STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

September 15, 2015

Administrator
Hagerstown reproductive Health Services
160 West Washington St., Suite 100
Hagerstown, MD 21740

Dear

Enclosed is a list of State deficiencies resulting from a relicensure survey that was completed at your facility on August 14, 2015.

Please note that an Acceptable Plan of Correction (POC) for the identified deficiencies must include the following information:

1. **State how the management team will evaluate the scope of each deficiency cited.**

2. **State what process changes the management team will make to correct each specific deficiency identified.**

3. **Define the projected time line for each step in the corrective action plan for each deficiency cited.**

4. **Define the projected completion date for each deficiency cited.**

5. **Identify who will be responsible for assuring each step in the plan of correction is implemented.**

6. **State what specific quality indicators that the management team will monitor and evaluate the effectiveness of the corrective actions.**

7. **Define what will be the on-going schedule of the quality monitoring activities for each deficiency cited.**

IT IS IMPERATIVE THAT YOUR POC CONTAIN THE ABOVE COMPONENTS.
Please complete Forms CMS 2567 as follows:

1. **Use the official form provided to you for your response.**
2. **Your Plan of Correction must be entered in the appropriate column on the right.**
3. **An authorized representative of your facility must sign and date the form in the designated space provided.**

PLEASE RETURN COMPLETED CMS 2567:

Barbara Fagan, Program Manager
Ambulatory Care Programs
Office of Health Care Quality
Spring Grove Center
Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiency(ies) being disputed, and an explanation of why you are disputing those deficiencies, to Dr. Tricia Nay, Director, Office of Health Care Quality, Bland Bryant Building, Spring Grove Center, 55 Wade Avenue, Catonsville, Maryland 21228. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Please submit a Plan of Correction within 10 calendar days of receipt of this letter. Please be advised that failure to submit an acceptable POC could result in a recommendation to terminate your facility from the Medicare program.

If you have any questions regarding these instructions, please call the undersigned at (410) 402-8040.

Sincerely,

Barbara Fagan
Program Manager
Ambulatory Care
Office of Health Care Quality

Cc: file

Office of Health Care Quality

PRINTED: 09/15/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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	A 000		

A relicensure survey was conducted at Hagerstown Reproductive Health Services on August 13 and 14, 2015. An exit interview was conducted on August 14, 2015.

The center performs surgical abortion procedures.
The facility includes two operating rooms.

The survey included: an on-site visit; an observational tour of the physical environment; observation of one surgical procedure; observation of cleaning of the procedure room, patient equipment and set up observation of the patient laboratory (blood draw) process; observation of patient ultrasound process; observation of the registered nurse pre operative assessment; observation of medication preparation; observation of patient education process; observation of patient discharge process; observation of hand hygiene; observation of instrument cleaning/sterilization process; interview of the facility's administrator, registered nurses (RN), counselors and medical assistants; review of the policy and procedure manual; review of the personnel files; review of quality assurance and infection control program, and review of professional credentialing.

A total of five clinical records were reviewed. The surgical abortion procedures that were performed between April and August of 2015 were reviewed.

Findings in this report are based on data present in the administrative records at the time of review. The agency's administrator was kept informed of the survey findings as the survey progressed. The agency administrator was given the opportunity to present information relative to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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	Continued From page 1 findings during the course of the survey. A key code for patients, medical staff and employees contained herein was provided to the agency administrator.	A 000		
A 420	.05 (A)(1)(e)(i) .05 Administration (e) Ensuring that all personnel: (i) Receive orientation and have experience sufficient to demonstrate competency to perform assigned patient care duties, including proper infection control practices; This Regulation is not met as evidenced by: Based on review of training files, review of the policy and procedure for infection control officer and interview of the administrator it was determined that one of two physicians did not have infection control training. Staff: B, I The findings include. Review of staff B's training file revealed there was no documentation the staff member had infection control staining. Review of the policy and procedure for "Infection Control Officer (ICO) revealed, The ICO will make sure each patient care employee understands such basic precautions as handwashing, wiping down equipment in contact with a patient, use of gloves, using proper personal protective equipment, proper disposal of soiled linen, glass, needles, and sharps. The ICO will schedule employee training of universal precautions and Occupational Safety & Health Administration (OSHA) blood-borne pathogens in coordination	A 420	The scope of this deficiency is limited to an individual staff member identified in the state's findings as "B." This individual will undergo updated training on infection control and provide documentation to that effect as soon as training is completed. In the future the named individual will participate in the group training routinely provided to all staff or seek training individually at the same time as the rest of the staff. Correction of this deficiency requires that "B" attend an appropriate training which will be arranged and completed by 11/1/15. "I" was deficient in ensuring that the above mentioned training was completed by ALL staff. In the future, the management team will be responsible for assuring that this is done every two years as required. An ancillary deficiency states that our documentation for this training does not reflect that the infection control training is good for two years. This clarification will be added to training documentation in the future.	11-1-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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 420	Continued From page 2 with regular Cardiopulmonary resuscitation (CPR) training. The ICO will assure each employee with direct patient care responsibilities has an understanding of universal precautions by means of observation and evaluation." Interview of the administrator (I) on August 14, 2015 at 11:05 AM revealed there is no infection control training for the physician's. Infection control training is part of the CPR training every two years. The infection control form does not document that the infection control training is good for two years.	A 420		
A 600	.05(C)(5) .05 Administration (5) Infection control for patients and staff; This Regulation is not met as evidenced by: Based on patient observations, review of infection control training policy and procedure and interview of the administrator it was determined that the administrator did not implement infection control policies and did not ensure that measures to prevent infection were practiced at the facility. These measures included not donning gloves when cleaning patient equipment and the patient area. Staff: D, I The findings include. Based on observation of patient #1's admission on [redacted] by the registered nurse (D) revealed, the nurse placed the blood pressure cuff on the patient's left arm, the nurse then removed the blood pressure cuff. The nurse withdrew a disinfection wipe without donning gloves and cleaned the cuff with her bare hands.	A 600	The observations that comprise this deficiency involved several examples of incorrect or inadequate infection control measures by staff member D as observed by the state survey team. Corrective action was taken immediately based on the those observations. The management team met with staff member D to discuss the issues and formulate short and longer term strategies to address them. First, the clinics own infection control procedures were reviewed with D. D was later observed in order to ensure compliance. In addition, D was asked to complete more formal re-training by an accredited provider of continuing nursing education. Two certificates were earned by staff member D, reflecting 6 contact hours for infection control and 1.5 contact hours for hand hygiene.	12-1-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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 600	Continued From page 3 The nurse did not wash their hands. The nurse then touched the patient's wrist with bare hands to take their pulse reading. The nurse did not wash her hands. The patient was transferred to the recovery room at 3:20 PM. At 3:35 PM again did not the patient used the toilet. Without washing hands or donning gloves the registered nurse (D) withdrew a disinfection wipe and cleaned the toilet. The nurse did not perform handwashing after cleaning the toilet. The nurse donned gloves and retrieved a sanitary pad from the waste basket in the bathroom. The nurse removed the gloves but did not perform handwashing. After the patient was discharged the nurse withdrew a disinfection wipe without donning gloves and cleaned the patient's recovery room chair. Review of the manufactures directions on the disinfection wipe label revealed, "When using this product wear disposable protective gloves, gowns, face mask or eye coverings. Wash hands thoroughly with soap and water after handeling." Review of the policy and procedure for "Infection Control Officer (ICO) revealed, The ICO will make sure each patient care employee understands such basic precautions as handwashing, wiping down equipment in contact with a patient, use of gloves, using proper personal protective equipment, proper disposal of soiled linen, glass, needles, and sharps. The ICO will schedule employee training of universal precautions and Occupational Safety & Health Administration (OSHA) blood-borne pathogens in coordination with regular Cardiopulmonary Resuscitation (CPR) training. The ICO will assure each employee with direct patient care responsibilities has an understanding of universal precautions by	A 600	A 600 CONTINUED "I" and "A" will monitor routine care provided by "D" to ensure that this plan of corrective action has accomplished its goals. Beginning August 20, 2015 through 9/03/15, weekly observation of D has occurred (and been documented) by "I." Beginning 10/01/15, monthly observation/evaluation through 12/2015 will be carried out (and documented) by "I."	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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 600	Continued From page 4 means of observation and evaluation." Interview of the administrator (I) on August 13, 2015 at 3:45 PM revealed she was not aware of the infection control breaches.	A 600		
A1020	.07(D) .07 Surgical Abortion Services D. Before conducting a surgical procedure, a physician or other qualified health professional shall conduct a history and physical examination. This Regulation is not met as evidenced by: Based on interview of the administrator, observation of one procedure and review of medical records it was determined that the physician did not conduct a history and physical examination before conducting the patient's surgical procedure for five of five patients receiving local sedation and did not assess one of one patient's with an elevated blood pressure. Staff: I Patients: #1, 2, 3, 4, 5 The findings include: Review of the medical records revealed the patients' form includes a physical findings section. The physical findings include an assessment of the patient's heart and/or lung sounds. Review of patient's #1, 2, 3, 4, and 5's medical records revealed that before conducting a surgical procedure the physician did not assess the patient's heart and/or lung sounds. The	A1020	11-1-15 Correction of this deficiency requires clarification of our protocol and a change in the medical chart to facilitate documentation of the physician's assessment of each patient's respiratory and cardiac status. Physicians will be instructed to note their findings accordingly. Revision of the chart (for this change and others) is currently underway and is expected to be completed by 11/1/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING: _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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
A1020	Continued From page 5 physician did not document the findings to establish the patient's baseline and to determine if the patient had any abnormal findings. Observation of Patient #1's admission assessment revealed the physician did not assess the patient's heart and/or lung sounds. The physician did not document the findings to establish the patient's baseline and to determine if the patient had any abnormal findings. Review of Patient #3"s medical record revealed the patient's pre-operative blood pressure was documented by the registered nurse as 150/100. A second blood pressure was not obtained. The physician did not document and perform a physical assessment of the patient that included a reassessment of the patient's blood pressure prior to the procedure to determine if the patient was medically stable for the procedure. Interview of staff I on August 14, 2015 at 11 AM revealed the administrator was aware the history and physical had not been completed. Review of Patient #3's medical record with staff I revealed that staff I was not aware that the patient had an elevated blood pressure prior to the procedure and that the physician had not performed a reassessment of the patient's status prior to performing the procedure.	A1020		
A1250	.10 (B)(5) .10 Hospitalization (5) Appropriate training for staff in the facility 's written protocols and procedures. This Regulation is not met as evidenced by: Based on interview of the administrator and	A1250	This deficiency has been corrected and was on schedule to be completed as part of our standard orientation practice for a new PART-TIME employee at the time of the survey. "G" had worked 10 times since her date of hire and, at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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
A1250	Continued From page 6 review of personnel files, it was determined that the administrator did not provide emergency training for patient transfers to the hospital for one of one new employees. This deficiency was cited on the previous survey conducted on February 28, 2013. Staff: G, I The findings include. Review of personnel files for staff G revealed the staff members date of hire is July 2, 2015. Review of the personnel file revealed that there is no documentary evidence that staff G received training for emergency patient transfer's to the hospital. Interview of the administrator (I) on August 14, 2013 at 12:30 PM revealed the administrator acknowledged that no training had been provided.	A1250	the time of the survey, had completed only a portion of the orientation process. Emergency training for patient transfers to the hospital was completed for "G" on Aug. 29, 2015, and means that all employees have received this training.	11-1-15
A1510	.15 (A) .15 Physical Environment A. The administrator shall ensure that the facility has a safe, functional, and sanitary environment for the provision of surgical services. This Regulation is not met as evidenced by: Based on review of policies and procedures, review of spore testing documentation, interview of the administrator it was determined that the administrator did not implement infection control policies and did not ensure that measures to prevent infection were practiced at the facility. The measures that were not done included weekly spore testing on the facility's two autoclaves. Staff: I The findings include.	A1510	More careful monitoring by "I" to ensure that the protocol is followed will address this deficiency. Additionally, the protocol will be modified to spell out provisions for holidays, in the event that the scheduled day for spore testing is a holiday. A missed day will be corrected at the earliest opportunity but must be completed before the next time patients are scheduled to be seen. A copy of the protocol is attached.	11-1-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000014	A. BUILDING _____ B. WING _____	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAGERSTOWN REPRODUCTIVE HEALTH SER	160 W WASHINGTON ST, SUITE 100 HAGERSTOWN, MD 21740

(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
A9999	Continued From page 8	A9999		

result in revocation of the license from the Department of Health and Mental Hygiene Surgical Abortion Facilities program.