Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130148	A. BUILDING: _____ B. WING _____	01/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD	6464 JOHN RYAN DRIVE FORT WORTH, TX 76132

(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	25 TAC 135 Ambulatory Surgery Centers 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. An unannounced re-survey was conducted on site. An entrance conference was held at Planned Parenthood of Greater Texas Health Services, 6464 John Ryan Drive, Fort Worth, Texas 76132, on 1/20/2016 with the facility's administrative representatives. It was explained to them the purpose and process of the survey. The survey was conducted under the authority of 25 TAC 135 - Ambulatory Surgical Center (ASC) Licensing Rules. An exit conference was held the afternoon of 01/20/2016 with the administrative representatives at which time the findings of the survey were explained to them. The facility's representatives were given an opportunity to provide evidence of compliance with those requirements of which non-compliance had been found. None was provided. Instructions were provided on writing plans of correction with instructions to return the plans of correction to the Arlington zone office within 10 days. This report was electronically sent to the facility. Standard deficiencies were cited.	T 000	REVIEWED FEB 16 2016 by: RJ RECEIVED FEB 12 2016 Zone II / Arlington	
T 153	135.6(b)(6) ADMINISTRATION OF A LICENSED ASC (b) Personnel policies shall be established and	T 153		

SOD - State Form
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: COO — (X6) DATE: 2-9-16

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T 153	Continued From page 1 implemented to facilitate attainment of the mission, goals, and objectives of the ASC. Personnel policies shall: (6) provide adequate orientation and training to familiarize all personnel with the ASC's policies, procedures, and facilities. This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to implement it's policy/procedure to provide adequate orientation and training to familiarize all personnel with the policies and procedures, in that, 3 of 3 registered nurses (Personnel #1, #9, and #10) who currently provide conscious sedation to the facility's patients did not have documented orientation and training for the administration of conscious sedation. Findings Included Personnel #1's, #9's, and #10's personnel record did not document an orientation and training for the administration of conscious sedation. During an interview on 01/20/2016 ending at 3:30 PM, Personnel #1 was asked for the conscious sedation training for Personnel #1, #9 and #10. Personnel #1 was able to show the surveyors the orientation and training document that should have been used to show the training occurred. Personnel #1 was asked if she could show the document had been completed for the 3 nurses. Personnel #1 stated, "No."	T 153	The Director of Quality Management updated the training form that documents orientation and training for the administration of conscious sedation. The Director of Quality Management provided ASC nurses additional training on the administration of sedation, based upon AORN guidelines. All ASC nurses providing moderate sedation have documented orientation and training for the administration of conscious sedation.	2/9/16 2/9/16 2/9/16

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T 210	Continued From page 2	T 210		
T 210	135.9(j)(4) MEDICAL RECORDS IN A LICENSED ASC (j) The (ASC) shall include the following in patients' medical records: (4) significant medical history and results of physical examination; This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to include the results of a physician's physical examination in the patients' medical records for 3 of 3 (Patient #17, 18, and #19) medical (non-surgical) patients, in that, Patient #17's, #18's, and #19's medical record did not include the results of a physician's physical examination. Findings Included Patient #17's, #18's, and #19's medical record did not include the results of a physician's physical examination. During an interview and electronic medical record review on 01/20/2016 ending at 2:35 PM, Personnel #15 was asked for the physician's physical examination for each of the above listed patients. Personnel #15 stated, "It is not there (physical exam)" and she was unable to find evidence of a physician's physical examination for Patient #17, #18, and #19.	T 210	ASC physicians are completing a physical exam on all ASC clients. The PPGT policy on abortion was revised to clarify that all clients receiving abortion procedures require a physical exam, including medication abortion clients. RQM will complete an audit to ensure that ASC medical records include the results of a physician's physical examination.	1/28/16 1/29/16 Q1 2016
T 228	135.10(a)(2) FACILITIES AND ENVIRONMENT IN A LIC ASC	T 228		

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T 228	Continued From page 3 (ASC) shall have the necessary personnel, equipment, and procedures to handle medical emergencies that may arise in connection with services sought or provided. At a minimum, the ASC shall provide: (2) procedures, including adequate surveillance techniques, that minimize sources and transmission of infections; This Requirement is not met as evidenced by: Based on record review and interview, the facility failed to have procedures that include adequate surveillance techniques, that minimize sources and transmission of infections; in that, Personnel #15 was unable to provide any surveillance techniques to minimize sources and transmissions of infections. Findings: 1. The facility was unable to provide a policy/procedure that included adequate surveillance techniques, that minimize sources and transmission of infections. 2. During an interview with Personnel #15 on 1/20/2016 in the afternoon, Personnel #15 stated that they did not have any surveillance that tracked infections of patients. Further, there was no surveillance being performed that minimize sources and transmission of infections.	T 228	PPGT has implemented a procedure for contacting all ASC clients after discharge in order to assess for any signs or symptoms of a procedure related infection. Any reported infections will be logged in PPGT's infection /complication log for tracking and review by the physician. RQM will audit this process annually	2/9/16 Q1 2016
T 231	135.10(c) FACILITIES AND ENVIRONMENT IN A LIC ASC (c) Facilities shall be clean and properly	T 231		

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T 231	Continued From page 4 maintained. This Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a safe and sanitary environment for surgical patients. Findings include: During a tour of the facility on 01/20/2016 at 10:00 AM the surveyor observed the following unclean and unsafe environmental issues: Operating Room #1: In the equipment cart in Operating Room #1 the surveyor observed: Laminaria -Jumbo Size X 3 expired 09/2014 Laminaria -Jumbo Size X 2 expired 04/2015 There were three suction machines that had no preventative maintenance stickers. A suction machine was located in each of the Operating Rooms (#1, #2, and #3). A review of the facility's inventory list revealed the 3 suction machines were not listed on the inventory list with the other facility's equipment. There was no documentation showing that any of the 3 suction machines had had preventive maintenance checks. Crash Cart: In the emergency crash cart the surveyor observed:	T 231	All expired Laminaria were disposed of. The Director of Quality Management reviewed with ASC staff the requirement to check for and to dispose of any expired medication or supplies in the ASC monthly. The ASC clinic manager will assure that staff document completion of this action. Preventative maintenance was performed on the three suction machines in the operating rooms. The Dir. Of Quality Management reviewed with ASC staff the policy that staff must ensure there is no medical equipment in any patient care area without a documented preventative maintenance sticker. These items must be clearly marked "Do Not Use", until maintenance has been performed and documented. RQM will conduct an audit twice annually to ensure all equipment has current preventative maintenance stickers. The suction machines were added to the inventory list	1/20/16 2/9/16 2/3/16 2/9/16 2x/yr 2/9/16

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T 231	Continued From page 5 Needles 22 gauge X 4 expired 09/2015 Needles 20 gauge X 1 expired 12/2013 Needles 18 gauge X 5 expired 12/2015 Post-op Area: There was no oxygen tank available for patient usage in an emergency situation. Main Storage in the Surgical Area: Three (3) cardboard shipping boxes were being stored on the bottom shelf where the sterile patient supplies were stored. Also, the surveyor observed a handheld feather duster lying beside the patient's clean and sterile supplies. This had the likelihood to contaminate supplies which could cause an infection due to the feather duster and cardboard shipping boxes being stored with the patient's clean and sterile supplies. The biohazard waste cardboard box was being stored in the same room with the patients' clean and sterile supplies. The biohazard box was beside the shelf that stored the clean and sterile patient supplies. This had the likelihood to contaminate the clean and sterile supplies from the waste products being brought into the room and placed into the biohazard box. Trash and dust particles were observed on the floor of the storage area where the open clean and sterile supplies were stored. The nationally accepted standards set forth by the Association for the Advancement of Medical Instrumentation (AAMI) state, "External shipping	T 231	The expired needles were removed from the crash cart during the survey by an ASC nurse. The Director of Quality Management reviewed with ASC nurses the requirement to ensure that supplies in the crash cart have not expired. Documentation of supplies listed on the crash cart log was reviewed with staff, A working oxygen tank is available in each procedure room & the recovery room for patient use in an emergency situation. ASC staff unpacked the 3 cardboard boxes, stocked the procedure rooms and placed any excess in plastic bins located in the storage area. Polices were updated to include that PPGT staff must remove supplies from shipping containers upon receipt and store supplies in the proper location, as per policy. The Director of Quality Management reviewed this requirement with ASC staff. The feather duster was removed from the storage area. RQM will conduct an audit twice annually to ensure compliance. The biohazard box was relocated to a storage closet, approved by DSGS staff during the survey. Staff was reminded of storage requirements for biohazards by the Director of Quality Management. PPGT management informed the janitorial staff of (1) the need to consistently remove all trash and dust particles in the storage area and the remainder of the ASC and (2) to return all cleaning supplies to the janitorial closet. A representative from the management services organization will be onsite to confirm janitorial staff are cleaning according to expectations.	1/20/16 2/9/16 1/20/16 1/20/16 1/27/16 2/9/16 1/20/16 2x/year 1/21/16 2/9/16 1/25/16 2/22/16

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T 231	Continued From page 6 containers have been exposed to unknown and potentially high microbial contamination. Also, shipping cartons, especially those made of corrugated material; serve as generators of and reservoirs for dust." (AAMI 5T46-Section 5.2 Receiving Items). Laundry Room: The surveyor observed an electrical outlet with no cover. The exposed wires were showing and was located close to where the water flows into the washing machine. This issue had the likelihood to cause an electrical hazard to the employees. The wall beside the dryer had multiple spots of plaster missing. The issue with the missing plaster made it to where employees could not clean the wall, which had the likelihood to cause an unsanitary environment. Pharmacy Area: In the Pharmacy area, the surveyor observed 3 automatic vital sign equipment with no visible sign to indicate if the equipment was clean or dirty. There were cardboard boxes that contained nourishments for the patients that were sitting on top of a metal cart. The top of the cart was covered with dust particles. Also, in the pharmacy area were 2 more metal carts and each cart was covered in dust particles. An interview with Personnel #3 on 01/20/2016 at 11:30 AM confirmed the above findings.	T 231	The electrical outlet cover was replaced. The plaster on the wall beside the dryer was replaced. The vital signs machines and the metal carts were relocated to storage since they are not currently in use. The cardboard box with patient nourishment were unpacked and relocated to storage Polices were updated to include that PPGT staff must remove supplies from shipping containers upon receipt and the Director of Quality Management reviewed this requirement with ASC staff. RQM will conduct an audit twice annually to ensure compliance. The metal carts were cleaned of dust particles and relocated to storage. PPGT management informed the janitorial staff of (1) the need to consistently remove all trash and dust particles in the storage area and the remainder of the ASC	2/8/16 2/8/16 1/24/16 1/24/16 1/27/16 2/9/16 2x/yr 1/20/16 1/25/16
T 233	135.10(e) FACILITIES AND ENVIRONMENT IN A LIC ASC	T 233		

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T 233	Continued From page 7 (e) All equipment, including emergency equipment, shall be properly maintained and periodically tested. This Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the oxygen equipment was ready for patient use in an emergency situation in the recovery room area. Findings Included: During a tour of the facility on 01/20/2016 at approximately 10:00 AM, the surveyor observed there was no oxygen tank available for use in the recovery room area. An interview with Personnel #10 on 01/20/2016 at approximately 10:00 AM confirmed the above findings.	T 233	The ASC charge nurse ensured that a working oxygen tank is available in each procedure room and the recovery room for patient use in an emergency situation. The Director of Quality Management reviewed with ASC staff that Equipment for use in Emergency situations must be fully assembled, maintained per protocol and be stored 'ready for use'. RQM will conduct an audit twice annually to ensure all tanks have gauges.	1/20/16 2/9/16 2x/yr
T 258	135.11(b)(11)(A-G) ANESTHESIA & SURGICAL SVCS IN A LIC ASC (11) A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, shall be assured through the provision of adequate space, equipment, and personnel. (A) Provisions shall be made for the isolation or immediate transfer of patients with communicable diseases. (B) All persons entering operating rooms shall be properly attired. (C) Acceptable aseptic techniques shall be used by all persons in the surgical area. (D) Only authorized persons shall be allowed in	T 258		

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T 258	Continued From page 8 the surgical area. (E) Suitable equipment for rapid and routine sterilization shall be available to assure that operating room materials are sterile. (F) Environmental controls shall be implemented to assure a safe and sanitary environment. (G) Operating rooms shall be appropriately cleaned before each operation. This Requirement is not met as evidenced by: Based on observation, record review, and interview: A. The facility's personnel failed to wear the proper operating room attire and follow the facility's policy on Surgical Attire. B. The facility's personnel failed to maintain the sterility of the surgical instruments. There were 24 peel pack packages observed in the operating rooms and sterile instrument storage area that were not sealed correctly. Also, the facility failed to maintain performance records for the small autoclave during operation that included pressures, temperatures, and times at the desired temperature and pressure. This had the likelihood to cause contamination and microbial growth in the sterile instrument packages. C. The facility failed to know the Hepatitis B status of 4 (#3, #4, #9 and #10) of 8 personnel working in the Ambulatory Surgery Center. This had the likelihood to place personnel and patients at a risk to be exposed to the Hepatitis B virus.	T 258	The Director of Quality Management reviewed with ASC staff proper OR attire. RQM will conduct an audit twice annually to ensure ASC staff are donning appropriate PPE. All instruments in peel packs were re sterilized and peel packs were sealed correctly to ensure sterilization The Director of Quality Management reviewed with ASC staff the proper sealing of peel packs. RQM will conduct an audit twice annually to ensure sterility of surgical instruments A new autoclave printer was ordered to ensure that the ASC is maintaining performance records for the autoclave. Staff will continue to document daily on the PPGT sterilization log results of biological indicator (BI) and Chemical Integrator (CI) strips. A BI and a CI are processed in a representative wrapped pack, pouch or tray, called a process challenge device (PCD) to ensure their effectiveness in sterilizing medical devices. HepB titers were drawn on the ASC staff that required a titer to supplement their previously documented vaccination record.	2/9/16 2x/yr 1/25/16 2/9/16 2x/yr 2/2/16 Ongoing 1/27/16

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T 258	Continued From page 9 Findings Included: A. During a tour of the operating rooms on 01/20/2016 at approximately 10:30 AM, the surveyor observed the personnel not wearing any type of head covers as they entered and exited the surgical area. A review of the facility policy titled, "Standard Precaution and PPE" revealed the following: "F. Head covers/shoe covers Surgical caps/hoods and/or shoe covers/boots are used in any instances where "gross Contamination' is anticipated. If worn, they must be charged when visibly soiled, wet, or worn and always be removed prior to leaving the surgical or procedural area." As per the AORN (Association of Perioperative Registered Nurses) guidelines titled, "Recommended practices for surgical attire" revealed the following: "Clean surgical attire, including shoes, head covering, masks, jackets, and identification badges should be worn in the semi restricted and restricted areas of the surgical or invasive procedure settings." An interview with Personnel #3 on 01/20/2016 at 10:30 AM confirmed the above findings that head coverings were not being worn and the facility policy was not followed for surgical attire. B. During the tour on 01/20/2016 with Personnel #3, the surveyor observed peel packages that	T 258	The Director of Quality Management reviewed with ASC staff proper OR attire including head covers. RQM will conduct an audit twice annually to ensure compliance.	2/9/16 2x/yr

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T 258	Continued From page 10 were not sealed correctly. The peel packages had a perforated line where the package was to be folded, but the packages were not folded on the perforated line which had caused the packages not to be sealed completely and allowed for contamination. In Operating Room #1 there were 8 peel packages not sealed correctly. In Operating Room #2 there were 6 peel packages not sealed correctly. In Operating Room #3 there were 10 peel packages not sealed correctly. An interview with Personnel #3 on 01/20/2016 at 11:30 AM confirmed the peel pouches were not sealed correctly. The facility failed to maintain performance records for the small autoclave during operation that included pressures, temperatures, and times at the desired temperature and pressure. The printer on the small autoclave (sterilizer) had not been working since July 2015, so there was no print out to confirm that the autoclave had reached the pressure, temperature, and times at the desired temperature and pressure for the sterilization of the instruments. This facility had performed 729 cases from July 2015 to present. An interview with Personnel #3 on 01/20/2016 at 11:30 AM confirmed the above findings. C. A review of #3's personnel file revealed no documentation of the Hepatitis B status. A review of #4's personnel file revealed no documentation of the Hepatitis B status. A review of #9's personnel file revealed no documentation of the Hepatitis B status. A review of #10's personnel file revealed no	T 258	All instruments in peel packs in OR room #1, #2 and #3 were sterilized again after sealing properly. The Director of Quality Management reviewed with ASC staff proper sealing of peel packs. RQM will conduct an audit twice annually to ensure compliance. A new autoclave printer was ordered to ensure that the ASC is maintaining performance records for the autoclave. Staff will continue to document daily on the PPGT sterilization log results of biological indicator (BI) and Chemical Integrator (CI) strips. A BI and a CI are processed in a representative wrapped pack, pouch or tray, called a process challenge device (PCD) to ensure their effectiveness in sterilizing medical devices. HepB titers were drawn on the ASC staff that required a titer to supplement their previously documented vaccination record.	1/25/16 2/9/16 2x/yr 2/2/16 Ongoing 1/27/16

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T 258	Continued From page 11 documentation of the Hepatitis B status. A review of the facility's policy titled, "Vaccine Preventable Disease Policy" revealed the following: "PURPOSE: Because of their contact with patients and/or infective material from patients, Planned Parenthood of Greater Texas (PPGT) staff are at risk for exposure to (and possible transmission of) vaccine-preventable diseases. PPGT has a responsibility to take reasonable precautions to prevent transmission of vaccine-preventable diseases to patients and staff. The PPGT vaccination program is an essential part of the PPGT infection prevention and control program. Optimal use of recommended vaccines helps maintain immunity and safeguard PPGT staff from infection, thereby helping protect patients and the community from becoming infected. At PPGT, Human Resources (HR) joins Health Services and Clinical Quality Improvement (CQI) in assuring that each employee receives information about the PPGT occupational health program and services offered and that the requisite forms are completed. Employees should report any concerns of an unsafe work environment to their supervisor, HR or CQI. The purpose of this policy is to protect the health and safety of patients, employees, patient and employee family members, and the community as a whole from vaccine preventable diseases and to comply with state law. F. HR maintains a secure, system to manage vaccination records for PPGT staff so records can be retrieved as needed. Each record should reflect immunity status for indicated vaccine-preventable diseases (i.e., documented disease, vaccination history, or serology results),	T 258		

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PLANNED PARENTHOOD	6464 JOHN RYAN DRIVE FORT WORTH, TX 76132

(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 258	Continued From page 12 as well as any vaccinations administered during employment and any documented episodes of adverse events after vaccination." A review of the standard of care guidelines for "OSHA (Occupational Safety & Health Administration); Occupational Exposure to Blood borne Pathogens" revealed the following: "Persons at substantial risk of HBV who are demonstrated or judged likely to be susceptible should be vaccinated. They include the following: 1. Persons with occupational risk. HBV is a major infectious occupational hazard for health care and public safety workers. The risk of acquiring HBV infection from occupational exposures is dependent on the frequency of percutaneous and per mucosal exposure to blood or blood products. Any health-care or public-safety worker may be at risk for HBV exposure depending on the tasks that he or she performs. If those tasks involve contact with blood or blood-contaminated body fluids, such workers should be vaccinated. Vaccination should be considered for other workers depending on the nature of the task. Risks among health-care professionals vary during the training and working career of each individual but are often highest during the professional training period. For this reason, when possible, vaccination should be completed during training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions before workers have their first contact with blood." An interview with Personnel #15 on 01/20/2016 at 3:00 PM confirmed the facility did not know the Hepatitis B status of four (4) personnel working at the Ambulatory Surgery Center.	T 258		

Texas Department of State Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130148	A. BUILDING: _____ B. WING _____	01/20/2016

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PLANNED PARENTHOOD	6464 JOHN RYAN DRIVE FORT WORTH, TX 76132

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T 261	135.11(b)(14) ANESTHESIA & SURGICAL SVCS IN A LIC ASC (14) Periodic calibration and/or preventive maintenance of all equipment shall be provided in accordance with manufacturer's guidelines. This Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to maintain preventative maintenance records for three (3) suction machines that were available for patient use in the surgical area. During a tour of the surgical area on 01/20/2016 at 11:00 AM, the surveyor observed three suction machines that had no preventative maintenance stickers. A suction machine was located in each of the operating rooms (#1, #2, and #3). A review of the facility's inventory list revealed the 3 suction machines were not listed on the inventory list with the other facility's equipment. An interview with Personnel #1 on 01/20/2016 at 11:00 AM confirmed the above findings. This facility had performed 729 cases from July 2015 to present.	T 261	Preventative maintenance was performed on the suction machines. The charge nurse is conducting an accurate inventory of all medical equipment that needs to have preventative maintenance completed and will list the location where the equipment is located. The Dir. Of Quality Management reviewed with ASC staff the policy that staff must ensure there is no medical equipment in any patient care area without a documented preventative maintenance sticker. These items must be clearly marked "Do Not Use", until maintenance has been performed and documented. RQM will conduct an audit twice annually to ensure all equipment has current preventative maintenance stickers.	2/3/16 2/9/16 2/9/16 2x/yr
T 370	135.41(b)(2) FIRE PREVENTION AND INSPECTION (2) Portable fire extinguishers. Every portable fire extinguisher located in an ASC or upon ASC property shall be installed, tagged, and maintained in accordance with National Fire Protection Association 10, Standard for Portable Fire Extinguishers, 2002 Edition.	T 370		

Texas Department of State Health Services

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T 370	Continued From page 14 This Requirement is not met as evidenced by: Based on observation and interview, the facility's personnel failed to conduct a monthly examination of the fire extinguishers for 1 of 2 fire extinguishers in the facility and follow the facility's policy. During a tour of the facility on the morning of 01/20/2016 at 11:00 AM with Personnel #10, the surveyor observed that one of the fire extinguishers had not been examined in the last 2 months. The last time the fire extinguisher was examined was during the month of November 2015. A review of the facility's policy titled, "Fire Prevention, Protection, and Safety" revealed the following: "10. Every portable fire extinguisher located in the ASC or upon ASC property shall be installed, tagged, and maintained in accordance with National Fire Protection Association 10, Standard for Portable Fire Extinguishers, 2002 Edition. 11. An evacuation floor plan shall be prominently and conspicuously posted for display throughout the ASC in public areas that are readily visible to patients, employees, and visitors. 12. The installed fire sprinkler systems comply with National Fire Protection Association 13, Standard for the Installation of Sprinkler Systems, 1999 edition (NFPA 13). 13. Fire extinguishers at the facility are equipped to handle A, B, and C class fires and are marked accordingly. Portable fire extinguishers will be visually inspected by the Fire Marshall or designee annually.	T 370	The Director of Quality Management reviewed with staff the requirement to complete and document monthly inspection of the fire extinguisher including that staff must a. Verify extinguishers are in place according to the inventory and required placement. b. Check the charge indicator gauge (gauge will be in the green). c. Insure the inspection tag is in place and properly completed. d. Insure the tamper seal is intact. e. Verify there are no obstructions of access or visibility. f. Check for physical damage. g. Initial and date inspection tag at time of inspection."	2/9/16

Texas Department of State Health Services

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T 370	Continued From page 15 14. Every portable fire extinguisher located in the ASC or upon ASC property shall be installed, tagged, and maintained in accordance with National Fire Protection Association 10, Standard for Portable Fire Extinguishers, 2002 Edition. These checks and inspections will be documented and attached to the fire extinguishers. Inspections will include the following: a. Verify extinguishers are in place according to the inventory and required placement. b. Check the charge indicator gauge (gauge will be in the green). c. Insure the inspection tag is in place and properly completed. d. Insure the tamper seal is intact. e. Verify there are no obstructions of access or visibility. f. Check for physical damage. g. Initial and date inspection tag at time of inspection." An interview with Personnel #10 on 01/20/2016 at approximately 10:00 AM confirmed a monthly examination of the fire extinguishers had not been conducted, initialed, and dated per facility's policy.	T 370		