MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

Office of Health Care Quality, 55 Wade Avenue, Catonsville, Maryland 21228

July 30, 2018

Administrator
Potomac Family Planning Center
966 Hungerford Drive, #24
Rockville, MD 20850

Dear Administrator:

Enclosed is a list of deficiencies resulting from a licensure survey which was completed at your agency on July 17, 2018.

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 the State Form 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.

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA000011	A. BUILDING: ______ B. WING ______	07/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTOMAC FAMILY PLANNING CENTER	966 HUNGERFORD DRIVE, #24 ROCKVILLE, MD 20850

(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 licensure survey of Potomac Family Planning Center was conducted on July 16 and 17, 2018. The survey included: interview of the staff; an observational tour of the physical environment; observation of a surgical procedure; observation of reprocessing of surgical equipment; review of the policy and procedure manual; review of clinical records; review of professional credentialing; review of personnel files and review of the quality assurance and infection control programs. The facility included two procedure rooms. A total of six patient clinical records were reviewed. The procedures were performed between September 2017 to July 2018. Findings in this report are based on data present at the time of review. The agency's staff was kept informed of the survey findings as the survey progressed. The agency staff was given the opportunity to present information relative to the findings during the course of the survey.	A 000		
A 450	.05 (A)(2)(a) .05 Administration (2) The administrator shall ensure that: (a) The facility's policies and procedures as described in §C of this regulation are: (i) Reviewed by staff at least annually and are revised as necessary; and (ii) Available at all times for staff inspection and reference; and This Regulation is not met as evidenced by: Based on a review of policy and procedure manual and interview of staff, the administrator did not ensure that staff reviewed and revised, as needed, the policy and procedure manual on an	A 450		

OHCQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 450	Continued From page 1 annual basis. The findings include: Review of the policy and procedure manual on 7/16/18 at 11:00 am revealed no documented evidence that it had been reviewed and revised, as needed, by staff on an annual basis. Interview of staff on 7/16/18 at 3:30 pm revealed that she/he acknowledged that there was no documented evidence that the policy and procedure manual had been reviewed and revised, as needed, by staff as needed on an annual basis.	A 450		
A 860	.06(D)(2)(e) .06 Personnel (e) Physician practice patterns as reviewed through the facility 's quality assurance program. This Regulation is not met as evidenced by: Based on review of the physician's credentialing files, review of the policy and procedure manual and interview of staff, the administrator failed to ensure the physicians performance pattern had been assessed through the quality assurance program, as part of the physician's biennial reappointment for three of three physicians reviewed. The findings include: Review of staff credentialing files on 7/16/18 at 12:00 pm revealed no documented evidence that their performance pattern had been assessed as part of their bienniel reappointment to the facility.	A 860		

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A 860	Continued From page 2 Review of the policy and procedure manual on 7/17/18 at 10:30 am revealed that the "Quality Assurance Program" policy and procedure does not include evaluation of the physician's performance pattern as part of the bienniel reappointment to the facility. Interview of staff on 7/16/18 at 3:30 pm revealed that physicians do not participate in peer review, or an evaluation process through the quality assurance program as part of their bienniel reappointment to the facility.	A 860		
A1280	.11 (B)(1) .11 Pharmaceutical Services B. Administration of Drugs. (1) Staff shall prepare and administer drugs according to established policies and acceptable standards of practice. This Regulation is not met as evidenced by: Based on an observational tour of the facility and interview of staff, the agency staff failed to identify and discard expired medications and supplies. The findings include: During a tour of the facility on 7/17/18 at 10:00 am, the following expired medication was observed in the storage cabinet: a. Pitocin, 2 vials, expired 5/2018. The following expired medication was located in the refrigerator: a. Influenza vaccine, 2 vials, expired 4/2018. Two needles that expired 6/2018 were observed in the emergency cart. Interview of staff on 7/17/18 at 10:00 am revealed	A1280		

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A1280	Continued From page 3 that she/he acknowledged that the staff failed to identify and discard the expired medications and supplies.	A1280		
A1490	.14 (A) .14 Patients' Rights and Responsibilities The administrator shall ensure that the facility develops and implements written policies and procedures concerning patients ' rights and responsibilities, including but not limited to: A. The opportunity to participate in planning their medical treatment; and This Regulation is not met as evidenced by: Based on review of the policy and procedure manual and interview of staff, the administrator failed to develop and implement policies and procedures regarding patient rights, to include the right of the patient to participate in planning their medical treatment. The findings include: Review of the policy and procedure manual on 7/17/18 at 10:30 am revealed there were no policies and procedures regarding patient rights, to include the right of the patient to participate in planning their medical treatment. Interview of staff on 7/17/18 at 1:00 pm revealed that she/he acknowledged that policies and procedures on patient rights were not developed, to include the right of the patient to participate in planning their medical treatment.	A1490		