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 21, 2015

Administrator
Hillcrest Clinic, Inc.
5602 Baltimore National Pike, Suite 600
Baltimore, MD 21228

Dear

Enclosed is a list of State deficiencies resulting from a follow up relicensure survey that was completed at your facility on September 3, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SA00002	A. BUILDING: _____ B. WING _____	R 09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CLINIC, INC	5602 BALTIMORE NATIONAL PIKE, SUITE 600 BALTIMORE, MD 21228

(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 follow up survey was conducted at Hillcrest Clinic in Baltimore, MD on September 2 and 3, 2015 to the deficiencies cited on May 19 and 20, 2015. An exit interview was conducted on September 3, 2015. The survey included: an on-site visit; an observational tour of the physical environment; interview of the facility's administrator; review of the policy and procedure manual; review of the personnel files; review of quality assurance and review of professional credentialing. The center performs surgical abortion procedures and includes three procedure rooms. Clinical records were reviewed for procedures that had been performed between May 2015 and July 2015. 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 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 530}	.05(C)(1) .05 Administration C. Policies and Procedures. The facility shall have policies and procedures concerning the following: (1) The scope and delivery of services provided by the facility either directly or through contractual arrangements;	{A 530}		

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{A 530}	Continued From page 1 This Regulation is not met as evidenced by: Based on review of the plan of correction (POC) from the previous survey and review of policies, it was determined that the facility staff did not have policies and procedures in place to provide oversight of the center. The findings include: 1. Review of the POC for the survey completed on 05/20/15 revealed that "(Staff) will determined which policies are in fact missing and assign appropriate personnel to write policies as needed. This will be completed by Sept. 1, 2015." 2. Review of policies on 09/02/15 revealed that policies remained incomplete. Facility staff is expected to ensure that it is in regulatory compliance for all of the facility's areas of operation. Missing policies include the following: a. Procedures to ensure personnel are free from communicable diseases; b. Credentialing and reappointment policies; c. Personnel policies; and d. Policy on laboratory turn around time and review of laboratory tests. Policy review revealed a policy entitled 'Personnel Policies Credentialing' that stated "Abortions at (site) will be provided by licensed practitioners. This category is intended to include physicians from various specialties as well as registered nurses, licensed practical nurses, medical assistants, and laboratory technicians." The policy was dated 06/15 but is not an	{A 530}	COMPLETION FOR ALL WILL BE BY 12/14/2015 STAFF M WILL BE RESPONSIBLE. a FILES ARE BEING REVIEWED MAKING SURE ALL MEDICAL PERSONNEL COMMUNICABLE DISEASE HISTORIES AND/OR IMMUNIZATIONS ARE UP TO DATE b FORMS HAVE BEEN SENT OR ARE BEING SENT FOR RECREDENTIALING AND c. POLICY WRITTEN FOR CREDENTIALING INCLUDING PERSONNEL POLICIES	

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{A 530}	Continued From page 2 acceptable alternative to policies on credentialing and reappointment of the medical staff or of personnel policies. Another policy entitled 'laboratory Turn Around Time and Review of laboratory Reports' stated "Any specimens sent to an outside laboratory are recorded in a separate binder as to day collected, day sent and day results were obtained. The administrator is to be made aware of all outgoing specimens and incoming results. The laboratory technician will follow the progress of the specimen." However, the policy fails to address an acceptable turn around time for specimens sent to an outside laboratory for processing.	{A 530} d	POLICY FOR TURN AROUND TIME HAS BEEN REVISED FOR SPECIMENS SENT TO AN OUTSIDE LAB (COMPLETED)	
{A 570}	.05(C)(2)(c) .05 Administration (c) Procedures to ensure personnel are free from communicable diseases; This Regulation is not met as evidenced by: Based on review the previous POC, review of credentialing and personnel records and interview, the facility staff did not comply with immunization requirements for all staff. This was evident for 8 of 15 staff members. Staff A, B, C, E, F, G, N, O The findings include: 1. Review of the POC for the survey completed 05/20/15 revealed that "Management has already assigned (staff member) to oversee employee health (immunizations, TB testing). (Staff) will write a policy for employee health. Will be implemented by Sept. 1, 2015."	{A 570}	RECORDS FOR STAFF ABCEFGNO ARE CURRENTLY BEING REVIEWED SO THAT THEY ARE IN COMPLIANCE WITH IMMUNIZATION REQUIREMENTS THIS IS BEING CONDUCTED BY STAFF MEMBERS M+G COMPLETION BY 12/14/2015 - POLICY FOR EMPLOYEE HEALTH WILL BE REVISED AND REVISED BY 12/14/2015 BY STAFF MEMBERS M+G.	

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{A 570}	Continued From page 3 2. Review of credentialing and personnel files on 09/03/15 revealed that current (2014-2015) documentation of compliance with immunization requirements were incomplete: a. documentation of tuberculosis (TB) immunization or TB signs/symptom screening - missing for Staff A, B, C, E, G, and O; b. documentation of Hepatitis B immunization or declination - missing for Staff F and N. 3. Interview with Staff M on 09/03/15 at 8:55 AM revealed that the facility staff is behind on completing paperwork.	{A 570} 2a 2b	STAFF M & G WILL REVIEW RECORDS FOR STAFF A, B, C, E, G, O, MAKING SURE THEY INCLUDE TB TESTING OR TB SIGN/SYMPTOM TESTING STAFF M AND G WILL REVIEW RECORD FOR FOR STAFF F AND N FOR DOCUMENTION OF HEPATITIS B IMMUNIZION OR DECLINATION ABOVE WILL BE COMPLETED BY 12/14/2015	
{A 650}	.06(B)(1) .06 Personnel B. Credentialing of Physicians. The facility shall collect, review, and document the following information concerning a physician licensed under Health Occupations Article, Title 14, Annotated Code of Maryland: (1) The physician ' s education; This Regulation is not met as evidenced by: Based on a review the previous POC, review of the policy manual, review of physician files, and interview, the facility staff did not credential the medical staff. This was evident for six of six staff. Staff #A, B, C, D, N, O The findings include: 1. Review of the POC from the survey completed on 05/20/15 revealed "(Staff) will designate an employee to write a policy. (Staff) will review and see that all physician files are current. This includes CRNA files. This will be implemented by	{A 650} 1	POLICY REVISED FOR CRNA AND PHYSICIAN CREDENTIALING AND RECREDENTIALING STAFF A AND H WILL BE RESPONSIBLE. COMPLETION BY 12/14/2015	

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{A 650}	Continued From page 4 Sept. 1, 2015." 2. Policy review on 09/03/15 revealed a policy entitled 'Personnel Policies Credentialing' that stated "Abortions at (site) will be provided by licensed practitioners. This category is intended to include physicians from various specialties as well as registered nurses, licensed practical nurses, medical assistants, and laboratory technicians." The policy was dated 06/15 but is not an acceptable alternative to policies on credentialing and reappointment of the medical staff. 3. Physician and allied health professional files were reviewed on 09/03/15. The files did not contain all necessary documentation regarding the granting of initial or temporary privileges. The following credentialing information was missing from the files: a. Current curriculum vitae - Staff B; b. Letter with initial and/or biennial reappointment to center - Staff A, B, C, D, N, O; c. documentation of peer review - Staff A, B, C, D, N, O; d. Utilization, quality and risk data - Staff A, B, C, D, N, O; e. MD practice patterns via QA program - Staff A, B, C, D; f. Documentation of current certification in Basic Life Support (BLS)/Advanced Cardiac Life Support (ACLS) - Staff D. 4. Interview with Staff M on 09/03/15 at 10:50 AM revealed that the facility staff is behind on completing paperwork.	{A 650} a b c d e	POLICY AND CREDENTIALING ARE BEING UPDATED. TO BE COMPLETED BY 12/14/15 STAFF A AND M WILL BE RESPONSIBLE. STAFF A WILL OBSERVE AND INTERVIEW ALL PHYSICIANS AND CRNA'S, TO EVALUATE PERFORMANCE AND PATIENT CARE. WILL BE COMPLETED BY 12/14/2015	
{A 810}	.06(D)(1) .06 Personnel	{A 810}		

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{A 810}	Continued From page 5 D. The administrator shall establish a procedure for the biennial reappointment of a physician which includes: (1) An update of the information required in §B of this regulation; and This Regulation is not met as evidenced by: Based on review the previous POC, review of credentialing files and interview, it was determined that there was no evidence that the scope of procedures performed and medical staff privileges were reappraised by the administrator for six of six files reviewed. Staff: A, B, C, D, N, O The findings include: 1. Review of the POC for the survey completed on 05/20/15 revealed "(Staff) will include this in policy, procedure and implementation with A650." There was no date of implementation. 2. Policy review on 09/02/15 failed to revealed a policy on the biennial reappointment of the medical staff. 3. Review of credentialing files for Staff A, B, C, D, N and O on 09/03/15 failed to reveal documentation that medical staff privileges and scope of procedures had been reappraised. 4. Interview with Staff M on 09/03/15 at 8:55 AM revealed that the facility staff is behind on paperwork.	{A 810}	POLICY UPDATED AND INFORMATION CORRENTLY BEING OBTAINED FOR BIENNIAL REAPPOINT. TO BE COMPLETED BY STAFF A AND M. BY 12/14/15.	
{A 870}	.06(E)(1)(a) .06 Personnel E. Credentialing of Health Professionals.	{A 870}		

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{A 870}	Continued From page 6 (1) Direct Hires. (a) The facility shall collect, review, and verify evidence of the following information for all licensed or certified health professionals that are employed by the facility: This Regulation is not met as evidenced by: Based on the previous POC, review of the policy manual, review of personnel files and interview, the facility staff did not implement personnel policies for all staff. This was evident for eight of eleven staff reviewed during the survey. Staff E, F, G, H, J, L, N The findings include: 1. Review of the POC for the survey completed on 05/20/15 revealed that "(Staff) will review each employee chart to determine if a. through j. are up to date and collect info and update files as needed. Will be completed by Sept 1, 2015." 2. Review of policies on 09/02/15 revealed a policy entitled 'Personnel Policies Credentialing' that stated "Abortions at (site) will be provided by licensed practitioners. This category is intended to include physicians from various specialties as well as registered nurses, licensed practical nurses, medical assistants, and laboratory technicians." This statement is not an acceptable alternative to personnel policies. 3. Personnel files were reviewed on 09/03/15. The reviews revealed that the following required items of documentation were missing: a. current license - Staff L b. documentation of annual infection control training - Staff N	{A 870}	STAFF MEMBER G IS REVISIONG FILES FOR STAFF E F G H J L N FOR CURRENT LICENSES, DOCUMENTATION OF ANNUAL INFECTION CONTROL TRAINING, TB TESTING OR SIGN/SYMPTOM SCREENING. CURRENT BLS FOR STAFF H HEPATITIS IMMUNIZATION OR DECLINATION FOR STAFF N + F COMPLETION BY 12/11/15	

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{A 870}	Continued From page 7 c. documentation of TB skin test or signs/symptoms screening - Staff E, G, O d. documentation of Hepatitis B immunization or declination - Staff F, N e. documentation of current Basic Life Support - Staff H, J. 4. Interview with Staff M on 09/03/15 at 10:50 AM revealed that the facility is behind on paperwork.	{A 870}		
{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 interview of the registered nurse administrator, review of the policies and procedures and observation during a tour of the facility, it was determined that the registered nurse (RN) did not discard expired medication. Staff: M The findings included: Review of the policies and procedures for use and storage of medications and outdated medications revealed, "The director of the clinical department is responsible for ensuring support and assistance in the expectation of the policies in this document and in its application to the performance of employees under her/his direction. Medications bearing an expiration date will not be dispensed or distributed beyond the expiration date. Expiration dates on all medications will be checked on a monthly basis. Expired, discolored, damaged or inappropriately	{A1280}		

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{A1280}	Continued From page 8 labeled medications shall be discarded. All medications will immediately be pulled from use when they reach their expiration date." During a tour of room #4 on September 2, 2015 at 9:25 AM revealed the following expired medications: 1. One single dose vial of Dextrose 50% (replacement fluid) for injection one bottle expired on June 1, 2015. During a tour of room #2 on September 2, 2015 at 9:43 AM revealed the following expired medications: 2. Atropine sulfate (treats low heart rate) one milligram abboject for injection, one expired on August 1, 2015 and two expired on September 1, 2015. 3. One single dose vial of Dextrose 50% (replacement fluid) for injection one bottle expired on June 1, 2015. During a tour of the recovery room on September 2, 2015 at 9:55 AM revealed two ninety milliliter containers with screw on lids. One container was labeled "Tylenol 500 milligrams and one was labeled Motrin 800 milligrams." The expiration date and lot number was not included on the handwritten label. There is no assurance of the cleanliness of the transfer of the medication from the stock bottle to the containers to prevent cross- contamination. During a tour of the locked medication box on September 3, 2015 at 10 AM revealed one bottle of ferric subsulfate monsels solution used to control bleeding expired on November 2014. Interview of the registered nurse administrator (M) on September 3, 2015 at 10 AM revealed that	{A1280}	POLICY ON DRUG USAGE, STORAGE, LABELING AND EXPIRATION WAS REVISED. A CHART WAS DEVISED FOR ALL NURSING PERSONNEL INVOLVED WITH DISPENSING MEDICATION STAFF M IS RESPONSIBLE IT WILL BE IMPLEMENTED BY 10/6/2015	

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{A1280}	Continued From page 9 the administrator was not aware that the medications were expired.	{A1280}		
{A1570}	.16 (B) .16 Quality Assurance Program B. The facility shall conduct ongoing quality assurance activities and document the activities on a continuous basis, but not less than quarterly. This Regulation is not met as evidenced by: Based on review of the policy manual and interview of the registered nurse administrator, it was determined that the administrator has not implemented an ongoing quality assurance program. The findings include: Review of the policy and procedure manual revealed that the facility staff performs and documents quality assurance activities that evaluates the quality of care the patients' receive. Interview of the administrator (M) on September 3, 2015 at 9 AM revealed that the administrator looks at patient records but does not document a quality assurance review. The administrator stated that they have not had the time to perform and document quality assurance.	{A1570}	QA POLICY REVISED AND REWRITTEN. PARTIAL IMPLEMENTATION BY STAFF A 9/29/15. THIS POLICY INCLUDES INTERDISCIPLINARY QUARTERLY MEETINGS; TO EVALUATE PATIENT CARE, IDENTIFY PROBLEMS, REVIEW PATIENT RECORDS, REVIEW PATIENT COMPLAINTS AND COMPLICATIONS. STAFF M WILL MAKE SURE ALL EMPLOYEES HAVE REVIEWED ANNUALLY OUR POLICY AND PROCEDURE MANUAL AND ARE FAMILIAR WITH ALL EMERGENCY POLICIES COMPLETION BY 12/1/15
{A9999}	Final Comments An exit conference was conducted with the administrator on September 3, 2015 and the survey findings were reviewed. The administrator was directed to submit a written plan of correction in response to the State	{A9999}		

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{A9999}	Continued From page 10 of Maryland 2567 form, following the attached guidelines, within ten calendar days. Failure to submit an acceptable plan of correction may result in revocation of your license from the Department of Health and Mental Hygiene Surgical Abortion Facilities program.	{A9999}		

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October 19, 2015

Administrator
Hillcrest Clinic, Inc.
5602 Baltimore National Pike, Suite 600
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RE: ACCEPTABLE PLAN OF CORRECTION

Dear

We have reviewed and accepted the Plan of Correction submitted as a result of a followup Re-licensure survey completed at your facility on September 3, 2015.

Please be advised that an unannounced follow-up visit may occur prior to the standard survey to ensure continual compliance.

If there are any questions concerning this notice, please contact this Office at 410-402-8040.

Sincerely,

Barbara Fagan, Program Manager
Ambulatory Care Programs
Office of Health Care Quality

cc: License File