_										
	Texas	Health and Human Servi	ces Commission		•	PRINTED: 05/02/2 FORM APPRO				
		MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED				
			140013	B. WING						
	NAME O	F PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE	04/23/2019				
	WHOL	E WOMAN'S HEALTH ALLI	ANCE 8401 NC	ORTH IN 35 SUIT						
	(X4) (0	D SUMMARY ST	ATEMENT OF DEFICIENCIES	I, TX 76753						
	PREFIL	X (EACH DEFICIENC) REGULATORY OR 1	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COURSE	ET 6			
	60	000 TAC 139.1 Initial Con	nments	6 000					-	
		Note: The State Form document. All informa unchanged except for	tion must remain entering the plan of	an a		and the second second second			E.	
		correction, correction space. Any discrepan- citation(s) will be refer	dates, and the signature cy in the original deficiency red to the Office of the al (OAG) for possible fraud.							
		If information is inadve	ententiy changed by the State Survey Agency (SA)							
		and Licensing Act, Her	ose of this chapter is to bortion Facility Reporting alth and Safety Code.							
		Chapter 245, which pro Human Services Comu to establish rules gove regulation of abortion f annual reporting requir performed. This chapter	ovides the Health and nission with the authority ming the licensing and acilities and to establish ements for each abortion	*				. :		
		(b) Scope and applicab (1) Licensing requirem	-	, and and a star of the star o		50 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				-
		(A) A person may no abortion facility in Texas	t establish or operate an without a license issued as the person is exempt							
		(B) The following nee this chapter:	d not be licensed under							
	i	(i) a hospital license Safety Code, Chapter 2	41;							
			rgical center licensed	VICT I MANAGE						
ŝ	OD - State Fo	orm _		1						
			ATURE	E	דודנב ducational and Training Specialist	(X6) DATE 6/7/2019				
				esse Pitt	IWI 1	If continuation sheet 1 of	7			

•

· .

-

(X4) ID PREFIX TAG SL (EACH (EACH REGUL 6 000 TAC 139.1 I Note: The S document. A unchanged a correction, c space. Any a citation(s) w Texas Attorr If information provider/sup should be not (a) Purpose. implement th and Licensir Chapter 245 Human Serv to establish regulation of annual repor performed. T Woman's Ri Code, Chap (b) Scope ar (1) Licensir (A) A pers abortion faci					(X3) DATE SURVEY COMPLETED	
(X4) ID PREFIX TAG SL (EACH (EACH REGUL 6 000 TAC 139.1 I Note: The S document. A unchanged a correction, c space. Any a citation(s) w Texas Attorr If information provider/sup should be not (a) Purpose. implement th and Licensir Chapter 245 Human Serv to establish regulation of annual repor performed. T Woman's Ri Code, Chap (b) Scope ar (1) Licensir (A) A pers abortion faci			B. WING		04	/23/2019
(EACH (EACH TAG (EACH 6 000 TAC 139.1 I Note: The S document. A unchanged a correction, a space. Any a citation(s) w Texas Attorn If information provider/sup should be not (a) Purpose. implement th and Licensir Chapter 245 Human Server to establish regulation of annual report performed. To Woman's Ri Code, Chap (b) Scope ar (A) A pers abortion faci		NCE 8401 N	ADDRESS, CITY, STAT ORTH IH 35 SUITE 2 N, TX 78753			
Note: The S document. A unchanged e correction, c space. Any o citation(s) w Texas Attorr If information provider/sup should be no (a) Purpose. implement th and Licensir Chapter 245 Human Serv to establish regulation of annual repor performed. T Woman's Ri Code, Chap (b) Scope ar (1) Licensir (A) A pers abortion faci	EFIX (EACH DEFICIENCY MUST BE PI AG REGULATORY OR LSC IDENT FY		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
from licensir (B) The fo this chapter: (i) a hosp	State Form All informa d except for , correction y discrepan- will be refer orney Gener ion is inadve upplier, the notified imm se. The purp t the Texas A sing Act, He 45, which pre ervices Com th rules gove of abortion porting requi th. This chapt Right to Kno apter 171. and applica sing require erson may n acility in Texa chapter unl sing require following ne er:	is an official, legal tion must remain entering the plan of dates, and the signature cy in the original deficiency red to the Office of the ral (OAG) for possible fraud. extently changed by the State Survey Agency (SA) hediately. oose of this chapter is to abortion Facility Reporting eath and Safety Code, rovides the Health and mission with the authority erning the licensing and facilities and to establish rements for each abortion ter also implements the bow Act, Health and Safety bility. ments. ot establish or operate an as without a license issued ess the person is exempt ments. eed not be licensed under	6 000			
(ii) an an	de, Chapter	241:				

If continuation sheet 1 of 7

PRINTED: 05/02/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED		
		140013	B. WING		04	04/23/2019		
AME OF P	ROVIDER OR SUPPLIER	STREET A	TREET ADDRESS, CITY, STATE, ZIP CODE					
	OMAN'S HEALTH ALL	14NCE 8401 NO	RTH IH 35 SUITE 2	200				
		AUSTIN	, TX 78753					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE		
6 000	Continued From pag	e 1	6 000					
	under Health and Sa	fety Code, Chapter 243; or						
	Texas Medical Board medicine in the State	a physician licensed by the d and authorized to practice e of Texas, unless the office se of performing more than 2-month period.						
	facilities and facilities licensing shall compl (relating to Annual R Abortions Performed An entrance confere Director of Clinical S 04/22/19. The purpo	nce was held with the facility ervices on the morning of se and process of the ere discussed, and an						
	Continued licensure approved plan of cor	is recommended, with an rection.						
	Director of Clinical S	fternoon of 04/23/19. of the survey were						
6 033	TAC 139.48 Physica Requirements	l and Environmental	6 033					
	The physical and enables and enable	vironmental requirements for acility are as follows.						
	(1) A facility shall:							
		nd sanitary environment, , equipped, and maintained						

STATE FORM

PIHW11

If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			B. WING	04	/23/2019	
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
	VOMAN'S HEALTH ALLI	ANCE 8401 NC	ORTH IH 35 SUITE 2	200		
-	[AUSTIN	I, TX 78753			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLE ⁻ DATE
6 033	Continued From page	e 2	6 033			
	to protect the health and safety of patients and staff at all times;					
	procedures can be p	cedure room so that erformed in a manner that safety of all individuals in the				
	sedation/analgesia, o	te recovery room if moderate deep sedation/analgesia, or re administered at the				
	evacuation for fire an the facility's geograph member employed by facility shall be able to responsibility to imple	protocol for emergency d other disasters tailored to hic location. Each staff y or under contract with the o demonstrate their role or ement the facility's on protocol required by this				
	(E) store hazardou compounds in a secu substances;	is cleaning solutions and ire manner and label				
	liquids. The facility m packaged food to pat If other food is provid	city to provide patients with ay provide commercially tients in individual servings. led by the facility, it shall be ments of Chapter 228 of this I Food);				
		hand washing facilities for luding running water, and				
	(H) have two funct functioning toilet; and					

SOD - State Form STATE FORM

PIHW11

AND PLAN OF CORRECTION IDENTIFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING			04/23/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WHOLE WOMAN'S HEALTH ALLIANCE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE A401 NORTH IH 35 SUITE 200 AUSTIN, TX 78753 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE C							
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES	ID		_D BE	(X5) COMPLETE DATE	
6 033	Continued From page	ə 3	6 033				
	instruments, equipme accordance with §139	available to sterilize ent, and supplies in 9.49(d) of this title (relating tandards) before use in the					
	be electrically safe an	or vacuum aspiration shall nd designed to prevent in facilities that provide					
	to existing buildings s phased so that on-sit minimize disruptions Access, exit ways, ar maintained so that th			The Clinic Manager is respons insuring the physical and environmental safety for all pa that come to WWHA. The Clinic Manager installed a the door of the laundry room of 04/24/2019 to ensure that pat not able to access hazardous of	tients lock on on ients are	04/24/201	
	Based on a tour of th store hazardous clea	ire manner. Failure to do so		solutions. Staff was instructed 4/24/2019 to ensure that they initiating the lock after each ac any hazardous cleaning solutio	l on are ccess to		
	unlocked laundry roo	acility on 04/23/19, the m contained items including ay, laundry detergent, and		In order to monitor continued compliance, the Clinic Manage randomly observe that the staf utilizing the lock after each acc 90 days to ensure that only sta access to hazardous cleaning s	f is cess for ff has		
		rmed in an interview with during a tour of the facility.					

STATE FORM

PIHW11

If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		04/23/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE	, ZIP CODE		
WHOLE V	VOMAN'S HEALTH ALLI	ANCE	ORTH IH 35 SUITE 2 I, TX 78753	00		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
6 041	Continued From page	e 4	6 041			
6 041	TAC 139.56 Emerger	ncy Services	6 041			
	emergencies and the requiring further eme The facility shall ensu practice at the facility (1) have active adm that provides obstetri care services and is I miles from the abortic (2) provide the preg (A) a telephone nu woman may reach th care personnel emple facility at which the a induced with access medical records, 24 H assistance for any co the performance or ir ask health-related qu abortion; and	itting privileges at a hospital itting privileges at a hospital ical or gynecological health located not further than 30 on facility; mant woman with: mber by which the pregnant e physician, or other health byed by the physician or the bortion was performed or to the woman's relevant nours a day to request omplications that arise from nduction of the abortion or uestions regarding the				
	nearest hospital to th woman at which an e abortion would be tre (b) The facility shall h equipment and perso	nave the necessary onnel for cardiopulmonary ribed in §139.59 of this title				
		ng direct patient care shall in basic life support bythe				

SOD - State Form STATE FORM

PIHW11

PRINTED: 05/02/2019 FORM APPROVED

STATEMEN	alth and Human Servic IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	140013 IAME OF PROVIDER OR SUPPLIER STREE				04/2	23/2019
NAME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
	VOMAN'S HEALTH ALLI	ANCE 8401 NO	RTH IH 35 SUIT	E 200		
WHOLL V	VOMAN STEALTH ALL	AUSTIN	, TX 78753			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
6 041	Continued From page	e 5	6 041			
	Cross, or the America Institute, or in accord	ance with their individual e requirements, and if		ponsible for patient with number of the ome of the n an emergency would be	05/21/20	
	Based on a review of interview the facility f physicians who pract pregnant woman with number of the neares pregnant woman at w from the abortion wow The facility also failed providing direct patie certified in basic life s Heart Association, th the American Safety accordance with their licensure requirement description or job res Findings included: Review of medical re * 2 of 10 medical re documentation that th number of the neares pregnant woman at w from the abortion wow to the patient. * Surgical Patient #8 information sheet tha However on their disc	ailed to ensure that the ice at the facility provide the ice at the facility provide the it he name and telephone at hospital to the home of the which an emergency arising uld be treated. It to ensure that personnel int care shall be currently support by the American e American Red Cross, or and Health Institute, or in r individual professional its, and if required in their job ponsibilities.		The Director of Clinical S conducted a re-training o with the Whole Woman's Coordinator, and all clinic Aftercare staff will review abnormal signs and symp patient, and what to do if should arise from their at are aware they will the US finder to look up the near and phone number, provi information to the patien document the informatio surgical record in the after In order to monitor conti compliance, the Clinic Ma monthly conduct chart au that staff is documenting hospital and phone numb surgical record.	n 05/21/2019 Health Clinic cal staff. normal and tooms with the an emergency portion. Staff Shospital rest hospital ide the t, and n on the ercare section. nued anager will udits to ensure nearest	

SOD - State Form STATE FORM

PIHW11

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL		
		140013	B. WING			04/23/2019	
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	FATE, ZIP CODE			
WHOLE W	VOMAN'S HEALTH ALLI	ANCE	RTH IH 35 SUIT	E 200			
			, TX 78753				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
6 041	Continued From page	e 6	6 041				
	This would not be the number of the neares patient, which would * Medical Patient #1 in Cameron, Texas. H paperwork, they were phone number for a M The phone number of home of the patient. be in Cameron, Texa not a hospital. * Medical Patient #3 in San Antonio, Texas discharge paperwork name and phone num emergency center in be the name and tele nearest hospital to th nearest hospital to th nearest hospital to th nearest hospital. The facility based job Assistant stated in pa "Experience and Gen * Certification in Basic Review of personnel * Staff member #10 2019.	e name and telephone st hospital to the home of the be in Uvalde, Texas. listed their home address dowever on their discharge e provided with the name and Medical Services Center. rovided was for a family would not be the name and the nearest hospital to the The nearest hospital would s. Also a physician office is d listed their home address s. However on their they were provided with the nber for a free standing Austin Texas, this would not phone number of the e home of the patient. The d be in San Antonio, Texas. emergency clinic is not a description for Medical art, to Life Support". files revealed the following: s CPR expired in February /23/19 staff member # 12		The Clinic Manager is responsib ensuring all staff providing direc patient care will be currently cer basic life support. The staff member #10 was notifit they were out of compliance and deadline to complete course. The member was attending the CPR the time of the inspection. On 04/23/2019 staff member did co the approved Basic Life Support training successfully and a copy completed training was placed in staff personnel record. In order to monitor continued compliance, the Clinic Manager conduct monthly personnel char to ensure that all staff Basic Life	ed that given a e staff class at CPR of n the will	04/23/201	

SOD - State For STATE FORM

6899

PIHW11

If continuation sheet 7 of 7