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
	140007	A. BUILDING: _____ B. WING _____	11/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLE WOMANS HEALTH OF SAN ANTONIO	4025 E SOUTHCROSS BLVED BLDG 5 SUITE 30 SAN ANTONIO, TX 78222

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A 000	TAC 139 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 co-owner on the morning of 11-7-16. 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 co-owner and other administrative staff on the afternoon of 11-8-16. Preliminary findings of the survey were discussed, and an opportunity given for questions.	A 000	REVIEWED DEC 13 2016 BY: Wanda Wilson, RN	
A 033	TAC 139.8(a) Quality Assurance (a) Quality Assurance (QA) Program. A licensed abortion facility shall maintain a QA program in the facility which shall be implemented by a QA committee. The QA program shall be ongoing and have a written plan of implementation. This plan shall be reviewed and updated or revised at least annually by the QA Committee. The QA program shall include measures for quality improvement in the measurement of the facility's delivery of service. Quality assurance documents pertinent to the facility shall be kept within the facility.	A 033		

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A 033	Continued From page 1 This Requirement is not met as evidenced by: Based on a review of documentation and interview, the facility failed to maintain a QA program as evidence by failing to ensure the written plan of quality assurance was implemented. Findings included: Facility policy entitled, "Quality Assurance Program" stated in part; "The Q A Committee will meet quarterly or more often as necessary in order to identify issues with respect to which QA assurance activities are necessary." Review of the Quality Assurance meeting minutes for 2016 revealed the following: * The meeting minutes for Quarter 1 (dated 04/07/16) and Quarter 2 (dated 08/18/16) were the exact same minutes. * The meeting minutes for Quarter 1 (dated 04/07/16) referred to discrepancies identified on 05/11/16 and an inventory of equipment completed on 06/20/2016/ * The meeting minutes for Quarter 1 (dated 04/07/16) also appeared to have white out present where the date of 04/07/16 was recorded on the signature page for these minutes. In an interview on 11/08/16, staff members # 10 and 11 confirmed the quality minutes for Quarter 1 (04/07/16) appeared to be a duplicate of the actual meeting conducted for Quarter 2 on 08/18/16. The meeting minute for Quarter 1 (04/07/16) were not an accurate account of the review of quality activities/measures quarterly, per the facility quality assurance plan.	A 033	A 033 The Clinic Manager will be responsible for ensuring that the QA committee meets Quarterly or more often if necessary to identify issues with respect to which QA assurance activities are necessary. A quality assurance committee meeting took place on 08/18/16, where the committee reviewed and confirmed the quality of care practices at Whole Woman's Health of San Antonio were aligned with best standards of care. However, the Clinic Manager at that time, who was terminated prior to the department's survey, did not file the meeting minutes accurately. The current Clinic Manager along with the Director of Clinic Services, have audited the systems designed to ensure quality assurance for that timeframe, and have found that all measures were properly followed and the facility's delivery of service was not affected. In order to ensure continued compliance with the QA program, the Director of Clinical Services will Review all Quarterly Reports.	08/18/2016 01/15/2017

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A 143	Continued From page 2	A 143		
A 143	TAC 139.43(2)(3)(4)(5) Personnel Policies (2) a requirement for orientation of all employees, volunteers, students and contractors to the policies and objectives of the facility and participation by all personnel in employee training specific to their job; (3) job-related training for each position; (4) a requirement for an annual evaluation of employee performance; (5) in-service and continuing education requirements; This Requirement is not met as evidenced by: Based on review of documentation and interview, the facility failed to ensure that an annual evaluation of employee performance was completed. Findings included: Review of the facility personnel files revealed that 6 out 10 employees did not have a current annual evaluation completed. * Staff member # 1's last annual evaluation was completed on 10/15/15. * Staff member # 5's last annual evaluation was completed on 07/14/14. * Staff member # 7 had no annual evaluation completed with a hire date of 08/17/15. * Staff member # 8's last annual evaluation was completed in March 2015. * Staff member # 9 last had a 90 day review completed on 04/10/14. * Staff member # 10's last annual evaluation	A 143	A143 The Clinic Manager will be responsible for ensuring staff members received an annual evaluation of employee's performance. The Clinic Manager has created a detailed schedule to complete all staff's annual evaluations. this process was started on November 15, 2016, and all evaluation reports will be submitted to the DCS by January 15, 2017. The Director of Clinical Services will ensure that new Clinic Manager is trained to adhere to the current written employee policy. In order to ensure continued compliance with the Employee Policies, the Clinic Manager will ensure that all staff files are reviewed and evaluations are scheduled as part of the QA committee meeting.	01/15/2017

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A 143	Continued From page 3 was completed on 07/17/15. In an interview on 11/08/16, staff members # 10 and 11 confirmed the facility was unable to locate current annual evaluations for the above staff members.	A 143		
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:	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	A 201		

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A 201	Continued From page 4 Establishments); This Requirement is not met as evidenced by: Based on observation, the facility failed to store hazardous cleaning solutions and compounds in a secure manner. Findings were: During a tour of the facility on 11-8-16, the laundry area (closed off only by a curtain) contained a shelving unit where various cleaners and chemicals such as germicide, enzymatic cleaner and bleach were stored. The above was confirmed in an interview with the co-owner and Director of Clinical Services on the afternoon of 11-8-16.	A 201	A201 The Clinic Manager will be responsible for ensuring that hazardous cleaning solutions and compounds are stored in a secure manner. Cleaners and solutions stored in laundry room area will be moved to a designated storage area. A lock will be installed on the storage closet door. The Clinic Manager will conduct an in-service with all staff to advise what materials will be stored in the closet and also to advise staff that the storage room door must remain locked during clinic hours. To ensure continued compliance, the QA committee will inspect the storage closet during the QA committee meeting.	12/23/2016 01/17/2017