Utah Department of Health, Bureau of Licensing and C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	08/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 SOUTH 1000 EAST, SUITE 120 SALT LAKE CITY, UT 84102

(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
G 000	Initial Comments On 8/6/2020, a scheduled relicensure survey was conducted. The facility was surveyed according to R432-600 Rules for Abortion Clinics. One deficiency was identified and cited.	G 000	POC approved 8/24/2020 Correction date 8/20/2020 Licensing Manager Kristi Grimes	
G 265	R432-600/8(6)(h) Administrator (6) Responsibilities shall include at least the following: (h) Review all incident and accident reports and document what action was taken. This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY: Based on record review and interview, it was determined the Administrator did not review all incident and accident reports and document what action was taken. Findings include: On 8/6/2020 at 3:15 PM, a review of incident reports from February to June 2020 was conducted. Approximately 20 incident reports were reviewed. No documentation was found that the clinic Administrator had reviewed the incident reports. At 3:20 PM, an interview was conducted with the clinic Manager, who acknowledged there was no documentation to verify the Administrator had reviewed all incident reports.	G 265	Complication report form updated to have a clear area for Administrator review. See attachment. Administrator will review and sign all complication reports on a regular basis. All complication reports will be reviewed by Administrator by the end of the month.	8/20/20

Bureau of Licensing and Certification

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
VGalindo (Veronica Galindo)	Clinic Manager	8/20/2020

PLANNED PARENTHOOD ASSOCIATION OF UTAH
ABORTION COMPLICATION REPORT FORM

Name of patient_____ PRN# _____

DOB___/___/____ Date of Incident _____Gest age_____

Date of procedure _____/_____/_____ Surgical provider_____

Complication:

____retained POC
____missed ectopic
____Molar pregnancy
____perforation
____laceration
____continuing pregnancy
____hematometra
____excessive bleeding EBL : _____
____post abortal infection
____Vasovagal reaction
____allergic reaction
Mife ID# (11 digits)_____

____other_____

Details of complication:

Treatment provided:

Follow-up recommended:

Signature of person reporting _____ Date _____/_____/_____

Surgical Director review:

Action recommended:

Surgical Director Signature_____ Date _____/_____/_____

Administrator Comments:

Reviewed by _____ Date _____/_____/_____

8/2020

Confidential: This form is a part of a Quality Assurance program and protected from discovery under Utah Code Annotated 26-25-1 ET SEQ