings of steps in the survey propportunity was providiscussion. | in is an official, legal ation must remain or entering the plan of a dates, and the signature oncy in the original deficiency erred to the Office of the eral (OAG) for possible fraud. Wertently changed by the estate Survey Agency (SA) mediately. Once was conducted with the found the work of the unannounced onsite and survey process were unity was provided for sions.  If was conducted per 25TAC the abortion facility is requirements at 25 TAC 139 sing rules) using survey | A 000   |  |                                   |                          |
| A 117                    | noncompliance was i   | venuneu.  | A 117   |  |                                   |                          |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

4GFK11

Texas Department of State Health Services

SOD - State Form

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|---|----------------------------|--|--|---|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |                            | (X2) MULTIPLE                                      | CONSTRUCTION   | (X3) DATE SURVEY  |  |  |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:         |                            | A. BUILDING:                                       |  | COMPLETED   |  |  |
|   |                            | ·  |  |   |  |  |
|   |                            | 000000   | B WING   |   |  |  |
|   |                            | 008036   | 13: 11110  |   | 09/04/2013   |  |
| NAME OF P   | ROVIDER OR SUPPLIER        | STREET A   | DDRESS, CITY, STA  | ATE, ZIP CODE   |  |  |
|   |                            | 802 8011   | TH MAIN STREE  |   |  |  |
| WHOLE V   | VOMANS HEALTH OF MO        | :All FN I P  | EN, TX 78501   | • •   |  |  |
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| (X4) ID   |                            | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID   | PROVIDER'S PLAN OF CORRECTIO                                  |  |  |
| PREFIX<br>TAG   |                            | SC IDENTIFYING INFORMATION)                        | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP |  |  |
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| A 117   | Continued From page        | 2 1  | A 117  |   |  |  |
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| A 118   |                            |  | A 118  |   |  |  |
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STATE FORM 4GFK11 If continuation sheet 2 of 5

If continuation sheet 3 of 5

Texas Department of State Health Services

STATE FORM

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  |                   |  |  |
|--|--|---|---|--|-------------------|--|--|
|  |  | 008036  | B. WING                                 |  | 09/04/2013        |  |  |
|  | NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  WHOLE WOMANS HEALTH OF MCALLEN LP  802 SOUTH MAIN STREET MC ALLEN, TX 78501 |   |   |  |                   |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE COMPLETE |  |  |
| A 118  | Continued From page  | ⊋ 2   | A 118                                   |  |                   |  |  |
|  |  |   |   |  |                   |  |  |
| A 230  |  |   | A 230                                   |  |                   |  |  |

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Texas Department of State Health Services

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                    |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:                        |   | (X3) DATE SURVEY<br>COMPLETED  |  |
|---|--|--|---|---|--|--|
|   |  | 008036   | B. WING   |   | 00/04/0040   |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE |  |  |   |   | 09/04/2013   |  |
|   | OMANS HEALTH OF MO   | 802 SOUT   | H MAIN STREE  |   |  |  |
| WHOLE W   |  | MC ALLE  | N, TX 78501   |   |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE COMPLETE  |  |
| A 230   | Continued From page 3  |  | A 230   |   |  |  |
|   |  |  |   |   |  |  |
| A 249   | 139.44(e) Orientation  | , Training, Competency   | A 249   |   | one work of the state of the st |  |
|   |  | ocument in each employee '<br>idence of all training and   | п всеговрани протого по при |   |  |  |
|   | Reviewed personnel t<br>two out of seven staff<br>cardio pulmonary resu  | not met as evidenced by: raining files and found that members had expired ucitation (CPR) certification. ed that staff members had tion. |   |   |  |  |
| A 295   | 139.49(b)(1)(A)(i) Infe  | ction Control Standards  | A 295   |   |  |  |
|   | (b) Prevention and co<br>HIV, HBV, HCV, TB, a<br>(1) Universal/standard<br>(A) An abortion facility<br>comply with universal/<br>defined in this paragra<br>(i) Universal/standard<br>procedures for disinfe<br>reusable medical devi<br>use of infection contro<br>the use of protective by | ntrol of the transmission of<br>and SP.<br>I precautions.<br>I shall ensure that all staff<br>standard precautions as<br>aph.            |   |   |  |  |
|   | Reviewed policies and  | not met as evidenced by:<br>d procedures and<br>ff and found that personnel  |   |   |  |  |

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STATE FORM 6899 4GFK11 If continuation sheet 4 of 5 Texas Department of State Health Services

| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  WHOLE WOMANS HEALTH OF MCALLEN LP  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 295  Continued From page 4 at facility were not following proper sterilization procedures. Findings: a. In review of sterilization packs and sterilization logs. All sterilization, load number and autoclave. Observed that sterilization packs at facility are only labeled with date and initials of the person who performed the wrap. The time of sterilization, load number and autoclave are not included on sterilization label. Observed in sterilization log date and instrilization log that sterilization load numbers are not included on log.  | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |          |
|---|---|--|---|---|--|-------------------------------|----------|
| WHOLE WOMANS HEALTH OF MCALLEN LP  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 295  Continued From page 4 at facility were not following proper sterilization procedures. Findings: a. In review of sterilization packs and sterilization logs. All sterilization, load number and autoclave. Observed that sterilization packs at facility on person who performed the wrap. The time of sterilization, load number and autoclave are not included on sterilization logd. Observed in sterilization log that sterilization load  autoclave are not included on sterilization load. Observed in sterilization log that sterilization log that sterilization load |   |  | 008036  | B. WING                                 | ***************************************                        | 09/0                          | 4/2013   |
| WHOLE WOMANS HEALTH OF MCALLEN LP  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 295  Continued From page 4 at facility were not following proper sterilization procedures. Findings:  a. In review of sterilization packs and sterilization logs. All sterilized items were not labeled with date/time of sterilization, load number and autoclave. Observed that sterilization packs at facility are only labeled with date and initials of the person who performed the wrap. The time of sterilization logd that sterilization log that sterilization load  Observed in sterilization log that sterilization load  Observed in sterilization log that sterilization load  | NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA                         | TE, ZIP CODE   |                               |          |
| (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 295  Continued From page 4 at facility were not following proper sterilization procedures. Findings:  a. In review of sterilization packs and sterilization logs. All sterilized items were not labeled with date/time of sterilization, load number and autoclave. Observed that sterilization packs at facility are only labeled with date and initials of the person who performed the wrap. The time of sterilization logs that sterilization log that sterilization load  Observed in sterilization log that sterilization load  | WHOLE   | VOMANS HEALTH OF MC  | CALLEN LP   |   | Т  |                               |          |
| at facility were not following proper sterilization procedures. Findings:  a. In review of sterilization packs and sterilization logs. All sterilized items were not labeled with date/time of sterilization, load number and autoclave. Observed that sterilization packs at facility are only labeled with date and initials of the person who performed the wrap. The time of sterilization, load number and autoclave are not included on sterilization label.  Observed in sterilization log that sterilization load   | PREFIX  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX                            | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR | BE                            | COMPLETE |
| b. Interviewed staff at facility who conduct sterilization staff # 2, Registered Nurse (RN) was interviewed at 10:20am on September 3, 2013 and staff #3, Certified Nursing Assistant (CNA) at 10:30am on September 3, 2013 in the sterilization room of the facility. Both interviewees confirmed that the time of sterilization, load number and name of autoclave were not included on the label of the sterilized packs. The load number was not included in the sterilization log. Both staff members interviewed was not able to show that this requirement was met.  | A 295   | at facility were not foll procedures. Findings: a. In review of steril sterilization logs. All s labeled with date/time number and autoclave sterilization packs at f date and initials of the wrap. The time of sterilization the sterilization sterilization umbers are not included. b. Interviewed staff sterilization staff #2, I interviewed at 10:20a and staff #3, Certified 10:30am on Septemb room of the facility. Both that the time of sterilization are of autoclave we of the sterilized packs included in the sterilizemembers interviewed | lization packs and sterilized items were not e of sterilized items were not e of sterilization, load e. Observed that facility are only labeled with e person who performed the rilization, load number and uded on sterilization label, ion log that sterilization load uded on log.  at facility who conduct Registered Nurse (RN) was am on September 3, 2013 I Nursing Assistant (CNA) at per 3, 2013 in the sterilization ooth interviewees confirmed cation, load number and ere not included on the label is. The load number was not cation log. Both staff I was not able to show that | A 295                                   |  |                               |          |

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