

Texas Department of State Health Services

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER SUBURBAN WOMENS CLINIC | STREET ADDRESS, CITY, STATE, ZIP CODE 3101 RICHMOND #250 HOUSTON, TX 77098 |
|--|--|

| (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 |
|--------------------------|--|---------------------|---|--------------------------|
| A 000 | Initial Comments 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 entrance conference was held with the facility administrative staff on in the morning of 01/09/18. The purpose and process of the licensure resurvey were discussed, and an opportunity given for questions. Continued licensure is recommended, with an approved plan of correction. An exit conference was held with the facility Administrator the afternoon of 01/10/18. Preliminary findings of the survey were discussed, and an opportunity given for questions. | A 000 | REVIEWED FEB 03 2018 BY: <i>Dan Wilson</i> | |
| A 037 | TAC 139.8(d)((5)(6)(7) Quality Assurance (d) Minimum responsibilities. The QA committee shall: (5) address medication therapy practices; (6) address the integrity of surgical instruments, medical equipment, and patient supplies; and (7) address services performed in the facility as they relate to appropriateness of diagnosis and treatment. This Requirement is not met as evidenced by: | A 037 | As The Medical Director I plan to make sure The QA Committee meets quarterly, document contents of the meeting and also identify issues such as: a) Medications to patient are appropriate for the treatments they receive. b) Share with patients side effects of such medications and to call my office for | 02/23/18 |

OD - State Form

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE

DATE FORM

TITLE

ADMINISTRATOR

(X6) DATE

02/01/2018

If continuation sheet 1 of 12

Texas Department of State Health Services

| | | | | |
|--|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
| NAME OF PROVIDER OR SUPPLIER SUBURBAN WOMENS CLINIC | | STREET ADDRESS, CITY, STATE, ZIP CODE 3101 RICHMOND #250 HOUSTON, TX 77098 | | |
| (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 |
| A 037 | Continued From page 1 Based on a review of documentation, the QA committee failed to address the minimum areas as specified. Findings were: Upon review of Quality Assurance meeting minutes for 2017, the committee failed to address the integrity of surgical instruments, medical equipment, and patient supplies; and services performed in the facility as they relate to appropriateness of diagnosis and treatment. The above was confirmed in an interview with the Medical Director on the afternoon of 1-10-18. | A 037 | any untoward effects. c) All equipment and instruments will be properly inspected, old or aging equipment or instruments will be replaced, and patient supplies will continue to be adequate for the number of patients seen at this facility. | |
| A 038 | TAC 139.8(e)(1) Quality Assurance (e) Patient care and service issues. The QA committee shall identify and address patient care services and information issues and implement corrective action plans as necessary. (1) Identifying issues that necessitate corrective action. The QA committee shall be responsible for identifying issues that necessitate corrective action by the committee, such as issues which negatively affect care or services provided to patients. This Requirement is not met as evidenced by: Based on a review of documentation, the QA committee failed to address the minimum areas as specified. Findings were: Upon review of Quality Assurance meeting | A 038 | I The Medical Director will ensure that The QA Committee addresses and documents issues such as making efforts to make sure patients receive necessary follow up visits after treatment for appropriate diagnosis and desired treatment by each patient. Each patient can reach my office and speak with me about any complication or side effect of treatment 24/7. | 02/23/18 |

Texas Department of State Health Services

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUBURBAN WOMENS CLINIC

3101 RICHMOND #250
HOUSTON, TX 77098

| (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 |
|--------------------------|--|---------------------|--|--------------------------|
| A 038 | Continued From page 2 minutes for 2017, the committee failed to address patient care and service issues and identify issues that necessitate corrective action by the committee, such as issues which negatively affect care or services provided to patients. The above was confirmed in an interview with the facility Medical Director on the afternoon of 1-10-18. | A 038 | | |
| A 197 | TAC 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 tour and interview, the facility failed to ensure a safe and sanitary environment, properly maintained to protect the health and safety of patients and staff at all times. Findings included: The facility based Patient Bill of Rights stated in part, "Safe Environment-Patients have the right to receive care and treatment in a safe environment, which meets appropriate safe and infection control standards." | A 197 | I The Medical Director will have all equipment and supplies maintained according to manufacturers recommended guidelines; and equipments include ultra-sounds, Schuco suction machine. Any expired drugs will be discarded whether they are needed for abortion services or otherwise. Any defect in any exam tables in room 1 and 2 will be properly repaired. I will remove and replace the mattresses in recovery room. All containers, biohazard or otherwise will be properly labelled. | 02/23/18 |

Texas Department of State Health Services

FORM APPROVED

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUBURBAN WOMENS CLINIC

3101 RICHMOND #250
HOUSTON, TX 77098

| (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 |
|--------------------------|--|---------------------|--|--------------------------|
| A 197 | <p>Continued From page 3</p> <p>Facility based policy stated in part, "Intra-Operative Procedures...</p> <p>2. Emergency equipment in the facility will include:...</p> <p>Equipment and supplies will be readily available and records that they have been checked and maintained on a schedule basis."</p> <p>The manual for the "Oil-Less Schuco Vac Instruction Manual for Model Numbers SS320 A130, S130-Glass, S320A" stated in part, "Recommended Service Procedure for Schuco-Vac Products</p> <p>1. Preventative Maintenance</p> <p>Preventative Maintenance on Schuco-Vac Suction Units should be completed a minimum of once each year."</p> <p>During a tour of the facility on 01/10/18 the following observations were made:</p> <p>* The following medical equipment did not have current inspection tags/stickers present during the tour. In exam room #1 the ultrasound inspection tag indicated the last maintenance was completed on 12/16 and due by 12/17. The blood pressure/vital sign machine inspection sticker expired on October 2011. In the procedure room, the ultrasound machine did not have any inspection tag/sticker present. In the recovery room the vital sign machine did not have an inspection tag/sticker present. The Schuco suction machine did not have any inspection tag/sticker present. Per interview on 01/10/18, staff member # 3 stated the suction machine had not been inspected in the 7 years they had been employed at the facility. Per the manufacturer manual, preventative maintenance should completed annually on this machine. Without routine inspection and preventative maintenance,</p> | A 197 | | |

Texas Department of State Health Services

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER SUBURBAN WOMENS CLINIC | STREET ADDRESS, CITY, STATE, ZIP CODE 3101 RICHMOND #250 HOUSTON, TX 77098 |
|--|--|

| (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 |
|--------------------------|--|---------------------|--|--------------------------|
| A 197 | Continued From page 4. it cannot be ensured that all medical equipment is in proper working order for patient use. * The following expired medications were noted: In the procedure room 1 bottle of Nitroglycerin 0.4 mg tabs expired 05/17, 1 bottle Adenosine 4 ml bottle expired 12/16, 1 bottle Solumedrol 125 mg powder expired 06/17, Ventolin Inhaler 90 mcg expired 10/17, and 22 bottles of Phenergan 25 mg/ml expired 11/17. Expired medication should not be available for patient use. * Examination tables in Room # 1 and 2 had small tears (< .5 inch in size) in the vinyl at the foot of the bed, preventing effective cleaning of these surfaces and potential contamination. In the procedure room a 3 x 3 inch was worn on the vinyl at the foot of the exam table. * In the recovery room 2 of 4 stretcher mattresses were observed to have large amounts of duct tape covering openings in the mattress. Tape cannot be effectively cleaned presenting a risk of contamination to these mattresses. * In a facility procedure room: An open box of sterile drapes and 2 boxes of dressing retainers were observed stored on the floor, this placed these supplies at risk of contamination. Approximately 2 large external shipping containers were being stored on the floor. External shipping containers are exposed to a number of environmental contaminants en route to their final destination and are considered dirty items. According to APIC: "Supplies must be: Removed from shipping cartons or cardboard boxes before storage to prevent contamination with soil/debris that may be on cartons ...Do not leave outer shipping boxes in clinical areas (due to risk of environmental contamination)." Preventing Infection in Ambulatory Care, Winter 2011/2012; available: http://apic.org/Resource_/TinyMceFileManager/Education/Preventing-Inf-in-Amb-Care-Winter2012 | A 197 | | |

Texas Department of State Health Services

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|--|--|--|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUBURBAN WOMENS CLINIC

**3101 RICHMOND #250
HOUSTON, TX 77098**

| (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 |
|--------------------------|---|---------------------|---|--------------------------|
| A 197 | Continued From page 5 -FINAL.PDF. * In the sterilization area it was noted the freezer used for the storage of products of conception (POC) which is biohazardous for pick up and disposal, was not labeled as biohazard. The above findings were confirmed in an interview with staff members # 1, 3, and 4 on 01/10/18. | A 197 | | |
| A 201 | TAC 139.48(1)(E)(F) Physical & Environmental Requirements The physical and environmental requirements for a licensed abortion facility are as follows. (1) A facility shall: (E) store hazardous cleaning solutions and compounds in a secure manner and label substances; (F) have the capacity to provide patients with liquids. The facility may provide commercially packaged food to patients in individual servings. If other food is provided by the facility, it shall be subject to the requirements of §§229.161 - 229.171 of this title (relating to Texas Food Establishments); This Requirement is not met as evidenced by: Based on a tour of the facility, the facility failed to store hazardous cleaning solutions and compounds in a secure manner. Failure to do so increases the risk of harm to patients. Findings were: During a tour of the facility on 01/10/18, the unlocked supply closet contained the following items including Lysol wipes, Lysol spray, EZ-kil | A 201 | I The Administrator will make sure The Physical and Environmental requirements are met, always. Liquid for patients need will be provided. I will store, lock away any hazardous material of any kind to protect patient's safety. | 02/23/18 |

Texas Department of State Health Services

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUBURBAN WOMENS CLINIC

3101 RICHMOND #250
HOUSTON, TX 77098

| (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 |
|--------------------------|--|---------------------|---|--------------------------|
| A 201 | Continued From page 6 wipes, and Speed Clean Autoclave cleaner. The unlocked sterilization area contained the following items: Pine-sol, Clorox liquid, Windex glass cleaner, AF315 disinfectant, and powder laundry detergent. The above was confirmed in an interview with staff members # 3 and 4 on 01/10/18 during a tour of the facility. | A 201 | | |
| A 246 | TAC 149.49(d)(5)(G)(i)(ii) Infection Control Standards (G) Sterilizers. (i) Steam sterilizers (saturated steam under pressure) shall be utilized for sterilization of heat and moisture stable items. Steam sterilizers shall be used according to manufacturer's written instructions. (ii) Other sterilizers shall be used in accordance with the manufacturer's instructions. This Requirement is not met as evidenced by: Based on a review of documentation and interview, the facility failed to ensure that sterilizers were used in accordance with the manufacturer's instructions, as evidence by not performing maintenance per manufacturer recommendations. Findings included: Review of the manufacturer manual for the M11 Autoclave Steam Sterilizer stated in part, "Operator Maintenance, Monthly | A 246 | I as Administrator will make sure the sterilizer in the facility is maintained according to the manufacturers instructions and this includes flushing the system monthly. | 02/23/18 |

Texas Department of State Health Services

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER SUBURBAN WOMENS CLINIC | STREET ADDRESS, CITY, STATE, ZIP CODE 3101 RICHMOND #250 HOUSTON, TX 77098 |
|--|--|

| (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 |
|--------------------------|--|---------------------|--|--------------------------|
| A 246 | Continued From page 7 1. Flush the System -To protect the intricate parts of the unit, the system must be flushed once a month with Speed Clean Sterilizer Cleaner." Review of the autoclave log revealed that the sterilizer revealed the last 2 documented cleanings were on 11/02/17 and 01/03/18. In an interview with staff member #3 on 01/10/18 they stated that the system was flushed 2 months which does not meet the criteria for monthly flushing set by manufacture recommendations. The above findings were confirmed in an interview with staff members # 3 and 4 on 01/10/18. | A 246 | | |

Texas Department of State Health Services

| | | | |
|---|---|--|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED |
| | 008028 | | 01/10/2018 |

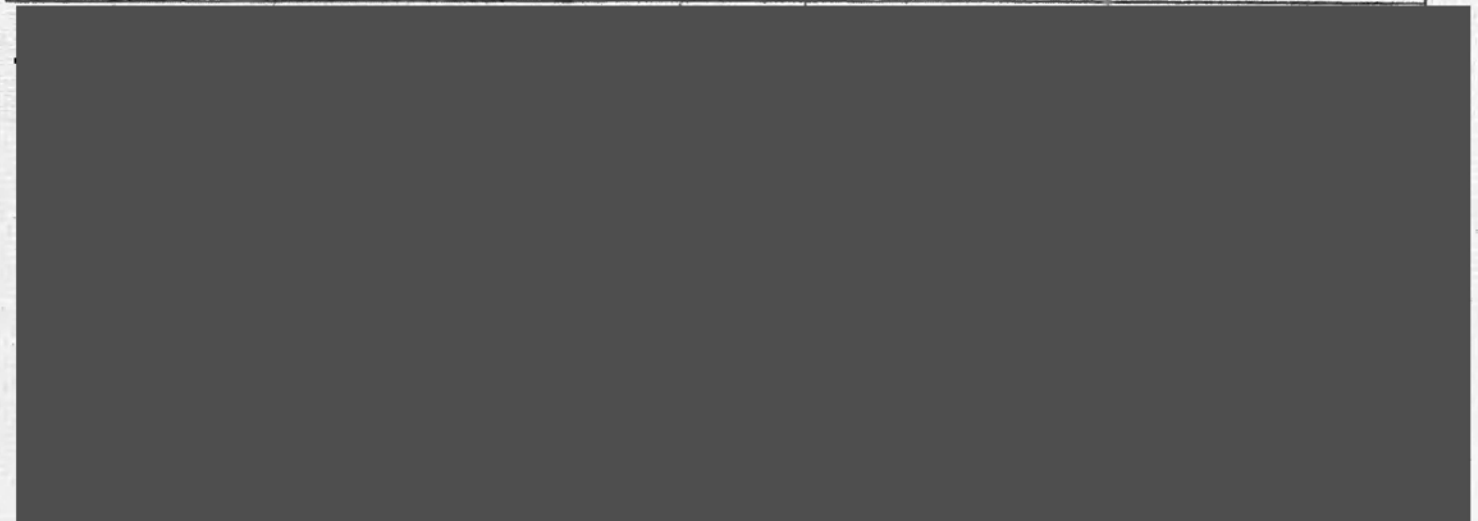
NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUBURBAN WOMENS CLINIC

3101 RICHMOND #250
HOUSTON, TX 77098

| | | | | |
|--------------------------|--|---------------------|--|--------------------------|
| (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 |
|--------------------------|--|---------------------|--|--------------------------|



| | | | |
|---|---|--|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED |
| | 008028 | | 01/10/2018 |

| | | | | |
|--------------------------|--|---------------------|--|--------------------------|
| (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 |
|--------------------------|--|---------------------|--|--------------------------|

Texas Department of State Health Services

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER SUBURBAN WOMENS CLINIC | STREET ADDRESS, CITY, STATE, ZIP CODE 3101 RICHMOND #250 HOUSTON, TX 77098 |
|--|--|

| | | | | |
|--------------------------|--|---------------------|--|--------------------------|
| (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 |
|--------------------------|--|---------------------|--|--------------------------|



A 328 HSC Code, D173.063(d)((1)(2)(e)(1)(2)(f))
Abortion-Inducing Drugs

(d) The physician who gives, sells, dispenses, administers, provides, or prescribes an abortion-inducing drug shall provide the pregnant woman with:

- (1) a copy of the final printed label of that abortion-inducing drug; and
- (2) a telephone number by which the pregnant woman may reach the physician, or other health care personnel employed by the physician or by the facility at which the abortion was performed with access to the woman's relevant medical records, 24 hours a day to request assistance for any complications that arise from the administration or use of the drug or ask health-related questions regarding the administration or use of the drug.

A 328

I The Medical Director will ensure that efforts are made to reach patients for the necessary follow up after medication abortion. All such efforts will be documented.

02/23/18

Texas Department of State Health Services

FORM APPROVED

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUBURBAN WOMENS CLINIC

3101 RICHMOND #250
HOUSTON, TX 77098

| (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 |
|--------------------------|---|---------------------|--|--------------------------|
| A 328 | <p>Continued From page 10</p> <p>(e) The physician who gives, sells, dispenses, administers, provides, or prescribes the abortion-inducing drug, or the physician's agent, must schedule a follow-up visit for the woman to occur not more than 14 days after the administration or use of the drug. At the follow-up visit, the physician must:</p> <p>(1) confirm that the pregnancy is completely terminated; and</p> <p>(2) assess the degree of bleeding.</p> <p>(f) The physician who gives, sells, dispenses, administers, provides, or prescribes the abortion-inducing drug, or the physician's agent, shall make a reasonable effort to ensure that the woman returns for the scheduled follow-up visit under Subsection (e). The physician or the physician's agent shall document a brief description of any effort made to comply with this subsection, including the date, time, and name of the person making the effort, in the woman's medical record.</p> <p>This Requirement is not met as evidenced by: Based on a review of documentation, the physician who gave, sold, dispensed, administered, provided or prescribed the abortion-inducing drug, or the physician's agent, did not make a reasonable effort to ensure that the woman returned for the scheduled follow-up visit under Subsection (e). The physician or the physician's agent failed to document a brief description of any effort made to comply with this subsection, including the date, time, and name of</p> | A 328 | | |

Texas Department of State Health Services

| | | | |
|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 008028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 01/10/2018 |
|---|---|--|---|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUBURBAN WOMENS CLINIC

3101 RICHMOND #250
HOUSTON, TX 77098

| (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 |
|--------------------------|--|---------------------|--|--------------------------|
| A 328 | <p>Continued From page 11</p> <p>the person making the effort, in the woman's medical record.</p> <p>Findings were:</p> <p>During the survey, a total of 16 clinical records were reviewed. 4 of these 16 records were of patients administered an abortion-inducing drug (medical procedure patients #1 through #4). Although all 4 patients had been given an appointment 14 days after the administration of the abortion-inducing drug, none of the patients presented for their follow-up appointments. The records of all 4 patients were stamped with a stamp that read "Missed Appointment" in the area where a follow-up appointment would be documented. None of the clinical records contained any documentation that any efforts had been made to contact the woman in any way following the missed appointment.</p> <p>The above was confirmed in an interview with the Medical Director on the afternoon of 1-10-18.</p> | A 328 | | |