Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 000	Initial Comments	S 000		

Relicensing Survey with Complaint #LA00044656.

Abbreviations

ADM	Administrator
AED	Automatic External Defibrillator
CDC	Centers for Disease Control
cm	centimeters
DON	Director of Nursing
GB	Governing Body
IC	Infection Control
ITOP (report)	Induced termination of pregnancy
LDH/HSS	Louisiana Department of Health/Health Standards Section
LEERS	Louisiana Electronic Event Registration System
LPN	Licensed Practical Nurse
MA	Medical Assistant
MD	Medical Doctor
MedDir	Medical Director
N/A	Not applicable
OfficeMgr	Office Manager
OSHA	Occupational Safety & Health Administration
PI	Performance Improvement
QA	Quality Assurance
QAPI	Quality Assurance Performance Improvement
RN	Registered Nurse
US	Ultrasound

Reviewed 3/31/2017 [redacted] RN

RECEIVED
MAR 16 2017
HEALTH STANDARDS

S 043 4407 E Survey Activities S 043

E. Statement of Deficiencies. Following any survey, the department surveyors shall complete the statement of deficiencies documenting

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE Administrator (X6) DATE

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 043	Continued From page 1	S 043		

relevant findings including the deficiency, the applicable governing rule, and the evidence supporting why the rule was not met including, but not limited to, observations, interviews, and record review of information obtained during the survey. The outpatient abortion facility shall receive a copy of the statement of deficiencies.

1. Display. The following statements of deficiencies issued by the department to the outpatient abortion facility must be posted in a conspicuous place on the licensed premises:

a. the most recent annual licensing survey statement of deficiencies; and

b. any follow-up and/or complaint survey statement of deficiencies issued after the most recent annual licensing survey.

2. Public Disclosure. Any statement of deficiencies issued by the department to an outpatient abortion facility shall be available for disclosure to the public within 30 calendar days after the outpatient abortion facility submits an acceptable plan of correction to the deficiencies or within 90 days of receipt of the statement of deficiencies, whichever occurs first.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to display the statement of deficiencies from the most recent surveys (licensing, follow up, and/or complaint) in a conspicuous place on the licensed premises as evidenced by no displayed survey results from the last survey.
Findings:

Observations of the facility on 01/23/17 at 12:10 p.m., escorted by S1OfficeMgr revealed no evidence to indicate the facility had posted a copy of the statement of deficiencies from the most

S 043 The LDH license to operate is framed and hung on the wall directly to the left when you enter the building. The deficiencies will be hung in the same location. 03/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 043	Continued From page 2 recent surveys (licensing, follow up, and/or complaint) in a conspicuous location on the licensed premises. In an interview on 01/23/17 at 12:10 p.m., S1OfficeMgr confirmed that the facility had no posted copy of the statement of deficiencies from the most recent surveys (licensing, follow up, and/or complaint) in a conspicuous location on the licensed premises.	S 043		
S 055	4409 B Changes in Outpatient Abortion Facility Info B. Change of Information. Any change regarding the outpatient abortion facility 's entity name, "doing business as" name, mailing address, telephone number, or any combination thereof, shall be reported in writing to the department within five calendar days of the change. Any change regarding the entity name or "doing business as" name requires a change to the outpatient abortion facility license and shall require a $25 fee for the issuance of an amended license. C. Change of Key Administrative Personnel. Any change regarding the outpatient abortion facility's key administrative personnel shall be reported in writing to the department within five calendar days of the change. For the purposes of this Chapter, key administrative personnel includes the administrator and medical director, and the outpatient abortion facility shall provide the individual's name, hire date, and qualifications as defined in this Chapter.	S 055		

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 055	Continued From page 3	S 055		

This Rule is not met as evidenced by:
Based on record review and interview Delta Clinic of Baton Rouge failed to ensure the department (Department of Hospitals) received notification of a change in Administrative personnel within 5 calendar days of the change. This deficient practice was evidenced by no documented proof the department had been notified of a change in Administrators for Delta Clinic of Baton Rouge in May of 2016.
Findings:

Review of Governing Body Meeting minutes, provided by S1OfficeMgr as current, revealed a meeting dated 05/02/16 via Skype Transmission (communication over the Internet using the software application, typically also viewing by webcam), in which the President /GB member was in attendance, as well as S12ADM. The minutes indicated the topic of discussion was the retirement of S9ADM and the assumption of the Administrator position by S12ADM. Further review revealed documentation that S12ADM was given full authority over daily operations of Delta Women's Clinic of Baton Rouge. The document was signed by the President and S12ADM and dated 05/02/16.

Review of documentation of the "Annual Meeting Board of Directors Meeting", dated 05/04/16, with the President and S9ADM present, revealed in part, S9ADM formally announced her retirement and it was noted S12ADM would be taking her place in the upcoming months. The minutes documented over the next few months, S4MedDir, S1OfficeMgr, and S9ADM would review policies and procedures for best practices.

S 055 An Organizational Chart was created and, after Board approval will be placed in the Administrative Manual. **See Exhibit A** 03/18/2017

The Board of Directors will approve their quarterly meetings will be held in March, June, September and December. 03/18/2017

Change of key personnel forms were submitted for [redacted] Administrator and [redacted] Director of Nursing on February 13, 2017. **Exhibit B** 3/18/2017

The Board will establish May 1, 2016 as the effective date for the new administrator, [redacted] to assume all day-to-day operations and administrative duties of the position. 03/18/2017

A Key Personnel Change form is going to be sent in for J[redacted] LPN to assume the position of Clinic Manager. **Exhibit C** 03/08/2017

With Board approval, [redacted] LPN will function as the Administrator and will be responsible for the day-to-day operations of the Clinic when [redacted] is not present or is unable to perform those duties. 3/18/22017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 055	Continued From page 4	S 055		

Further review revealed no date was provided for the change in administrators for the facility. The minutes documented S9ADM as the recording secretary, with no signatures noted.

Review of documents provided regarding LDH/HSS notification of a change in key personnel revealed a Key Personnel Change Form for another outpatient abortion clinic owned by the corporation that did not include documentation of a change in administrator for Delta Clinic of Baton Rouge.

Review of an Organizational Chart provided by S1OfficeMgr as current, with administrative positions filled in with staff names, revealed S9ADM as the Administrator.

In an interview 01/23/17 at 12:00 p.m. S1OfficeMgr reported S9ADM was the Administrator of Delta Clinic of Baton Rouge. S1OfficeMgr reported she was in charge in the absence of S9ADM, and she (S1OfficeMgr) oversaw the day to day operations of the facility. S1OfficeMgr indicated she had no documentation designating her to stand in for the administrator in the absence of the appointed administrator. S9ADM indicated that the administrator was not often at the clinic, and she had been in this position with these understood responsibilities for years.

In a phone interview 01/25/17 at 11:20 a.m. S7DON reported she reports to S1OfficeMgr, but indicated S9ADM is the administrator and her actual supervisor. S7DON reported she had spoken with S9ADM last month.

In a phone interview 1/25/17 at 3:00 p.m. S4MedDir indicated she thought S1OfficeMgr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 055	Continued From page 5	S 055		

was the administrator of Delta Clinic of Baton Rouge.

In a phone interview 01/25/17 at 1:45 p.m. S9ADM reported she had come to the clinic a few times over the last months of last year to assist S1OfficeMgr with some administrative duties, but had been told S12ADM was going to be the administrator of this clinic, and was under the impression that S12ADM had assumed the position of administrator. She reported S12ADM had told her she (S12ADM) had faxed a change in key personnel notification to the state offices for both facilities (Delta Clinic of Baton Rouge and another owned by the corporation), but that she(S9ADM) still had come to Delta Clinic of Baton Rouge to help S1OfficeMgr with administrative duties. S9ADM reported she was not aware of any GB meetings since last May (of 2016).

In a phone interview 01/25/17 at 2:35 p.m. S12ADM, indicated she was the administrator of Delta Clinic of Baton Rouge and of another clinic in another city. S12ADM reported she sent paperwork for change in administrators to the Abortion Facilities Program Desk 04/29/16, but indicated she did not have a copy she could provide. She reported she had come to the Baton Rouge clinic (Delta Clinic of Baton Rouge) about 3 months ago, and that she was on the GB.

In a communication with the Abortion Program Desk at LDH/HSS via a supervisor it was reported that no Key Personnel Change had been received for a change in Administrators for Delta Clinic of Baton Rouge to S12ADM from S9ADM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 107	Continued From page 6	S 107		
S 107	4421 A-B Governing Body	S 107		

A. The outpatient abortion facility shall be in compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances.
B. The outpatient abortion facility shall have a governing body that assumes full responsibility for the total operation of the outpatient abortion facility.
1. The governing body shall consist of at least one individual who will assume full responsibility.
2. The outpatient abortion facility shall maintain documentation on the licensed premises identifying the following information for each member of the governing body:
a. Name;
b. contact information;
c. address; and
d. terms of membership.
3. The governing body shall develop and adopt bylaws which address its duties and responsibilities.
4. The governing body shall, at minimum, meet annually and maintain minutes of such meetings documenting the discharge of its duties and responsibilities.

This Rule is not met as evidenced by:
Based on record review and interview Delta Clinic of Baton Rouge failed to ensure the GB maintained documentation on the licensed premises identifying information for each member of the governing body that included name, contact information, address, and terms of membership.

S 107 A list of the members of the Governing Body has been created. It includes their names, contact information, address and terms of membership. It will be maintained in the Administrative Policy and Procedure manual.

Exhibit D 03/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 107	Continued From page 7	S 107		

Findings:

Review of documentation provided related to the facility's GB, including the Bylaws, Meeting Minutes that included May 2, 2016, and May 4, 2016 revealed no documentation of the member(s) of the Governing Board.

Review of a policy and procedure provided by S1OfficeMgr as current revealed the name of the President of the corporation,Delta Clinic of Baton Rouge, who would assume all legal and financial responsibility for the Corporation. Further review revealed he appointed S9ADM as administrator. No date was noted on the document, and no documentation as to whether or not the president sat on the GB, and if there were other members of the GB. No contact information, address, or terms of membership were noted for either the president or S9ADM.

In an interview 01/25/17 at 1:45 p.m. .S9ADM reported she was still a member on the GB. She reported the GB consisted of her and the President of the Corporation, who lived out of state.

In an interview 1/25/17 at 2:35 p.m. S12ADM reported she was the administrator of Delta Clinic of Baton Rouge. S12ADM reported she was a member of the GB, as well as the President of the corporation.

In an interview 1/25/17 at 3:45 p.m. S1OfficeMgr reported she did not have a list of names and contact information of the GB for Delta Clinic of Baton Rouge. S1OfficeMgr confirmed no correspondence had been received from S12ADM regarding the GB.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 8	S 109		
S 109	4421 - C 1-4 Governing Body	S 109		

C. The governing body shall be responsible for:
1. ensuring the outpatient abortion facility's continued compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees, governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements, prohibited activity requirements, e.g. presenting or otherwise delivering any instruction or program on any health topic, including but not limited to human sexuality or family planning, to students at a public elementary or secondary school, or at a charter school that receives state funding or knowingly providing any materials or media regarding human sexuality or family planning for distribution or viewing at a public elementary or secondary school, or at a charter school that receives state funding, or any other matter addressed by law related to abortion or abortion procedures;
2. designating a person to act as the administrator and delegating sufficient authority to this person to manage the day-to-day operations of the facility;
3. designating a person to act as the medical director and delegating authority to this person to allow him/her to direct the medical staff, nursing personnel, and medical services provided to each patient;
4. evaluating the administrator and medical director's performance annually, and maintaining documentation of such in their respective personnel files;

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 9	S 109		

This Rule is not met as evidenced by:
Based on observation, record review, and interview, the Governing Body failed to demonstrate responsibility for ensuring:
1) the outpatient abortion facility's continued compliance with department rules, reporting requirements, prohibited activity requirements.
This deficient practice was evidenced by:
a) no documentation that ITOP reports submitted to the LEERS system were completed/certified within 15 days as per their policy and procedure, or within 30 days as required by state law and regulations. This deficient practice was evidenced by 13(#1, #2, #3, #4, #5, #6, #8, #9, #10, #12, #13, #14, #15) of 15 (#1-15) medical records with ITOP reports certified later than 30 days after an abortion of a total sample of 15, and
b) no documented policy and procedure of prohibited activity requirements, and
2) clear designation of a person to act as the administrator, and delegation of sufficient authority to manage the day-to day operations of the facility as evidenced by no documentation of appointment of the person to act in the administrator's absence and their authority.
Findings:

1). Failure to ensure the outpatient abortion facility's continued compliance with department rules, reporting requirements, prohibited activity requirements.
a. Failure to demonstrate the outpatient abortion facility's continued compliance with department rules, reporting requirements, prohibited activity requirements. This deficient practice was

S 109 A new policy has been written which will be approved by the Board of Directors, establishing Prohibited Activities. Prohibited Activities policy number 3108 will be maintained in the Personnel Policy and Procedure Manual. An in-service reviewing this policy with be conducted with the staff.
Exhibit E 3/18/2017.

A policy dictating the reporting of all pregnancy terminations to the State of Louisiana within thirty (30) days of the procedure has been written and will be approved by the Board. Policy number 2411. It will be maintained in the Patient Care Policy Manual. **Exhibit F**
3/18/2017

The Board will approve [redacted], LPN to be the Acting Administrator whose responsibilities and authority include day-to-day operations of the clinic in the absence of the Administrator, [redacted]. 03/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 10	S 109		

evidenced by a) no documentation that ITOP reports submitted to the LEERS system were completed/certified within 15 days as per their policy and procedure, or within 30 days as required by state law and regulations.

Review of LA RS 40:1299.35.10 Reports, revealed, in part "A. An individual abortion report for each abortion performed or induced shall be completed by the attending physician ...The report shall include:(25) Signature of the attending physician... C. All abortion reports shall be signed by the attending physician and submitted to the Department of Health and Hospitals within thirty days after the date of the abortion.

Review of the facility's Policy & Procedure title "Report of Induced Termination of Pregnancy", presented on 01/24/17 at 2:40 p.m. by S1OfficeMgr as current, read in part: Policy: Report of induced termination of pregnancy, form PHS 16-ab, shall be completed and submitted with appropriate certificates and consent forms required by LSA-R.S.40:1299.3510 (25) to the Vital Records Registry. Procedure: The report of induced termination of pregnancy from (as written) with appropriate certificates and consents will be submitted to the Vital Records of Registry within 15 days of an abortion. Further review revealed no procedure to provide evidence of the submission of the ITOP reports in the time required by facility policy and time required by state law. No procedure was noted to ensure the physician signed the ITOP report.

Patient #1
Review of the medical record for patient #1 revealed she had a non-surgical abortion 7/14/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 11	S 109		

Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 7/25/16.
Review of an ITOP report for Patient #1, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 10/20/16.

Patient #2
Review of the medical record for patient #2 revealed she had a surgical abortion 7/19/16.
Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 7/22/16.
Review of an ITOP report for Patient #2, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 10/20/16.

Patient #3
Review of the medical record for patient #3 revealed she had a non-surgical abortion 8/19/16.
Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 8/22/16.
Review of an ITOP report for Patient #3, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 9/30/16.

Patient # 4
Review of the medical record for patient #4 revealed she had a surgical abortion 10/04/16.
Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 10/17/16.
Review of an ITOP report for Patient #4, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 11/23/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 12	S 109		

Patient #5
Review of the medical record for patient #5 revealed she had a non-surgical abortion 9/6/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 9/14/16.
Review of an ITOP report for Patient #5, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 11/23/16.

Patient #6
Review of the medical record for patient #6 revealed she had a non-surgical abortion 9/9/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 9/16/16.
Review of an ITOP report for Patient #6, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 12/01/16.

Patient #8
Review of the medical record for patient #8 revealed she had a non-surgical abortion 10/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 10/17/16.

Patient #9
Review of the medical record for patient # revealed she had a surgical abortion 07/14/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 7/22/16. Review of an ITOP report for Patient #9, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 13 9/30/16. Patient #10 Review of the medical record for patient #10 revealed she had a surgical abortion 12/09/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 01/11/17. Patient #12 Review of the medical record for patient #12 revealed she had a non-surgical abortion 7/14/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 7/25/16. Patient #13 Review of the medical record for patient #13 revealed she had a surgical abortion 11/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 1/09/16. Patient #14 Review of the medical record for patient #14 revealed she had a surgical abortion 11/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 01/24/17. Patient #15 Review of the medical record for patient #15 revealed she had a non-surgical abortion 12/17/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 1/09/16. In an interview 1/25/17 at 11:50 a.m. S1OfficeMgr	S 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 14	S 109		

reported she electronically entered information into the LEERs system after a patient had been discharged after having an abortion procedure. She indicated this was done usually a day or two after the procedure. She reported she then printed 2 copies. One was put in the patient's medical record, and the other is given to the physician to be signed. She entered a patient who had a procedure that day, and printed it to show how it worked. The date on the bottom of the page was 1/25/17, the date the report was printed. S1OfficeMgr, present for the interview and demonstration, reported that the physicians manually signed the forms, and then the forms were taken to post office and mailed to the state. S1OfficeMgr reported she did not have any documentation of the dates any of the ITOP reports were mailed.
S1OfficeMgr reviewed the ITOP reports for Patient #s 1-6, 8-10, and 12-15. S1OfficeMgr confirmed there was no certification date on their ITOP copy from the medical record, and the certification dates of the ITOP reports provided by the program desk showed them all to be later than the 15 days of their policy, and 30 days as required by state regulations and statues. S1OfficeMgr reported she could provide no documented evidence of required information, including the physician's signature certifying the report, having been provided to the State Registrar and Vital Statistics within 30 days of the patient's procedures.

b. no documented policy and procedure of prohibited activity requirements.

Review of the policy and procedure manual revealed no policy that addressed any prohibited activity requirements such as presenting or otherwise delivering any instruction or program on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 15	S 109		

any health topic, including but not limited to human sexuality or family planning, to students at a public elementary or secondary school, or at a charter school that receives state funding or knowingly providing any materials or media regarding human sexuality or family planing for distribution or viewing at a public elementary or secondary school, or at a charter school that receives state funding, or any other matter addressed by law related to abortion or abortion procedures.

In an interview 01/25/17 at 3:45 p.m. S1OfficeMgr verified there was no policy and procedure in the facility's manuals that addressed any prohibited activity such as the delivery of any instruction, program, materials or media regarding human sexuality or family planning at a elementary, secondary, or charter school that receives state funding or any other matter addressed by law related to abortion or abortion procedures. S1OfficeMgr confirmed facility did not have such a policy and procedure.

2)Failure to designate the person to act as the administrator in his/her absence and the authority to manage day-to day operations of the facility.

Review of Governing Body Meeting minutes, . provided by S1OfficeMgr, revealed a meeting dated 05/02/16 via Skype Transmission revealed no documentation regarding the designation of a person to act as administrator in the absence of the administrator.

Review of documentation of the "Annual Meeting Board of Directors Meeting", dated 05/04/16, with the President and S9ADM present, revealed no documentation regarding the designation of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 16	S 109		

person to act as administrator in the absence of the administrator.

Review of an Organization Chart provided by S1OfficeMgr as current, with administrative positions filled in with staff names , revealed S9ADM as the Administrator. Further review revealed no designation of the person to act as administrator in the absence of the administrator.

In an interview 01/23/17 at 12:00 p.m. S1OfficeMgr reported S9ADM was the Administrator of Delta Clinic of Baton Rouge. S1OfficeMgr reported she was in charge in the absence of S9ADM (who lived out of town), and she (S1OfficeMgr) oversaw the day to day operations of the facility. S1OfficeMgr indicated there was no documentation appointing her to stand in for the administrator in the absence of the appointed administrator. S9ADM indicated that the administrator was not often at the clinic, and she (S1OfficeMgr) had been in this position with these responsibilities understood for years. S9ADM reported she oversaw the day to day operations of Delta Clinic of Baton Rouge.

In a phone interview 1/25/17 at 3:00 p.m. S4MedDir indicated she thought S1OfficeMgr was the administrator of Delta Clinic of Baton Rouge.

In a phone interview 01/25/17 at 1:45 p.m. S9ADM reported she had come to the clinic a few times over the last months of last year to assist S1OfficeMgr with some administrative duties, but had been told S12ADM was going to be the administrator of this clinic, and was under the impression that S12ADM had assumed the position of administrator in May of last year (2016). S9ADM reported she did not remember

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 109	Continued From page 17 the appointment or designation of a person to act in the administrator's place in her absence. In a phone interview 01/25/17 at 2:35 p.m. S12ADM, indicated she was the administrator of Delta Clinic of Baton Rouge and of another clinic under the corporation, in another city. . She reported she had last come to the Baton Rouge clinic about 3 months ago. S12ADM indicated that she did not come to Delta Clinic regularly. S12ADM reported there had not been an appointment or designation of someone to act in her absence (as administrator). .	S 109		
S 115	4421-C - 12 - 15 Governing Body 12. ensuring services that are provided through a contract with an outside source are provided in a safe and effective manner; 13. ensuring that the outpatient abortion facility develops, implements, monitors, enforces, and reviews at a minimum, quarterly, a quality assurance and performance improvement (QAPI) program; 14. developing, implementing, monitoring, enforcing, and reviewing annually written policies and procedures relating to communication with the administrator, medical director, and medical staff to address problems, including, but not limited to, patient care, cost containment, and improved practices; 15. ensuring that disaster plans for both internal and external occurrences are developed, implemented, monitored, enforced, and annually reviewed and that annual emergency preparedness drills are held in accordance with the disaster plan. The outpatient abortion facility shall maintain documentation on the licensed premises indicating the date, type of drill,	S 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 115	Continued From page 18 participants, and materials; This Rule is not met as evidenced by: Based on record review and interview, the facility's Governing Body failed to ensure that the QAPI program was developed, implemented, monitored, enforced and reviewed at least quarterly and the GB failed to ensure all contracted services were evaluated to ensure they were provided in a safe and effective way. Finding: Review of the facility's Policy & Procedure titled " Quality Assurance" presented (01/25/17) by S1OfficeMgr as being current read in part: The Professional Advisory Group (PAG) will meet quarterly to advise the Clinic on professional issues, to participate in the evaluation of the Clinic's program and to assist the Clinic in maintaining liaison with other health care providers.... Review of a document titled "Quality Assurance Indicators Year 2016" revealed the areas audited were: Patient volume (counseling, pill abortion, surgical abortion); Complications (ectopic, pill re-aspiration, surgical re-aspiration, retained tissue, bleeding, missed abortion, infection, other -fail, grievances, occurrences (patient), grievances- employee, occurrences-employee; Logs (refrigerator-lab, medication, cleaning, AED, Autoclave, in-services). Further review of QA documents provided revealed no evaluation(s) of contracted services provided in the facility. Review of the facility's Manual revealed no documented evidence that the facility's Governing	S 115	**S 115** It is very upsetting for this Administration to believe the Manager, who has been employed by this Clinic since 2004, would report to the Surveyors that we had never developed a QA Program. This employee has since been terminated. However, under her watch, apparently, the program was not implemented, monitored, enforced and reviewed at least quarterly. A staff meeting will be held and a Quality Assurance Coordinator will be identified. The program, which is attached, will be reviewed and implemented by the new Coordinator. **See Exhibit G** A Quality Assurance Committee will be established and will meet at least quarterly. The Quality Assurance activities will be evaluated by the Governing Body at least quarterly. This will be established by 3/18/2017. Data will be gathered for January, February and March 2017 with reporting completed for QA Committee meeting in June and the Board of Directors meeting later that month to review the Quality Assurance Committee findings. 06/15/2017	

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 115	Continued From page 18 participants, and materials; This Rule is not met as evidenced by: Based on record review and interview, the facility's Governing Body failed to ensure that the QAPI program was developed, implemented, monitored, enforced and reviewed at least quarterly and the GB failed to ensure all contracted services were evaluated to ensure they were provided in a safe and effective way. Finding: Review of the facility's Policy & Procedure titled " Quality Assurance" presented (01/25/17) by S1OfficeMgr as being current read in part: The Professional Advisory Group (PAG) will meet quarterly to advise the Clinic on professional issues, to participate in the evaluation of the Clinic's program and to assist the Clinic in maintaining liaison with other health care providers.... Review of a document titled "Quality Assurance Indicators Year 2016" revealed the areas audited were: Patient volume (counseling, pill abortion, surgical abortion); Complications (ectopic, pill re-aspiration, surgical re-aspiration, retained tissue, bleeding, missed abortion, infection, other -fail, grievances, occurrences (patient), grievances- employee, occurrences-employee; Logs (refrigerator-lab, medication, cleaning, AED, Autoclave, in-services). Further review of QA documents provided revealed no evaluation(s) of contracted services provided in the facility. Review of the facility's Manual revealed no documented evidence that the facility's Governing	S 115	Delta Clinic of Baton Rouge's Board of Directors met on March 13, 2017. A Quality Assurance Coordinator was appointed and a Quality Assurance Committee was established. An Infection Control Coordinator was appointed and an Infection Control Committee was established. The Coordinator's will ensure appropriate documentation is completed regarding certain aspects of the care provided in the Clinic to maintain strict enforcement of infection control policies and procedures and compliance with quality assurance guidelines. Data is compiled daily and is collected daily, weekly, monthly and annually. It is reported quarterly. For the purpose of this Louisiana Department of Health Survey Response, the data available for January and February will be compiled and ready for review Monday, March 27, 2017. Data for March will be compiled and completed, ready for review by Monday, April 3, 2017.	

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 115	Continued From page 19 Body was conducting quarterly reviews of the QAPI program. In an interview on 01/25/17 at 12:10 p.m., S1OfficeMgr indicated that the facility's QAPI indicators were not reviewed/monitored quarterly by the Governing Body.	S 115	It is the intention of the Coordinator and the Committee to ensure documentation is compiled, collected and ready for review by the end of the first week of the next month, every month.	
S 121	4423 B 1-2 Staffing Requirements, Qual & Respons. B. Administrator. The outpatient abortion facility shall have an administrator designated by the governing body who is responsible for the day-to-day management, supervision, and operation of the outpatient abortion facility. The administrator shall be a full-time employee, available and on-site, during the designated business hours. 1. Qualifications. The administrator shall be at least 18 years of age and possess a high school diploma or equivalent. 2. The outpatient abortion facility shall designate a person to act in the administrator's absence, and shall ensure this person meets the qualifications of the administrator pursuant to this Chapter. The outpatient abortion facility shall maintain documentation on the licensed premises identifying this person and evidence of their qualifications. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have an administrator, clearly designated by the governing body, and documentation of the appointment/designation of a person to act in the administrator's absence. This failed practice was	S 121		

Page 20 A

BOARD OF DIRECTORS
BOARD DECLARATION
QUALITY ASSURANCE, INFECTION CONTROL

Delta Clinic has established a Quality Assurance Coordinator, a Quality Assurance Committee, and Infection Control Coordinator and an Infection Control Committee.
The Coordinator's will establish a program of implementing the documentation of policies and procedures relating to the Programs, and will gather this data monthly. Quarterly the data will be reviewed by the Committees who will then present the data to the Board of Directors.

[redacted]

[redacted]

3-13-17
Date

3-13-17
Date

03/14/2017
Date

3/14/17
Date

DELTA CLINIC OF BATON ROUGE

DATA COLLECTED	DAILY	WEEKLY	MONTHLY	QUARTERLY	ANNUALLY
Patient Volume			X		
Patient Satisfaction Surveys	X				
Patient Medical Records					
Chart Audits			X		
LEERS Audits			X		
Pt. Complications	X				
Occurrences– Patients, Employees	X				
Grievances – Patients, Employees	X				
Infection Control			X		
Cleaning Logs			X		
Hand Washing Observation				X	
Autoclave Maintenance, Cleaning			X		
Autoclave Indicators, Spore Testing			X		
Logs					
Refrigerator Temps			X		
Medication Refrigerator Temps			X		
Personnel					
Personnel Files					
Annual Evaluation					X
Skills Competency Check Lists					X
Job Descriptions					X
Licensure, CPR					X
In-Services			X		
AED and Code Kit			X		
Oxygen Tanks			X		
Fire Extinguishers			X		
Smoke Detectors			X		

[redacted], Administrator

Date

[redacted] Director of Nursing

03/20/2017
Date

SIGNING FOR [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 115	Continued From page 19 Body was conducting quarterly reviews of the QAPI program. In an interview on 01/25/17 at 12:10 p.m., S1OfficeMgr indicated that the facility's QAPI indicators were not reviewed/monitored quarterly by the Governing Body.	S 115	**Deficiency states our Quality Assurance program failed to ensure contracted services were provided in a safe and effective manner.** **As part of our Quality Assurance program, contracted services will be evaluated at least annually and their policies, procedures and contracts will be reviewed. This information will be evaluated by the Governing Board.** 06/15/2017	
S 121	4423 B 1-2 Staffing Requirements, Qual & Respons. B. Administrator. The outpatient abortion facility shall have an administrator designated by the governing body who is responsible for the day-to-day management, supervision, and operation of the outpatient abortion facility. The administrator shall be a full-time employee, available and on-site, during the designated business hours. 1. Qualifications. The administrator shall be at least 18 years of age and possess a high school diploma or equivalent. 2. The outpatient abortion facility shall designate a person to act in the administrator's absence, and shall ensure this person meets the qualifications of the administrator pursuant to this Chapter. The outpatient abortion facility shall maintain documentation on the licensed premises identifying this person and evidence of their qualifications. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have an administrator, clearly designated by the governing body, and documentation of the appointment/designation of a person to act in the administrator's absence. This failed practice was	S 121	**S 121 A staff meeting will be held to establish common knowledge of the members of the Board of Directors and Administrative Staff.** 03/18/2017	

DEPARTMENT OF HEALTH

Health Standards Section

KEY PERSONNEL CHANGE FORM

This form must be signed by the proposed employee and the administrator.

Legal Entity Name: Delta Clinic of Baton Rouge, INC **Agency DBA Name:**	**Provider License #:** 07
Address: 756 Colonial Drive #B **City, State, Zip:** Baton Rouge, La 70804	**Provider CMS ID if applies#:**
Telephone Number: 225-924-4442	**Administrator's Email Address:** WHCCNO@gmail.com
Fax Number: 225-924-4465	**Proposed Employee's Email Address (if available):** WHCCNO@gmail.com

Circle the Position that is changing (Please circle only those appropriate to the Provider Type):

(**Administrator** (the person with overall responsibility for the day-to-day administrative operations)
Director of Nursing (the RN providing leadership of nursing services – if applicable)
Medical Director (the physician providing oversight of the clinical operations – if applicable)
Other: _____

Name of previous employee in this position: [redacted]
Name of proposed employee for this position
Effective Date of Change: 05/01/2014

Verification Date of Current LA Professional License: N/A / /
Please enter the date on which the agency verified the current professional licensure of the proposed employee, *if licensure is a requirement for the position.* The date should precede the effective date of change.

Attestations of Compliance

We hereby certify that the proposed employee listed herein meets all state and federal requirements set forth by the Louisiana Department of Health and Hospitals (DHH), Health Standards Section; the Centers for Medicare and Medicaid Services; and any other regulatory agency applicable to the Provider Type, to function in the role indicated. We further understand that it is the responsibility of the administrator to ensure that the agency maintains compliance with state and federal regulations on an ongoing basis. DHH Health Standards Section will be promptly notified of any changes to Key Personnel.

[redacted] _____ 02/13/2017

Printed Name of Proposed Employee | Signature of Proposed Employee | Date (mm/dd/yy)

[redacted] _____ 02/13/2017

Printed Name of Administrator | Signature of Administrator | Date (mm/dd/yy)

PLEASE NOTE: This form is used for all Health Standards Section licensed providers/suppliers. Definitions of Key Personnel may be found in the applicable state licensing regulations for the specific Provider Type.

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://new.dhh.louisiana.gov/

Received 03/08/17

DEPARTMENT OF HEALTH

Health Standards Section

KEY PERSONNEL CHANGE FORM

This form must be signed by the proposed employee and the administrator.

Legal Entity Name: Delta Clinic of **Agency DBA Name:** Baton Rouge	**Provider License #:** 07
Address: 756 Colonial Drive * B **City, State, Zip:** Baton Rouge, La 70806	**Provider CMS ID if applies#:**
Telephone Number: 225 . 924 . 4442	**Administrator's Email Address:** WHCCNO @ gmail . Com
Fax Number: 225 . 924 . 4465	**Proposed Employee's Email Address (if available):** ~~WHC~~ Deltaclinic756@gmail.com

Circle the Position that is changing (Please circle only those appropriate to the Provider Type):

Administrator (the person with overall responsibility for the day-to-day administrative operations)
Director of Nursing (the RN providing leadership of nursing services – if applicable)
Medical Director (the physician providing oversight of the clinical operations – if applicable)
Other: CLINIC MANAGER

Name of previous employee in this position: [redacted]
Name of proposed employee for this position:
Effective Date of Change: 3 / 1 / 17

Verification Date of Current LA Professional License: 02 / 18 / 2016
Please enter the date on which the agency verified the current professional licensure of the proposed employee, *if licensure is a requirement for the position.* The date should precede the effective date of change.

Attestations of Compliance

We hereby certify that the proposed employee listed herein meets all state and federal requirements set forth by the Louisiana Department of Health and Hospitals (DHH), Health Standards Section; the Centers for Medicare and Medicaid Services; and any other regulatory agency applicable to the Provider Type, to function in the role indicated. We further understand that it is the responsibility of the administrator to ensure that the agency maintains compliance with state and federal regulations on an ongoing basis. DHH Health Standards Section will be promptly notified of any changes to Key Personnel.

[redacted] — 3-8-17

Printed Name of Proposed Employee | Signature of Proposed Employee | Date (mm/dd/yy)

[redacted] — 3-8-17

Printed Name of Administrator | Signature of Administrator | Date (mm/dd/yy)

PLEASE NOTE: This form is used for all Health Standards Section licensed providers/suppliers. Definitions of Key Personnel may be found in the applicable state licensing regulations for the specific Provider Type.

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://new.dhh.louisiana.gov/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 121	Continued From page 20	S 121		

evidenced by interviews which demonstrated different understandings of exactly whom was the designated current administrator, conflicting documentation of whom was appointed/designated administrator, and absence of documentation of the appointment of a person to act in the absence of the administrator. Findings:

Review of Governing Body Meeting minutes for 2016 to date of review 1/23/17, provided by S1OfficeMgr as current, revealed a meeting dated 05/02/16 via Skype Transmission, in which the President/GB member was in attendance, as well as S12ADM. The minutes indicated the topic of discussion was the retirement of S9ADM and the assumption of the Administrator position by S12ADM. Further review revealed documentation that S12ADM was given full authority over daily operations of Delta Women's Clinic of Baton Rouge. The document was signed by the President and S12ADM and dated 05/02/16.

Review of documentation of the "Annual Meeting Board of Directors Meeting", dated 05/04/16, with the President and S9ADM documented present, revealed in part, S9ADM formally announced her retirement and it was noted S12ADM would be taking her place in the upcoming months. The minutes documented over the next few months, S4MedDir, S1OfficeMgr, and S9ADM would review policies and procedures for best practices. Further review revealed no date was provided for the change in administrators for the facility. The minutes documented S9ADM as the recording secretary, with no signatures noted.

Review of documents provided regarding Health Standards Section (of LA. Dept of Health)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 121	Continued From page 21	S 121		

notification of a change in key personnel revealed no documented notification of a change in administrator for Delta Clinic of Baton Rouge.

Review of an Organizational Chart, provided by S1OfficeMgr as current, with administrative positions filled in with staff names , revealed S9ADM as the Administrator.

In an interview 01/23/17 at 12:00 p.m. S1OfficeMgr reported S9ADM was the Administrator of Delta Clinic of Baton Rouge. S1OfficeMgr reported she was in charge in the absence of S9ADM, and she (S1OfficeMgr) oversaw the day to day operations of the facility. S1OfficeMgr indicated there was no documentation appointing/designating her to stand in for the administrator in the absence of the appointed administrator. S9ADM indicated that the administrator was not often at the clinic, and she (S1OfficeMgr) had been in this position with these understood responsibilities for a number of years.

In a phone interview 01/25/17 at 11:20 a.m. S7DON reported she reports to S1OfficeMgr, but indicated S9ADM is the administrator and her actual supervisor. S7DON reported she had spoken with S9ADM last month.

In a phone interview 1/25/17 at 3:00 p.m. S4MedDir indicated she thought S1OfficeMgr was the administrator of Delta Clinic of Baton Rouge.

In a phone interview 01/25/17 at 1:45 p.m. S9ADM reported she had come to the clinic a few times over the last months of last year to assist S1OfficeMgr with some administrative duties, but had been told S12ADM was going to be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 121	Continued From page 22 administrator of this clinic, and was under the impression that S12ADM had assumed the position of administrator. She reported S12ADM had told her she (S12ADM) had faxed a change in key personnel notification to the state offices for both facilities, but that she still had come (to Delta Clinic of Baton Rouge) to help . S9ADM indicated she thought she was still a member of the GB, but the last meeting was last year, and the annual meeting wouldn't be held until May (of this year). S9ADM reported she did not remember the appointment of a person to act in the administrator's place in her absence. In a phone interview 01/25/17 at 2:35 p.m. S12ADM, indicated she was the administrator of Delta Clinic of Baton Rouge and of another clinic in another city. S12ADM reported she sent paperwork for change in administrators (to herself) to the Abortion Facilities Program Desk 04/29/16, but indicated she did not have a copy. She reported she had come to the Baton Rouge clinic about 3 months ago, and that she was on the GB. S12ADM indicated that she did not come to Delta Clinic regularly. She indicated there had been a meeting just last month, and would send a copy of minutes for that meeting to the clinic. S12ADM reported there had not been an appointment of someone to act in her absence (as administrator). By the end of the survey, at 4:30 p.m. 01/25/17, no documentation had been received from S12ADM.	S 121		
S 159	4425 -A Patient Med. Records/Reporting Requirements A. General Provisions 1. The outpatient abortion facility shall establish and maintain a patient medical record	S 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 159	Continued From page 23	S 159		

on each patient.

2. The patient medical record shall be:

a. completely and accurately documented; and

b. readily available and systematically organized to facilitate the gathering of information.

3. The outpatient abortion facility shall ensure compliance with privacy and confidentiality of patient medical records, including information in a computerized medical record system, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, and/or all applicable state laws, rules, and regulations.

4. Safeguards shall be established to protect the patient medical records from loss or damage and/or breach of confidentiality in accordance with all applicable state laws, rules, and regulations.

This Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure safeguards of medical records stored in the facility, against loss and/or damage were implemented.
Findings

Observation of the facility on 01/23/17 at 12:15 p.m., revealed storage of medical records in 4 upright floor to ceiling revolving record storage cabinets with 8 shelves on each side (32 total). The storage cabinets were noted to have the capability to be locked and closed. There were open spaces between each cabinet with visual appearance of the records between each space when closed resulting in the inability to ensure for protection against loss or damage.

S 159

Safeguarding our medical records from theft and destruction is a serious concern of this Clinic.

Having received the bid for construction of a fire proof chart storage closet, it has been determined the excessive cost is prohibitive. See attached.

The Board has come together with the plan of: Combining two patient waiting rooms (in the front hall). The room where sterile instruments/ instrument trays are made ready for the day will then move next door into the other waiting room.

The instrument room is the next room to the office. It will be made ready to be the chart room. It will be painted with fire-resistant paint and a fire-proof door will be hung. It will be treated as the acceptable chart room is at our sister clinic, Women's Health Care Center, Inc. in New Orleans.

The Closet will be completed by June 15, 2017.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 159	Continued From page 24 Review of the Facility's Policy titled "Patient Records Content", presented by S1OfficeMgr as being current, read in part: Policy: Safeguards are established to maintain confidentiality and protection from fire, water, or other sources of damage. In an interview on 01/23/17 at 12:15 p.m., S1OfficeMgr indicated that she could not give an estimated number of how many medical records were stored in the facility. She indicated that all medical records stored in the facility were active patient records. She indicated that the facility had no safeguards in place to protect the records from loss and or damage from fire or water.	S 159		
S 169	4425 - E-F Patient Med Records/Reporting Requirements E. Other Reports. The outpatient abortion facility shall maintain a daily patient roster of all patients receiving a surgical or chemically induced abortion. Patients may be identified corresponding to the patient's medical record. This daily patient roster shall be retained for a period of three years F. Reporting Requirements 1. The outpatient abortion facility shall maintain documentation to support that the outpatient abortion facility is compliant with all reporting requirements, including, but not limited to, the induced termination of pregnancy (ITOP) form and other documentation as required by federal, state, and local statutes, laws, ordinances, and department rules and regulations. 2. The outpatient abortion facility shall report in accordance with all applicable state laws for	S 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 169	Continued From page 25	S 169		

the reporting of crimes against a child that include but are not limited to:

a. rape;
b. sexual battery;
c. incest; and
d. carnal knowledge of a juvenile

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure they were compliant with reporting requirements to have ITOP reports completed/certified within 15 days, as per their policy and procedure. The facility failed to ensure they maintained documentation to support they were compliant with state statutes and licensing regulations to have ITOP reports completed/certified within 30 days after the date of the abortion. This deficient practice was evidenced by ITOPs not completed/certified within 30 days from the date of the abortion for 13 (#1, #2, #3, #4, #5, #6, #8, #9, #10, #12, #13, #14, #15) of 15(#s 1-15) medical records reviewed for required reporting compliance, out of a total sample of 15.
Findings:

Review of LA RS 40:1299.35.10 Reports, revealed, in part "A. An individual abortion report for each abortion performed or induced shall be completed by the attending physician ...The report shall include:...(25) Signature of the attending physician... C. All abortion reports shall be signed by the attending physician and submitted to the Department of Health and Hospitals within thirty days after the date of the abortion.

Review of the facility's Policy & Procedure titled

S 169 A policy has been written and adopted by the Board of Directors establishing the appropriate time for information reported to the LEERS system regarding all pregnancy terminations. Policy number 2411 will be maintained in the Patient Care Manual. Staff will be in-services on the proper time frame for reporting. 03/18/2017

It was discovered our reporting procedures were inadequate. Instructions were received, policies were read, understood and followed. Changes have been made in the reporting process to have each report completed timely and have them certified by the physician and registered, as appropriate. **See Exhibit F**

03/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 169	Continued From page 26	S 169		

"Report of Induced Termination of Pregnancy", presented 01/24/17 at 2:40 p.m. by S1OfficeMgr as current, read in part: Policy: Report of induced termination of pregnancy, form PHS 16-ab, shall be completed and submitted with appropriate certificates and consent forms required by LSA-R.S.40:1299.3510 (25) to the Vital Records Registry. Procedure: The report of induced termination of pregnancy from (as written) with appropriate certificates and consents will be submitted to the Vital Records of Registry within 15 days of an abortion. Further review revealed no procedure to provide documentation/evidence of the submission of the ITOP reports in the time required by facility policy and time required by state law. No procedure to ensure the physician signed the ITOP report was noted.

Patient #1
Review of the medical record for patient #1 revealed she had a non-surgical abortion 7/14/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 7/25/16.
Review of an ITOP report for Patient #1, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 10/20/16.

Patient #2
Review of the medical record for patient #2 revealed she had a surgical abortion 7/19/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 7/22/16.
Review of an ITOP report for Patient #2, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 10/20/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 169	Continued From page 27	S 169		

Patient #3
Review of the medical record for patient #3 revealed she had a non-surgical abortion 8/19/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 8/22/16.
Review of an ITOP report for Patient #3, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 9/30/16.

Patient # 4
Review of the medical record for patient #4 revealed she had a surgical abortion 10/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 10/17/16.
Review of an ITOP report for Patient #4, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 11/23/16.

Patient #5
Review of the medical record for patient #5 revealed she had a non-surgical abortion 9/6/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 9/14/16.
Review of an ITOP report for Patient #5, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 11/23/16.

Patient #6
Review of the medical record for patient #6 revealed she had a non-surgical abortion 9/9/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 9/16/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 169	Continued From page 28	S 169		

Review of an ITOP report for Patient #6, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 12/01/16.

Patient #8
Review of the medical record for patient #8 revealed she had a non-surgical abortion 10/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 10/17/16.

Patient #9
Review of the medical record for patient # revealed she had a surgical abortion 11/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 1/09/17.
Review of an ITOP report for Patient #1, provided by the LDH State Registrar and Vital Records office, revealed a certification and registration date of 10/20/16.

Patient #10
Review of the medical record for patient #10 revealed she had a surgical abortion 12/09/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 01/11/17.

Patient #12
Review of the medical record for patient #12 revealed she had a non-surgical abortion 7/14/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 7/25/16.

Patient #13
Review of the medical record for patient #12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 169	Continued From page 29	S 169		

revealed she had a surgical abortion 11/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 1/09/16.

Patient #14
Review of the medical record for patient #14 revealed she had a surgical abortion 11/04/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 01/24/17.

Patient #15
Review of the medical record for patient #15 revealed she had a non-surgical abortion 12/17/16. Further review of the medical record revealed no certification or registration date on the ITOP form, which had a printed date of 1/09/16.

In an interview 1/25/17 at 11:50 a.m. S3Office reported she electronically entered information into the LEERs system after a patient had been discharged after an abortion procedure. She indicated this was done usually a day or two after the procedure. She reported she then printed 2 copies. One was put in the patient's medical record, and the other is given to the physician to be signed. S1OfficeMgr, present for the interview reported that the physicians manually signed the forms, then the forms were taken to the post office and mailed to the state. S1OfficeMgr reported she did not have any documentation of the dates any of the ITOP reports were mailed.

S1OfficeMgr reviewed the ITOP reports for Patient #s 1-6, 8-10, and 12-15. S1OfficeMgr confirmed there was no certification date on the ITOP copies from the medical records, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 169	Continued From page 30 certification dates of the ITOP reports provided by the program desk showed them all to be later than the 15 days of their policy, and 30 days required by state regulations and statues. S1OfficeMgr reported she could provide no documented evidence of required information, including the physician's signature certifying the report, having been provided to the State Registrar and Vital Statistics within 30 days of the patient's procedures.	S 169		
S 171	4427 A-1 Quality Assurance/Performance Improvement Pro A. The outpatient abortion facility shall develop, implement, enforce, maintain, and annually review a written QAPI program subject to approval by the governing body, which puts systems in place to effectively identify issues for which quality monitoring and performance improvement activities are necessary. The QAPI program shall include plans of action to correct identified issues including, but not limited to, monitoring the effect of implemented changes and making necessary revisions to the plan of action. 1. Plans of Action. The outpatient abortion facility shall develop and implement a QAPI plan of action designed to effectively identify issues for which quality monitoring and performance improvement activities are necessary. This Rule is not met as evidenced by: Based on record review and interview, the facility	S 171	**S 171** A Board of Directors meeting will be held to establish a Quality Assurance Coordinator, Quality Assurance Committee and a plan of action for monitoring changes and making revisions to the program. A system will be established to identify and address issues designated in the Quality Assurance Program. These policies and procedures will be reviewed, implemented, followed and documented. 03/18/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 171	Continued From page 31	S 171		

failed to develop, implement, enforce, maintain, and annually review a written QAPI program that was approved by the governing body, which put systems in place to effectively identify issues for quality monitoring and PI activities. The QAPI program failed to include a plan of action to correct identified issues, monitor the effect of implemented changes, and make revisions to the plan of action. This deficient practice was evidenced as the facility had no active QAPI Program in place.
Findings:

Review of the facility's Policy & Procedure titled " Quality Assurance" presented (01/25/17) by S1OfficeMgr. as being current, read in part: The Professional Advisory Group (PAG) will meet quarterly to advise the Clinic on professional issues, to participate in the evaluation of the Clinic's program and to assist the Clinic in maintaining liaison with other health care providers.... The PAG will serve in a utilization review capacity to: 1. Review patient records concurrently and retrospectively. 2. Determine that professional and patient care policies are followed in providing services. 3. Review ten percent (10%) random sample from active and discharged medical records to evaluate the necessity, appropriateness and effectiveness of the Clinic's services each quarter. 4. Make recommendations based on findings to the Administrator. The objectives of the review will be to: 1. Evaluate the appropriateness of admission and discharge policies and procedures. 2. Evaluate implementation of medical treatment plans and care plans. 3. Evaluate the effective/efficient use of resources and identity over or under utilization trends. 4. Evaluate for non-payment, status change or management problems and make

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 171	Continued From page 32 recommendations as appropriate. Review of a document titled "Quality Assurance Indicators Year 2016" revealed the following areas of audit: Patient volume (counseling, pill abortion, surgical abortion); Complications (ectopic, pill re-aspiration, surgical re-aspiration, retained tissue, bleeding, missed abortion, infection, other -fail, grievances, occurrences (patient), grievances- employee, occurrences-employee; Logs (refrigerator-lab, medication, cleaning, AED, Autoclave, in services). In an interview on 01/25/17 at 12:10 p.m., S1OfficeMgr indicated that the facility had no system in place to identify/address issues through the QAPI Program. She indicated that she collected the numbers monthly for the Quality Assurance Indicators and summed up the total at the end of the year. She indicated that she had no documented evidence that the data collected was reviewed by the QAPI committee. In a telephone interview on 01/25/17 at 1:45 p.m., S9ADM indicated that the facility had a policy & procedure for a QAPI Program and failed to implement their policy and procedure.	S 171		
S 173	4427 - A-3 Quality Assurance/Performance Improvement Pro 2. The QAPI plan of action shall include on a quarterly basis the following: a. processes for receiving input regarding the quality of medical and clinical services received; b. processes for review of patient medical	S 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 173	Continued From page 33	S 173		

records to ensure that such are complete and current;

c. processes for identifying on a quarterly basis the risk factors that affect or may affect the health and safety of the patients of the outpatient abortion facility receiving medical and clinical services. Examples may include, but are not limited to:

i. review and resolution of patient grievances; and

ii. review and resolution of patient/employee incidents involving medication errors and equipment failure;

d. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above.

3. The QAPI outcomes shall be documented and reported to the administrator in writing for action, as necessary, for any identified systemic problems.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that the QAPI plan of action included a quarterly review of the following: 1) a process for receiving input regarding the quality of medical and clinical services received, 2) a process for identifying, on a quarterly basis, the risk factors that affect or may affect the health and safety of the patients, 3) a process to review and develop action plans to resolve all system wide issues identified, and 4) document outcomes and report to the administrator in writing for action, for any identified systemic problems. This deficient practice was evidenced by the facility not having an effective QAPI Program in place.

S 173 Our newly established Quality Assurance Coordinator and Quality Assurance Committee will meet at least quarterly and the Board of Directors will review the results at least quarterly.

We do have a system in place to identify and address issues through the program. We will implement these systems with the new Quality Assurance coordinator.

The quarterly review will include:

1. A process for receiving input regarding the quality of medical and clinical services received.
2. Process, quarterly, for identifying the risk factors that affect or may affect the health and safety of patients.
3. Process for review and development of action plans to resolve all system-wide issues identified.
4. Documentation of outcomes and reporting to administrator, in writing, for action of identified systemic problems.

06/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 173	Continued From page 34 Finding: Review of the facility's Policy & Procedure titled " Quality Assurance" presented (01/25/17) by S1OfficeMgr. as being current read in part: The Professional Advisory Group (PAG) will meet quarterly to advise the Clinic on professional issues, to participate in the evaluation of the Clinic's program and to assist the Clinic in maintaining liaison with other health care providers.... Review of a document titled "Quality Assurance Indicators Year 2016" revealed the following areas audited: Patient volume (counseling, pill abortion, surgical abortion), Complications (ectopic, pill re-aspiration, surgical re-aspiration, retained tissue, bleeding, missed abortion, infection, other(fail), grievances, occurrences (patient), grievances- employee, occurrences-employee; Logs (refrigerator-lab, medication, cleaning, AED, Autoclave, in services). Review of the facility's Manual revealed no documented evidence that a quarterly review was conducted by the QAPI committee. In an interview on 01/25/17 at 12:10 p.m., S1OfficeMgr indicated that the facility had no system in place to identify/address issues through the QAPI Program. She indicated that she collected the numbers monthly for the Quality Assurance Indicators and summed up the total at the end of the year. She indicated that she had no documented evidence that the data collected was reviewed by the QAPI committee. In a telephone interview on 01/25/17 at 1:45 p.m., S9ADM indicated that the facility had a Policy &	S 173		

S 173 Continued From page 35

Procedure for a QAPI Program and failed to implement their policy and procedure.

In an interview on 01/25/17 at 12:10 p.m., S1OfficeMgr indicated that the facility's QAPI indicators were not reviewed/monitored quarterly by the QAPI committee.

S 221 4445 -A 1 - 3 General Requirements

A. General Provisions

1. The outpatient abortion facility shall be designed, constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public at all times.

2. The outpatient abortion facility shall meet the provisions for physical environment under this Section, unless otherwise noted herein.

3. For the purposes of this Section, major renovations are defined as such renovations that affect the alteration to the functionality or original design of the facility 's construction. Painting walls, re-tiling floors, installation of carpet, repairing roof damage or reroofing are not considered to be major renovations for purposes of this Section.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to ensure the facility was maintained to protect the health and safety of patients and personnel. This deficient practice was evidenced by an observation of Room C with a holes on the lower part of 2 walls, about 2 inches above the base board. Findings:

S 221

We realize the holes in the wall caused by the ultrasound machine stand are a health hazard and they will be repaired on Friday, March 31, 2017.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 221	Continued From page 36 Observation of Room C on 01/23/17 at 12:30 p.m., revealed a hole in 2 of the walls, near the baseboards. The holes were observed to be approximately 6 cm by 1.5 cm in one wall, and approximately 2 cm by 4 cm in the other wall. In an interview on 01/23/17 at 12:30 p.m., S1OfficeMgr, present for the observation, reported she was aware of the holes and indicated it was from the Ultrasound machine being pushed into the wall. She confirmed that the hole in the wall allowed for passage of dirt particles and/or rodents.	S 221		
S 243	4447 B Infection Control A. The outpatient abortion facility shall develop, implement, enforce, monitor, and annually review, with the approval of the medical director, written policies and procedures for preventing, identifying, reporting, investigating, controlling, and immediately implementing corrective actions relative to infections and communicable diseases of patients and personnel. At a minimum, the policies shall address: 1. alcohol based hand rub and hand hygiene; 2. use of all types of gloves; 3. decontamination of equipment between each patient use, including, but not limited to, chairs and procedure room tables; 4. linen cleaning, if applicable; 5. waste management including, but not limited to, the requirements of Part XXVII of LAC Title 51, Public Health/Sanitary Code; 6. environmental cleaning; 7. reporting, investigating, and monitoring of surgical infections; 8. sterilization procedures and processes, if	S 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 243	Continued From page 37	S 243		

applicable;
9. single use devices;
10. disinfecting procedures and processes; and
11. breaches of infection control practices.

This Rule is not met as evidenced by:
Based on record review, observation, and interview the facility failed to ensure infection control policies and procedures were developed, implemented, enforced, and monitored related to sterilization procedures and processes. This deficient practice was evidenced by policy and procedures that did not include using chemical indicators inside sterilization packs. The facility did not keep information related to each load of surgical instruments sterilized that would be required to verify sterilization parameters were met, and monitor and track data in the event of an identified infection. Findings:
Review of a facility policy and procedure titled "Infection Control Autoclave Testing-Daily" with no date or number, provided by S1Office Manager as current, revealed in part, instruments would be placed in heat sensitive bags, and heat sensitive indicator strips would be placed in each set of wrapped instruments before each sterilization process. A Tray Record Card (heat sensitive indicator) would be placed in each load. The indicator strips and the Tray Record Card would be maintained in an orderly fashion in the Clinic for QA purposes. Further review revealed no procedure to include a chemical(heat sensitive) indicator inside all heat sensitive bags (also know as peel packs) and to place an indicator on the outside of pack wrapped instruments in addition to the internally placed

S 243 **Again, this Administration is in disbelief regarding the Manager's claim which stated the physician instructed staff not to properly sterilize instruments, include verification of sterilization, and document appropriately.**

This Clinic has always had an infection control and OSHA program which included proper handwashing, properly sterilizing instruments, and environmental cleanliness.

An Infection Control Coordinator will be assigned and an Infection Control Committee will be established. 03/18/2017

Documentation will be collected as part of the Quality Assurance program.

Documentation includes, but is not limited to: Hand washing observation to be completed quarterly. Exhibit H

03/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 243	Continued From page 38	S 243		

indicator.
Review of the CDC Guideline for Disinfection and Sterilization in Healthcare Facilities,2008 revealed, in part, indicate that the item (that underwent sterilization) had been exposed to the sterilization process. Chemical indicators are affixed on the outside of each pack to show that the package has been processed through a sterilization cycle, but these indicators do not prove sterilization has been achieved. Further review revealed a chemical indicator also should be placed on the inside of each pack to verify sterilant penetration.
An observation 1/23/17 at 12:40 p.m. revealed surgical instruments in sealed peel packs, having an outside indicator with a color change that the package had been through the sterilization process. Further observation revealed no chemical indicator inside the sealed peel pouch of instruments observed as follows: 23 packs in the sterilization room, 4 in Procedure Room A, and 3 in Room "B with no chemical indicators inside the packs. A total of 30 surgical instruments in processed sealed peel packs where observed without a chemical indicator inside the pack to demonstrate the temperature inside the peel pack had reached a temperature for long enough to sterilize the contents.
In an interview 1/23/17 at 12:40 p.m. S1OfficeMgr, present for the observation, verified the observed findings, and reported one of the physicians had instructed staff a few months prior (to the survey) to stop putting a chemical indicator into each sterilization package as it was not necessary. She indicated prior to that the practice was to always place an indicator inside each package sterilized.
A review of sterilization logs and documents revealed no log of indicators for each load of instruments sterilized ,other source of information

Clinic Cleaning to be performed daily and as needed. Cleaning logs to be collected monthly by Infection Control Coordinator. Logs are maintained in QA binder.

Exhibit I 03/18/2017

Sterilization processes, policies and logs are maintained in a binder which includes Spore testing cards and results; chemical indicators for each instrument pack; autoclave cleaning and maintenance.

Infection Control documentation and logs will be collected as part of the Quality Assurance Program. **Exhibit J** 03/18/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 243	Continued From page 39	S 243		

of the date, load #, temperature, length (in time), contents , results of the chemical indicator from the tray, or the person processing each load processed.
In an in interview 1/24/17 at 2:10 p.m. S1OfficeMgr reported process of the facility to keep a log of each load of instruments autoclaved for sterilization. S1OfficeMgr indicated there was no record of the date, temperature, length (in time), contents, results of the chemical indicator in the tray, or person processing the load of instruments. S1OfficeMgr indicated she was not aware such a log was required.
In an interview 1/24/17 at 3:45 p.m. S2MD reported that she had not instructed any staff to discontinue placing a chemical indicator inside the peel packs of instruments to be sterilized.
In a phone interview 1/25/17 at 11:20 a.m. S7DON indicated she was involved with Infection Control for the facility, but was not the IC Coordinator. S7DON indicated she had been in her current position as DON for approximately 2 years. She reported that she worked with S1OfficeMgr and S4MedDir in the IC program. She reported staff was instructed by S2MD to stop using chemical indicators inside the peel packs of instruments. When asked which nationally recognized guidelines the facility's IC policies and procedures were based, specifically sterilization procedures, she indicated the were based on "OSHA, and state guidelines." S7DON indicated that she completes a "checkoff list" every three months for IC surveillance which included handwashing, provides inservices for staff, observes the US tech for IC breeches, audits charts, sterilization process, and oversees S6LPN. S7DON indicated she gives a report to S1OfficeMgr regarding IC surveillance.
In a phone interview 1/25/17 at 3:10 p.m. S4MedDir indicated there was no one person

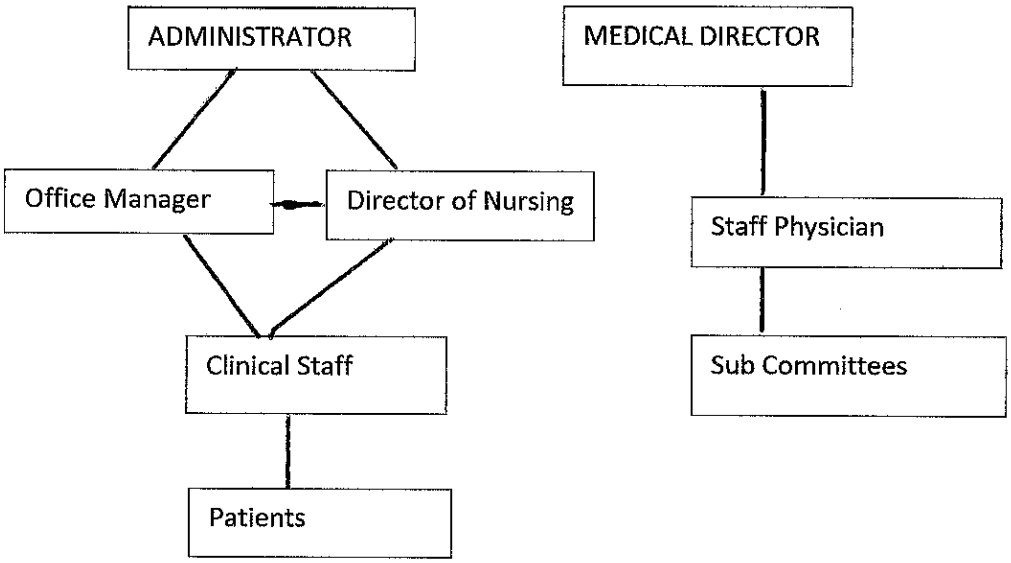
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	01/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
S 243	Continued From page 40 designated as the IC coordinator or responsible for the IC program. The Medical Director indicated she was not aware that the facility had stopped the use of chemical indicators inside the packages of instruments for sterilization. She indicated that the facility did not have meetings regarding IC, and she did not receive IC reports. Review of a document provided for hand hygiene monitoring for the last year, revealed a title of "Hand-washing Hygiene", with S7DON as the observer. Further review revealed a list of staff repeated twice, with dates of 2/25/16 and 8/23/16 with an observation documented each date for each staff member with documented compliance before and after contact. S3Office was noted as N/A on 8/23/17. It was noted that no physicians were included in the surveillance. No other hand hygiene surveillance documentation was presented. Review of QA indicators for the year 2016 revealed IC related indicators, under logs as follows: Refrigerator- Lab, Refrigerator-Medicine, Cleaning, AED, Autoclave, Inservices. Each category had a "C' for complete for each of the 12 months of 2016. Further review revealed no report on hand hygiene, sterilization and storage processes, environmental cleanliness, infections, or any other IC surveillance.	S 243		

DELTA CLINIC OF BATON ROUGE, INC.
ORGANIZATIONAL CHART

BOARD OF DIRECTORS



DEPARTMENT OF HEALTH

Health Standards Section

KEY PERSONNEL CHANGE FORM

This form must be signed by the proposed employee and the administrator.

Legal Entity Name: Delta Clinic of **Agency DBA Name:** Baton Rouge, INC	**Provider License #:** 07
Address: 756 Colonial Drive #B **City, State, Zip:** Baton Rouge, La 70804	**Provider CMS ID if applies#:**
Telephone Number: 225.924.4442	**Administrator's Email Address:** WHCCNO@gmail.com
Fax Number: 225.924.4445	**Proposed Employee's Email Address (if available):** laurenglonek@aol.com

Circle the Position that is changing (Please circle only those appropriate to the Provider Type):

Administrator (the person with overall responsibility for the day-to-day administrative operations)
Director of Nursing (the RN providing leadership of nursing services – if applicable)
Medical Director (the physician providing oversight of the clinical operations – if applicable)
Other: _____

Name of previous employee in this position: [redacted]
Name of proposed employee for this position [redacted]
Effective Date of Change: 02/13/2017

Verification Date of Current LA Professional License: 01/23/2017
Please enter the date on which the agency verified the current professional licensure of the proposed employee, *if licensure is a requirement for the position.* The date should precede the effective date of change.

Attestations of Compliance

We hereby certify that the proposed employee listed herein meets all state and federal requirements set forth by the Louisiana Department of Health and Hospitals (DHH), Health Standards Section; the Centers for Medicare and Medicaid Services; and any other regulatory agency applicable to the Provider Type, to function in the role indicated. We further understand that it is the responsibility of the administrator to ensure that the agency maintains compliance with state and federal regulations on an ongoing basis. DHH Health Standards Section will be promptly notified of any changes to Key Personnel.

[redacted] _____ 02/13/2017
Printed Name of Proposed Employee — Signature of Proposed Employee — Date (mm/dd/yy)

[redacted] _____ 02/13/2017
Printed Name of Administrator — Signature of Administrator — Date (mm/dd/yy)

PLEASE NOTE: This form is used for all Health Standards Section licensed providers/suppliers. Definitions of Key Personnel may be found in the applicable state licensing regulations for the specific Provider Type.

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://new.dhh.louisiana.gov/

POLICY AND PROCEDURE
PERSONNEL
PROHIBITED ACTIVITIES

POLICY

Prohibited activity requirements, such as presenting or otherwise delivering any instruction or program on any health topic, including but not limited to human sexuality or family planning, to students at a public elementary or secondary school, or at a charter school that receives state funding or knowingly providing any materials or media regarding human sexuality or family planning for distribution or viewing at a public elementary or secondary school, or at a charter school that receives state funding, or any other matter addressed by law related to abortion or abortion procedures.

DELTA CLINIC OF BATON ROUGE, INC.

POLICY AND PROCEDURE

PATIENT CARE – VITAL RECORDS REPORTING

POLICY

In accordance with LDH (Louisiana Department of Health) regulations, a vital record "Report of Induced Termination of Pregnancy Performed in Louisiana" is to be completed for each pregnancy termination performed.

The original report, the one sent to LDH, must be signed by the physician who performed the service. The copy of the report which is to be maintained in the patient's confidential medical record may be stamped with the physician's signature stamp.

The report must be submitted to LDH within thirty (30) days of the termination.

PROCEDURE

Effective August 29, 2011 the "Report of Induced Termination of Pregnancy" is to be completed online in the LEERS system using the web address provided by LDH: (https://leers.oph.dhh.la.gov). This form is to be completed within thirty (30) days of the procedure.

Upon completion of the report, the report is to be submitted to the state using the "drop to paper" function.

The report is then printed, signed by the physician, and mailed to Vital Records with a copy of the Ultrasound Report and the Certification of Informed Consent for Abortion form attached to the report.

POLICY AND PROCEDURE

PATIENT CARE

QUALITY ASSURANCE

POLICY

Women's Health Care Center, Inc., performs ongoing monitoring and evaluation of patient care. The Quality Assurance Program (QA) has a goal to consistently strive to improve the CLINIC'S provision of care in accordance with patient's needs, and professional and regulatory standards.

The QA Plan insures that the monitoring and evaluation of care is performed by the Clinical staff who are directly involved with the care of the patient. The QA Plan allows the identified problems to be solved in an orderly and constructive manner and provides for measures to address improvement.

PROCEDURE

The QA Plan is based on the following concepts:

Step 1 – Responsibility

The Medical Director and the Administrator will be responsible for setting up, monitoring and reviewing the quality assurance plan. The Administrator will be responsible for submitting the data to the governing board at least annually for review and approval.

Step 2 – Scope of Care and Services

The CLINIC is available for emergencies twenty-four (24) hours a day to all patients. Services include medical and surgical abortion procedures.

Step 3 – Important Aspects of Care

The following aspects of care have been identified as high-risk, high-volume, or problem prone. These aspects of care which reflect large numbers of patients place these patients at risk of serious consequences, or deprive them of substantial benefit if the care is not provided, provided incorrectly, or is provided when not indicated, or has tended to produce problems for the staff and patients.

Step 4 – Examples of Data Collected

These indicators have been identified and will be monitored:

Professionalism/ Confidentiality

Patient Satisfaction

Pain Control

Step 5 – Collection and Organization of Data

Data sources for monitoring and evaluation include:

- Patient medical record
- Patient complications
- Occurrence reports – Patients, Employees
- Grievance reports – Patients, Employees
- Logs
  - Refrigerators
  - Medications
  - Autoclave
  - Cleaning facility
  - AED and Code Kit
  - Inservices

Aspects of care selected for monitoring and evaluation are monitored monthly. Ten percent (10%) of the previous month's patient medical records will be audited.

The monthly QA reports will be reviewed by the Medical Director and the Administrator on a quarterly basis.

Step 6 – Evaluation of Care

When data reaches the threshold for evaluation, staff members, qualified in the particular area evaluate the care provided to determine whether a problem or opportunity to improve care exists. Once the problem has been identified, the CLINIC may take immediate corrective actions.

Step 7 – Actions to Solve Identified Problems

If the evaluation identified a problem or opportunity for improvement, the Medical Director along with the Administrator determines what corrective action is necessary.

The plan of corrective action identified, who or what is expected to change, who is responsible for implementing action, what action is appropriate in view of the problem's cause, scope and severity and when change is expected to occur. A record of action taken is maintained.

Step 8 – Assessment of Actions

The results of continual monitoring and evaluation are documented to provide a record of the efficiency of actions taken. If the quality and appropriateness of care in a specific area does not improve, then the problem, its cause and, the action taken to solve it is addressed. New action is then taken and once again, the effectiveness of the actions taken is assessed.

Step 9 – Communications

Monitoring and evaluation information is communicated to all necessary medical, nursing, and Administrative staff by either the Medical Director or the Administrator.

Step 10 – Annual Evaluation

The Quality Assurance Plan and manual are reviewed and approved annually by the Clinical Administrator, the Medical Director, and the Governing Board.

POLICY AND PROCEDURE

QUALITY ASSURANCE

ANNUAL PROGRAM EVALUATION

POLICY

An overall CLINIC evaluation will be conducted at least once each year by the Medical Director, Administrator and Governing Body.

PURPOSE

1. The evaluation shall consist of an overall policy and administrative review to assure the CLINIC policies are being followed.

2. To assess the extent to which the program is:

    a. Appropriately utilized
    b. Adequately meeting the needs of the community
    c. Demonstrating its effectiveness by assessing the degree that established objectives are met
    d. Organized and operated efficiently.

PROCEDURE

1. The committee shall maintain written records of all discovery which shall be subject to review by the Louisiana Department of Health and will include recommendations for modification. Results of the evaluation are reported to the Administrator, Medical Director and Board of Directors, and becomes part of Administrative records of the CLINIC.
2. The following outline for systematic formal evaluation will be utilized:

A.Activity/ Material Review	Purpose
Organizational Structure	
Clinic Code of Ethics	To determine compliance with stated CLINIC philosophy
Organizational Chart	To illustrate internal lines of responsibility
B.Administartive Policies	
Administrative	To determine adherence to regulatory standards
Clinical	To determine compliance with program objectives
C.Financial Management	
Preparation of Budgets	To establish a budget based upon service required and financial resources available.
	To provide for regular review of source of income versus expenditures
	To maintain fiscal accountability
Audit	
Clinic	For examination of accounts and record by an independent accountant
Cost Analysis	To determine and document costs
Fee schedule	
Sources of Income	To maintain a regular review of income
D.Business-Clerical Procedures	
Billling Procedures	To determine efficiency and effectiveness of billing procedures
Collection of Statistical Data	To determine degree of uniformity in collection process
	To determine effectiveness and efficiency of collection procedures
E.Time Data Analysis	To determine average time limit per unit of service and cost of same

F.Statistical Analysis

Population Served	To determine quality of services provided
Services Provided	To determined characteristics of population served, sources of referral and payment services
Number of Visits	
Payment Sources	
Referral Sources	

G.Medical Direction

Standing Orders	To provide clear, uniform, safe medical direction for direct service personnel
Relationship to Medical Staff	
Admission and Discharge Policies	To revise as indicated

H. Personnel and Staffing

Review of Staff by Type & Number	To employ personnel in sufficient ratio to service needs
Director, Service Personnel	To appropriately & efficiently utilize personnel
Administrative, Supervisory Personnel	
Business personnel	
Job Descriptions	To define functions according to educational and experience qualifications
Salary Schedule	To determine equitable financial remuneration for all personnel
Performance Evaluation	To determine level of performance and degree of competency
Staffing & Patterns & Policies	To assess adequacy of staff, productivity and turnover rates

Educational Program	
Clinic Personnel	
Orientation	To orient personnel to the CLINIC
License	To validate current state licensure
In-Services	To offer opportunities for personnel to increase their knowledge
I.Contracts and Cooperative Relationships	To supplement CLINIC provided services
	To provide other health providers and a community with needed health services.
	To maintain legal compliance
J. Quality Assurance	
Utilization Review	To evaluate appropriateness of services rendered and efficient use of community resources
Patient Care Conferences	To coordinate and review the care delivered by each discipline
Satisfaction Surveys	To determine patient/physician/ referral source satisfaction with staff and service
Chart Audit	To determine if established policies are carried out in providing services by both staff and contract personnel
Grievances	To address all complaints and grievances with patients and staff
K.Community Study	
Population Characteristics	To determine community needs
Age groups	
Morbidity rate	
Mortality rate	
Existing community health/ social resources	

Hand Hygiene Observation Form Date: ___/___/__ Observer_____

	Type of Healthcare Worker	Observation		
1	☐ Pre-op nurse ☐ Lab Technician ☐ Scrub ☐ Ultrasound Technician ☐ Recovery R.N. ☐ Doctor ☐ ☐	**BEFORE** touching the patient: ☐ABHR ☐Soap & water ☐Noncompliant	**BEFORE** performing an invasive procedure (e.g. placing an IV, removing an IV): ☐ABHR or soap & water and ☐gloves ☐Noncompliant	
		AFTER touching the patient or contaminated surfaces: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** removing gloves: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** contact with blood or body fluids: ☐Soap & water ☐Noncompliant
2	☐ Pre-op nurse ☐ Lab Technician ☐ Scrub ☐ Ultrasound Technician ☐ Recovery R.N. ☐ Doctor ☐ ☐	**BEFORE** touching the patient: ☐ABHR ☐Soap & water ☐Noncompliant	**BEFORE** performing an invasive procedure (e.g. placing an IV, removing an IV): ☐ABHR or soap & water and ☐gloves ☐Noncompliant	
		AFTER touching the patient or contaminated surfaces: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** removing gloves: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** contact with blood or body fluids: ☐Soap & water ☐Noncompliant
3	☐ Pre-op nurse ☐ Lab Technician ☐ Scrub ☐ Ultrasound Technician ☐ Recovery R.N. ☐ Doctor ☐ ☐	**BEFORE** touching the patient: ☐ABHR ☐Soap & water ☐Noncompliant	**BEFORE** performing an invasive procedure (e.g. placing an IV, removing an IV): ☐ABHR or soap & water and ☐gloves ☐Noncompliant	
		AFTER touching the patient or contaminated surfaces: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** removing gloves: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** contact with blood or body fluids: ☐Soap & water ☐Noncompliant
4	☐ Pre-op nurse ☐ Lab Technician ☐ Scrub ☐ Ultrasound Technician ☐ Recovery R.N. ☐ Doctor ☐ ☐	**BEFORE** touching the patient: ☐ABHR ☐Soap & water ☐Noncompliant	**BEFORE** performing an invasive procedure (e.g. placing an IV, removing an IV): ☐ABHR or soap & water and ☐gloves ☐Noncompliant	
		AFTER touching the patient or contaminated surfaces: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** removing gloves: ☐ABHR ☐Soap & water ☐Noncompliant	**AFTER** contact with blood or body fluids: ☐Soap & water ☐Noncompliant

EXAM ROOM 5

Date:

CLEANING DUTY	MON	TUES	WED	THUR	FRI	
WEEK 1						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						
WEEK 2						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Vacuum floor						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						
WEEK 3						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						
WEEK 4						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						

EXAM ROOM 6

Date:

CLEANING DUTY	MON	TUES	WED	THUR	FRI	
WEEK 1						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						
WEEK 2						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Vacuum floor						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						
WEEK 3						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						
WEEK 4						
Wipe countertop & sink						
Wipe Aspirator Machaine						
Clean procedure table						
Wipe lamp						
Wipe stool						
Sweep & Mop Floor						

ULTRASOUND ROOM

_____ 2012

Cleaning Tasks Listed by Room	MON	TUES	WED	THUR	FRI	
WEEK 1						
Wipe countertop						
Wash sink						
Clean exam table						
Wipe ultrasound mach						
Clean probes						
Empty trash						
Sweep & Mop floors						
WEEK 2						
Wipe countertop						
Wash sink						
Clean exam table						
Wipe ultrasound mach						
Clean probes						
Sweep & Mop floors						
Empty trash						
WEEK 3						
Wipe countertop						
Wash sink						
Clean exam table						
Wipe ultrasound mach						
Clean probes						
Sweep & Mop floors						
Empty trash						
WEEK 4						
Wipe countertop						
Wash sink						
Clean exam table						
Wipe ultrasound mach						
Clean probes						
Sweep & Mop floors						

QUALITY CONTRL LOG FOR KITCHEN

2012

DATE	FRIG. TEMP	INIT.
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
26		
27		
28		
29		
30		
31		

RECOVERY ROOM

DAILY CLEANING	MON	TUES	WED	THUR	FRI	
WEEK 1						
Wipe Desk						
Wipe Chairs						
Sweep Floor						
Mop Floor						
Empty Trash						
WEEK 2						
Wipe Desk						
Wipe Chairs						
Sweep Floor						
Mop Floor						
Empty Trash						
WEEK 3						
Wipe Desk						
Wipe Chairs						
Sweep Floor						
Mop Floor						
Empty Trash						
WEEK 4						
Wipe Desk						
Wipe Chairs						
Sweep Floor						
Mop Floor						
Empty Trash						

QUALITY CONTROL LOG FOR RECOVERY ROOM

MEDICATION STORED MUST BE @ CONSTANT TEMPERATURE OF 36-46 DEGREES F

2012

DATE	ROOM TEMP	FRIG TEMP	INIT.

CLEAN LOG

, 2012

DAILY CLEANING	MON	TUES	WED	THUR	FRI	
WEEK 1						
LOBBY						
RECEPTION AREA						
LAB ROOM						
KITCHEN & RESTROOMS						
COUNSELING ROOM						
DOCTOR'S OFFICE						
VACCU, SWEEP, MOP						
TRASH EMPTIED						
WEEK 2						
LOBBY						
RECEPTION AREA						
LAB ROOM						
KITCHEN & RESTROOMS						
COUNSELING ROOM						
DOCTOR'S OFFICE						
VACCU, SWEEP, MOP						
TRASH EMPTIED						
WEEK 3						
LOBBY						
RECEPTION AREA						
LAB ROOM						
KITCHEN & RESTROOMS						
COUNSELING ROOM						
DOCTOR'S OFFICE						
VACCU, SWEEP, MOP						
TRASH EMPTIED						
WEEK 4						
LOBBY						
RECEPTION AREA						
LAB ROOM						
KITCHEN & RESTROOMS						
COUNSELING ROOM						
DOCTOR'S OFFICE						
VACCU, SWEEP, MOP						

POLICY AND PROCEDURE

PERSONNEL

AUTOCLAVE MONITORING AND OBSERVATIONS

POLICY

Select employees will be trained in the care, use and maintenance of the autoclave.

Training will include:

1. Viewing the CD/ Video concerning procedures which comes with the equipment
2. Viewing the Manufacturer's website
3. Review of the Operating Manual
4. Reviewing instructions for care of the autoclave which hangs on the wall in the sub-sterile
5. Personal one-to-one instruction.

Procedural observations will be performed on a regular basis and will be included in the Quality Assurance Monitoring.

PROCEDURE

Routine observations will be performed and will include competency and follow-thru:

Spore Testing – Spore testing will be performed on every day the equipment is used. The testing results are kept in The Autoclave Binder in the Scrub (autoclave) room.

Steam Plus Sterilization Integrator Cards are placed in the autoclave with each loaf of instruments. These cards are maintained in a binder labeled "Integrator Cards" in the Scrub (autoclave) room.

Brief Cleaning – The inside and outside of the equipment will be cleaned on each day of use and the seals will be checked to ensure they are in place and on securely to prevent leaking during cycles.

Weekly Cleaning – Weekly the equipment will be taken apart, as per manufacturer's instructions, cleaned and returned to operating condition. Cleaning is documented in the Autoclave Cleaning Log which is in the Autoclave Binder.

Brief and Weekly Cleaning Logs are maintained in the QA Manual.

Instruments are: Cleaned of debris, appropriately

Rinsed with clean water

Soaked the appropriate length of time in Cavacide

Handled and packaged appropriately for sterilization.

POLLICY AND PROCEDURE - FORMS

QUALITY ASSURANCE

AUTOCLAVE PERFORMANCE TESTING MEASURES

Testing with Indicator Stripe are documented on a yearly calendar printed from the Manufacturers Internet site.

SPORE TESTING

Week 1	Date	Date Mailed	Initials	Results	Date Rec'd	Initials	Comments
Mon							
Tue							
Wed							
Thu							
Fri							
Sat							
Week 2							
Mon							
Tue							
Wed							
Thu							
Fri							
Sat							
Week 3							
Mon							
Tue							
Wed							
Thu							
Fri							
Sat							
Week 4							
Mon							
Tue							
Wed							
Thu							
Fri							
Sat							

POLICY AND PROCEDUR - FORMS

AUTOCLAVE SPORE TESTING TRAY CARD RESULTS

MONTH_____ 2016

	Day	Date	Load #	Results		Comments/ Initials
				Positive	Negative	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
28						
29						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						
32						
33						
34						
35						
36						
37						
38						
39						
40						

Signature: _____

Women's Health Care Center | Weekly Autoclave Deep Cleaning Log | 2016

Year: Month:	Week 1	Week 2	Week 3	Week4	Week 1	Week 2	Week 3	Week 4
Date:								
Clean and Scrub interior of autoclave, including all loading trays								
Run cycle with Vinegar to clean internal pumps								
Check door seals and gaskets								
Check to make sure gauges and timers are working correctly								
Clean exterior autoclave								
Complete a spore indicator test recording all results								
Initials								
Year: Month:	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Date:								
Clean and Scrub interior of autoclave, including all loading trays								
Run cycle with Vinegar to clean internal pumps								
Check door seals and gaskets								
Check to make sure gauges and timers are working correctly								
Clean exterior autoclave								
Complete a spore indicator test recording all results								
Initials								

WOMEN'S HEALTH CARE CENTER, INC .
Quality Assurance
Autoclave Performance Testing and Cleaning Measures

TESTING with INDICATOR STRIP is documented on a yearly calendar printed from the Manufacturers Internet Site.

SPORE TESTING RESULTS

Week 1	Date	Date Mailed	Initials	Results	Date Rec'd	Initials	Daily Cleaning Initials	Comments
Mon								
Tue								
Wed								
Thu								
Sat								
Week 2								
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
Week 3								
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								
Week 4								
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								

POLICY AND PROCEDURE - FORMS

QUALITY ASSURANCE

SKILLS COMPETENCY – AUTOCLAVE OPERATIONS, MAINTENANCE AND CLEANING

Date _____

A – Performs skill with competently knowledge.

B – Needs Review and Reinforcement

C – Needs Training

D – N/A

Employee: _____

	SKILL	A	B	C	D	Comments
1	Appropriate personal protective equipment is worn: Thick gloves and apron					
2	Infection control measures/ Blood Borne Pathogens regulations are followed.					
3	Washed hands before and after procedure.					
4	Autoclave is cleaned on each day of use. Outside is wiped down with Cavacide 1 Inside is cleaned with Hot Water Seals and gaskets are checked for continuity.					
5	Steam plus integrator cards are properly used, documented and appropriately Stored					
6	Spore testing is properly performed, documented and the results are maintained in the binder in the Scrub Room.					
7	Bi-Monthly cleaning: Equipment is taken apart. Reservoir drained. Inside is cleaned and scrubbed using Speedy clean. Seals and gaskets are checked for deterioration. Exterior is cleaned. A spore indicator test is performed and all results are recorded.					
8	Cleaning log is maintained					

Employee Signature_____ Date_____

Preceptor Signature_____ Date_____

POLICY AND PROCEDURE - FORMS

QUALITY ASSURANCE

SKILLS OBSERVATIONS – SCRUB ROOM COMPETENCY

Date _____

A – Performs skill with competently knowledge.
B – Needs Review and Reinforcement
C – Needs Training
D – N/A

Employee Name: _____

	SKILL	A	B	C	D	Comments
1	Appropriate personal protective equipment is used as designed and provided: Apron, Gloves, Goggles					
2	Infection control policies and procedures/ Blood Borne Pathogen guidelines are followed.					
3	Instruments are cleaned of debris with hot, soapy water and scrub brush.					
4	Instruments are rinsed clean in hot water.					
5	Instruments are soaked for 10 minutes in Cavacide. Rinsed for 5 minutes in hot water					
6	Instruments are appropriately handled and packaged for sterilization: Instruments are dry. Gloves are worn during packaging. Test strip inserted into each bag. Tray card is added to a load of 5 to make sure each individual load is sterilized properly					
7	Instruments are handled gently after sterilization so as not to tear bags. Then they are stored in the hallway sterile closet.					

Employee Signature_____ Date_____

Preceptor Signature_____ Date_____

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 000}	Initial Comments Follow Up Survey with a Complaint LA 45116 No deficiencies were cited for Complaint #LA45116 Abbreviations: ADM Administrator DON Director of Nursing GB Governing Body ITOP Induced termination of pregnancy LDH/HSS Louisiana Department of Health/Health Standards Section LEERS Louisiana Electronic Event Registration System LPN Licensed Practical Nurse N/A Not applicable QA Quality Assurance QAPI Quality Assurance Performance Improvement RN Registered Nurse	{S 000}	Reviewed 8/11/2017 [redacted] KN	
{S 055}	4409 B Changes in Outpatient Abortion Facility Info B. Change of Information. Any change regarding the outpatient abortion facility 's entity name, "doing business as" name, mailing address, telephone number, or any combination thereof, shall be reported in writing to the department within five calendar days of the change. Any change regarding the entity name or "doing business as" name requires a change to the outpatient abortion facility license and shall require a $25 fee for the issuance of an amended license. C. Change of Key Administrative Personnel. Any change regarding the outpatient abortion facility's key administrative personnel shall be reported in writing to the department within five calendar	{S 055}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 055}	Continued From page 1 days of the change. For the purposes of this Chapter, key administrative personnel includes the administrator and medical director, and the outpatient abortion facility shall provide the individual's name, hire date, and qualifications as defined in this Chapter. This Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to report in writing to the department within 5 calendar days of a change in key administrative personnel. Findings: During the entrance conference on 06/19/2017 at 10:10 AM, SF1Administrator (ADM) introduced herself as the facility's administrator and explained she became the active administrator on 05/01/2017. Review of Health Standards Section's (HSS) licensing software (POPS) on 06/19/17 indicated that SF5ADM was the current administrator. During an interview and review of records on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator effective 05/01/2017. SF1ADM confirmed that she did not notify the department in writing within 5 calendar days when she became administrator on 05/01/2017. During this interview on 06/20/2017 at 10:05 AM,	{S 055}	**S 055** The current administration was of the mistaken notion that the previous Administrator had submitted the Change of Key Personnel Form when the position changed to the current Administrator. Upon notification by the Louisiana Department of Health surveyors of the discrepancy, we immediately submitted the form to LDH. A copy of the Change of Key Personnel form and the fax delivery notice is attached. Completed 06/20/2017. See EXHIBIT A.	

MEMORY TRANSMISSION REPORT

TIME :06-20-'17 10:57
FAX NO.1 :2259244465
NAME :

FILE NO. : 619
DATE : 06.20 10:55
TO : 3423073
DOCUMENT PAGES : 2
START TIME : 06.20 10:55
END TIME : 06.20 10:57
PAGES SENT : 2
STATUS : OK

*** SUCCESSFUL TX NOTICE ***

FAX

Delta Clinic of Baton Rouge, Inc.
756 Colonial Drive, Ste. B
Baton Rouge, LA. 70806
(225) 923-3242 or 1-800-937-3242
Fax: (225) 924-4465

For: LDH Health Standards
Fax number: 225 342 3073
From: Delta Clinic [redacted]
Fax number: 225-924-4465
Date: 06-20-2017
Regarding: Change of Key Personnel
Number of pages: 2
Comments:

Thanks,

Notice of Confidentiality
The medical information in this FAX message is confidential and protected by both the State and Federal Law. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate medical information. If the reader of this warning is not the intended FAX recipient's agent you are hereby notified that you have received this FAX message by error and that review or further disclosure of the information contained in this FAX is strictly prohibited. If you have received this FAX in error, Please notify us immediately at the telephone number indicated below and either destroy these documents or return the originals to us by mail.

MEMORY TRANSMISSION REPORT

TIME : 07-27-'17 13:06
FAX NO.1 : 2259244465
NAME :

FILE NO. : 888
DATE : 07.27 13:05
TO : 3420157
DOCUMENT PAGES : 2
START TIME : 07.27 13:05
END TIME : 07.27 13:06
PAGES SENT : 2
STATUS : OK

*** SUCCESSFUL TX NOTICE ***

FAX

Delta Clinic of Baton Rouge, Inc.
756 Colonial Drive, Ste. B
Baton Rouge, La. 70806
(225) 923-3242 or 1-800-937-3242
Fax: (225) 924-4465

For: [redacted]
Fax number: 225-342-0157
From: [redacted]
Fax number: 225-924-4465
Date: 7/27/2017
Regarding: Key Personnel Change
Number of pages: 2 (including cover)
Comments: I will call to confirm receipt
I am also emailing to [redacted]

Thanks,

Notice of Confidentiality

This medical information in this FAX message is confidentiality and protected by both the State and Federal Law. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate medical information. If the reader of this warning is not the intended FAX recipient's agent you are hereby notified that you have received this FAX message by error and that review or further disclosure of the information contained in this fax is strictly prohibited. If you have received this FAX in error, Please notify us immediately at the telephone number indicated below and either destroy these documents or return the originals to us by mail.

Thank you!

FAX

Delta Clinic of Baton Rouge, Inc.
756 Colonial Drive. Ste. B
Baton Rouge, La. 70806
(225) 923-3242 or 1-800-937-3242
Fax: (225) 924-4465

For: [redacted]

Fax number: 225-342-0157

From: [redacted]

Fax number: 225-924-4465

Date: 7/27/2017

Regarding: Key Personnel Change

Number of pages: 2 (including cover)

Comments: I will call to confirm receipt
I am also emailing to [redacted]

Thanks,

DEPARTMENT OF HEALTH

Health Standards Section

KEY PERSONNEL CHANGE FORM

This form must be signed by the proposed employee and the administrator.

Legal Entity Name: Delta Clinic OD **Agency DBA Name:** Baton Rouge, LLC	**Provider License #:** 07
Address: 756 Colonial Drive A B **City, State, Zip:** Baton Rouge, La 70806	**Provider CMS ID if applies#:**
Telephone Number: 225 924. 4442	**Administrator's Email Address:** [redacted]
Fax Number: 225. 924. 4465	**Proposed Employee's Email Address (if available):** deltaclinic756@gmail.com

Circle the Position that is changing (Please circle only those appropriate to the Provider Type):

Administrator (the person with overall responsibility for the day-to-day administrative operations)
Director of Nursing (the RN providing leadership of nursing services – if applicable)
Medical Director (the physician providing oversight of the clinical operations – if applicable)
Other:_____

Name of previous employee in this position: [redacted]
Name of proposed employee for this position: [redacted]
Effective Date of Change: 05/01/2017

Verification Date of Current LA Professional License: 12/31/2016
Please enter the date on which the agency verified the current professional licensure of the proposed employee, *if licensure is a requirement for the position.* The date should precede the effective date of change.

Attestations of Compliance

We hereby certify that the proposed employee listed herein meets all state and federal requirements set forth by the Louisiana Department of Health and Hospitals (DHH), Health Standards Section; the Centers for Medicare and Medicaid Services; and any other regulatory agency applicable to the Provider Type, to function in the role indicated. We further understand that it is the responsibility of the administrator to ensure that the agency maintains compliance with state and federal regulations on an ongoing basis. DHH Health Standards Section will be promptly notified of any changes to Key Personnel.

[redacted]		11/20/17
Printed Name of Proposed Employee	Signature of Proposed Employee	Date (mm/dd/yy)
[redacted]	RN, DON Admin	6/20/17
Printed Name of Administrator	Signature of Administrator	Date (mm/dd/yy)

PLEASE NOTE: This form is used for all Health Standards Section licensed providers/suppliers. Definitions of Key Personnel may be found in the applicable state licensing regulations for the specific Provider Type.

Health Standards Section
P.O. Box 3767 • Baton Rouge, Louisiana 70821-3767
Phone #: 225/342-0138 • Fax #: 225/342-5073 • http://new.dhh.louisiana.gov/

Google recommends using Chrome
Try a fast, secure browser with updates built in

NO THANKS YES

in:sent

Gmail

Move to Inbox Move

1 of 485

COMPOSE

DCBR Key personnel change form

Inbox (1)
Starred
Important
Sent Mail
Drafts (51)
[Imap]/Drafts
[Imap]/Sent
[Imap]/Trash (835)

[redacted]

1:14 PM (0 minutes ago)

Show details

Hello,
Per our conversation 7/26/2017, I am emailing and faxing the Key Personnel Change form again. I will follow up with a phone call to confirm receipt. Have great day!

Jackie

No Hangouts contacts
Find someone

Click here to Reply or Forward

Gmail [redacted]

DCBR Key personnel change form

3 messages

[redacted] Thu, Jul 27, 1:14 PM

Hello,
Per our conversation 77/26/2017, I am emailing and faxing the Key Personnel Change form again. I will follow up with a phone call to confirm receipt. Have great day!
[Quoted text hidden]
Key Personnel Change.tif

[redacted] Thu, Jul 27, 1:39 PM

I received it-thank you.

[redacted]

Subject: DCBR Key personnel change form

[Quoted text hidden]

[redacted] Thu, Jul 27, 1:42 PM

Great, thanks for letting me know.
[Quoted text hidden]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 055}	Continued From page 2 SF2DON verified that SF1ADM replaced SF5ADM, effective 05/01/2017. SF2DON confirmed she was aware that the facility was responsible for notifying the department in writing of the administrative change. SF2DON presented the HSS - All -37 Key Personnel Change Form dated 05/01/2017 and confirmed it documented SF1ADM as the administrator effective 05/01/2017. SF2DON stated she thought SF5ADM faxed the change to the department and verified there was no fax confirmation that it was sent. The State Office Abortion Program Desk at LDH/HSS, on 6/20/17, confirmed that State Office had not received any written notification nor had the Abortion Program Desk been informed by the provider of the provider's change in Key Administrative Personnel from SF5ADM or SF1ADM.	{S 055}		
{S 109}	4421 - C 1-4 Governing Body C. The governing body shall be responsible for: 1. ensuring the outpatient abortion facility's continued compliance with all applicable federal, state, and local statutes, laws, rules, regulations, and ordinances, including department rules, regulations, and fees; governing or relating to outpatient abortion facilities, abortion or termination procedures, reporting requirements, ultrasound requirements, informed consent requirements, prohibited activity requirements, e.g. presenting or otherwise delivering any instruction or program on any health topic, including but not limited to human sexuality or family planning, to students at a public elementary or secondary school, or at a charter school that receives state funding or	{S 109}		

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	LA000464	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
(S 109)	Continued From page 9 knowingly providing any materials or media regarding human sexuality or family planning for distribution or viewing at a public elementary or secondary school, or at a charter school that receives state funding, or any other matter addressed by law related to abortion or abortion procedures; 2. designating a person to act as the administrator and delegating sufficient authority to this person to manage the day-to-day operations of the facility; 3. designating a person to act as the medical director and delegating authority to this person to allow him/her to direct the medical staff, nursing personnel, and medical services provided to each patient; 4. evaluating the administrator and medical director's performance annually, and maintaining documentation of such in their respective personnel files; This Rule is not met as evidenced by: Based on record review and interviews, the governing body failed to ensure the outpatient abortion facility's continued compliance with all applicable state statutes, rules, and regulations for reporting requirements for 4 (F3, F6, F7 and F9) out of 9 (F1 - F9) sampled patient records reviewed. Findings: Review of the provider's Policy and Procedure: Patient Care - Vital Records Reporting. Policy Form No. 2411 read in part: Policy: In accordance with LDH (Louisiana	(S 109)	S 109 In an effort to comply with all regulations regarding the thirty (30) day window to submit patient information into the LEERS program and complete the Induced Termination of Pregnancy Report (ITOP), we have created policies, procedures, forms and utilized the Plan-Do-Check-Act format. Angela Adkins, Administrative Assistant will be responsible for reviewing the LEERS Log at least weekly to ensure the ITOP forms are submitted within the thirty (30) day window. Procedure initiated 06/21/2017. See EXHIBIT B.	

TOPIC: LEERS

PRESENTED BY: [redacted] ADMINISTRATOR

DATE: JUNE 21, 2017

ATTENDED BY:

1. [redacted], Administrator
2. [redacted], Administrative Assistant
3. [redacted] Sonographer
4. [redacted] Medical Assistant
5. [redacted] Receptionist
6. [redacted], LPN
7. [redacted] Receptionist

POLICY AND PROCEDURE

PATIENT CARE

LEERS LOG

POLICY

A log will be maintained recording the timely completion of all LEERS documentation, and ensuring the LEERS input will be completed within thirty (30) days of termination.

The LEERS LOG will be included in the PILL ROSTER LOG for pill patients and in the SURGICAL/ PATHOLOGY/ LEERS LOG which is maintained for all surgical patients. The logs will be kept in the Recovery Room.

PROCEDURE

On the SURGICAL LOG, each page will be dated for one patient care day. All patients who present for termination that day will be listed on the form with name and chart number.

On the PILL LOG, dates will follow chronologically until the page is full.

The day their information is entered into the LEERS system the date will be entered into the log.

The physician will be notified the entries are ready for certification. She will certify each record.

Once the physician has completed certifying the entries and notifies the Data Entry Technician, the Technician will print the LEERS and input the date certified on each form.

The information on these logs will be monitored by the Quality Assurance Coordinator for completeness and timeliness to ensure certification is completed within thirty days of termination.

This data will be presented to the Quality Assurance Committee on a quarterly basis and will be presented to the Board of Directors quarterly, as part of our Quality Assurance program.

QUALITY ASSURANCE
LEERS LOG

1	IDENITFY	Need a way to ensure LEERS reports are entered into the system within the thirty (30) day window.
2	PLAN	A. Create a log to track LEERS input. B. Document the day the information is entered into the system. C. Notify physician they may certify each entry. D. Print each LEERS E. Document the certification date on the log.
3	DO	Write policy, create log and Complete log and print reports.
4	CHECK	As each page of the Log is complete, check to ensure the reports have been completed within the thirty (30) day window
5	ACT	Continue with process.
		Signature QA Coordinator: [redacted] Date: 10/2/17

WOMEN'S HEALTH CARE CENTER, INC
PILL ROSTER WITH LEERS

DATE RECEIVED: _____ PHYSICIAN: _____

LOT NUMBER OF BOX: _____

EXPIRATION DATE: _____

DATE	PATIENT'S NAME	CHART NUMBER	LOT NUMBER	MINOR	INITIALS	LEERS Date Entered	LEERS Date Certified

QA Auditor (Print name, Sign) : _____ Date: _____

QA Auditor (Print name, Sign) : _____ Date: _____

WOMEN'S HEALTH CARE CENTER, INC
SURGICAL/ PATHOLOGY LOG WITH LEERS

DATE: _____ PHYSICIAN: _____

Weeks	Pt's Name	Chart #	Minor	Rh	Specimens			LEERS	LEERS
					Sent to Stericycle	Sent to AML	Report Rec'd	Date Entered	Date Certified

QA Auditor (Print name, Sign) : _____ Date: _____

QA Auditor (Print name, Sign) : _____ Date: _____

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 109}	Continued From page 4 Department of Health) regulations, a vital record "Report of Induced Termination of Pregnancy Performed in Louisiana" (ITOP) is to be completed for each pregnancy termination performed. The original report, the one sent to LDH, must be signed by the physician who performed the service. ... The report must be submitted to LDH within thirty (30) days of the termination. Procedure: Effective August 29, 2011 the "Report of Induced Termination of Pregnancy" is to be completed online in the LEERS system using the web address provided by LDH. This form is to be completed within thirty (30) days of the procedure. Review of LA RS 40:1061.21 Reports, revealed, in part "C. All abortions reports shall be signed by the attending physician and submitted to the Louisiana Department of Health within thirty days after the date of the abortion..." Patient #F3 Review of Patient #F3's Induced Termination of Pregnancy (ITOP) report revealed Patient #F3's Date of Termination of Pregnancy was 03/30/17 and the Date Certified was 05/01/2017. Patient #F6 Review of Patient #F6's Induced Termination of Pregnancy (ITOP) report revealed Patient #F6's Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 05/01/2017. Patient #F7 Review of Patient #F7's Induced Termination of Pregnancy (ITOP) report revealed Patient #F7's Date of Termination of Pregnancy was 04/13/17 and the Date Certified was 05/15/2017.	{S 109}		

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 109}	Continued From page 5 Patient #F9 Review of Patient #F9's Induced Termination of Pregnancy (ITOP) report revealed Patient #F9's Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 05/01/2017. During an interview on 06/20/2017 at 3:55 PM, SF1Administrator (ADM) and SF2Director of Nursing (DON) reviewed the ITOP reports for Patients #F3, #F6, #F7, and #F9. Both verified that the provider did not ensure compliance with all reporting requirements when the ITOP reports for Patients #F3, #F6, #F7, and #F9 were not submitted to LEERS (Louisiana Electronic Event Registration System) within thirty (30) days after the date of the abortion.	{S 109}		
{S 159}	4425 -A Patient Med. Records/Reporting Requirements A. General Provisions 1. The outpatient abortion facility shall establish and maintain a patient medical record on each patient. 2. The patient medical record shall be: a. completely and accurately documented; and b. readily available and systematically organized to facilitate the gathering of information. 3. The outpatient abortion facility shall ensure compliance with privacy and confidentiality of patient medical records, including information in a computerized medical record system, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, and/or all applicable state laws, rules, and regulations.	{S 159}		

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 159}	Continued From page 6 4. Safeguards shall be established to protect the patient medical records from loss or damage and/or breach of confidentiality in accordance with all applicable state laws, rules, and regulations. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure safeguards were established to protect the patient medical records from loss or damage and/or breach of confidentiality in accordance with all applicable state laws, rules, and regulations. Findings The facility's Policy and Procedure Patient Care Patient Record Contents was presented by SF1ADM and SF2DON on 6/20/2017. The policy read in part: Safeguards are established to maintain confidentiality and protection from fire, water, or other sources of damage. A tour of the room/closet which the facility used to store patient medical records was conducted with SF1Administrator (ADM) at 10:25 AM on 6/19/2017. The location of the medical records room was verified to be in a hall across from a waiting room used by the facility for medicated patients to wait. During the tour, it was observed that patients utilized this hallway to access the restrooms. It was also observed that the door of the medical records room contained a doorknob which only	{S 159}	**S 159** Regarding our new chart room, the fireproof door was hung on 06/23/2017. The door will be locked at all times with the key maintained in the business office front desk to eliminate patient access. The painting has been completed with a third coat of paint. We are awaiting ICC Certification to approve the painting. We anticipate this inspection and approval within six weeks (6) which will be September 9, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 159}	Continued From page 7 locked from within the medical records room and the doorknob had no keyhole to unlock the door from outside the room. SF1ADM explained that the medical records room was painted on June 2, 2017 and June 3, 2017 with a Fire Retardant Paint and the provider was currently waiting on the arrival and installation of the Fire Retardant door which was supposed to arrive and be installed on Wednesday (6/21/2017). SF1ADM was asked about the areas of the medical records room which had not been completely covered with the white fire retardant paint. SF1ADM confirmed the areas included the walls at the top near the ceiling, near the base boards and around electrical boxes and light switches. S1ADM verified the medical records room was not completely painted with the Fire Retardant Paint. SF1ADM presented an opened bucket of paint which she explained was the paint used for the painting of the medical records room. The bucket of paint was labeled as Ff 88 (Fire Free 88, Fire Retardant / Resistant Coating). An observation of the manufacture's label on the bucket of Ff 88 paint, noted in part, under the Application Instructions: Fire Safety: in part ... The amount by which Ff 88 retards a particular fire will depend, among other things, on (i) the amount of Ff 88 applied ... It is the sole responsibility of the applicator to ensure that Ff 88 has been applied in accordance with the application directions. ... Thickness: All surfaces to which Ff 88 have been applied should be inspected by an ICC certified professional to verify that Ff 88 has been properly	{S 159}		

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 159}	Continued From page 8 applied in the required uniform thickness. When asked if the provider had received an inspection by an ICC certified professional to verify that Ff 88 has been properly applied in the required uniform thickness, SF1ADM said the provider had not obtained any such inspection by any such professional to ensure proper application of the Ff 88 paint used in the provider's medical record room. On 6/20/2017 at 10:15 AM, SF2DON verified that the medical records room only locked from within the medical records room. During this interview on 6/20/2017 at 10:15 AM, SF1ADM confirmed the facility staff had no key or device to unlock the medical records room from the outside of the door if it was locked from the inside of the room and the door was unable to be locked on clinic days when patients were across the hall from the medical records room. SF2DON and SF1ADM stated that the contractor would be in the facility on Friday (6/23/2017) to install the new Fire Retardant door. During an interview with SF3Receptionist on 6/20/2017 at 10:45 AM, SF3Receptionist verified that the doorknob on the medical records room was a bedroom style door knob which could only be locked from within the room. SF3Receptionist explained that she started putting patient records in the room early last week and said patient medical records were placed in the unlocked room on Thursday 6/15/17 when patients were present in the hall and waiting room located outside and across from the door of the unlocked medical records room. SF3Receptionist verified that facility staff was not always present or in line of sight of the medical records room where patient records were stored.	{S 159}		

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BC0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
(S 169)	Continued From page 9	(S 169)	S 169 We have initiated processes to ensure that the Clinic is in compliance with the state statute requiring ITOP reports which will be completed and certified within thirty days. We created a form and initiated a policy and procedure to ensure the documentation is being completed timely. All appropriate staff was in-serviced on the policy and procedure. Angela Adkins, Administrative Assistant will be responsible for reviewing the LEERS Log at least weekly to ensure the ITOP forms are submitted within the thirty (30) day window Established 06/21/2017. See EXHIBIT B	
(S 169)	4425 - E-F Patient Med Records/Reporting Requirements E. Other Reports. The outpatient abortion facility shall maintain a daily patient roster of all patients receiving a surgical or chemically induced abortion. Patients may be identified corresponding to the patient's medical record. This daily patient roster shall be retained for a period of three years F. Reporting Requirements 1. The outpatient abortion facility shall maintain documentation to support that the outpatient abortion facility is compliant with all reporting requirements, including, but not limited to, the Induced termination of pregnancy (ITOP) form and other documentation as required by federal, state, and local statutes, laws, ordinances, and department rules and regulations. 2. The outpatient abortion facility shall report in accordance with all applicable state laws for the reporting of crimes against a child that include but are not limited to: a. rape; b. sexual battery; c. incest; and d. carnal knowledge of a juvenile This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that they maintained documentation to support that the facility was in compliance with the state statute requiring ITOP (Induced Termination of Pregnancy) reports to be signed by the attending physician and submitted to the Louisiana Department of Health within thirty	(S 169)		

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 169}	Continued From page 10 days after the date of the abortion for 4 (Patients #F3, #F6, #F7, and F#9) of 9 (Patients #1 - #9) sampled patients. Findings: Review of LA RS 40:1061.21 Reports, revealed, in part "C. All abortions reports shall be signed by the attending physician and submitted to the Louisiana Department of Health within thirty days after the date of the abortion..." Patient #F3 Review of Patient #F3's Induced Termination of Pregnancy (ITOP) report revealed Patient #F3's Date of Termination of Pregnancy was 03/30/17 and the Date Certified was 05/01/2017. Patient #F6 Review of Patient #F6's Induced Termination of Pregnancy (ITOP) report revealed Patient #F6's Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 05/01/2017. Patient #F7 Review of Patient #F7's Induced Termination of Pregnancy (ITOP) report revealed Patient #F7's Date of Termination of Pregnancy was 04/13/17 and the Date Certified was 05/15/2017. Patient #F9 Review of Patient #F9's Induced Termination of Pregnancy (ITOP) report revealed Patient #F9's Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 05/01/2017. During an interview on 06/20/2017 at 3:55 PM, SF1Administrator (ADM) and SF2Director of	{S 169}		

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 08/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
(S 169)	Continued From page 11 Nursing (DON) reviewed the ITOP reports for Patients #F3, #F6, #F7, and #F9. Both verified that the provider did not ensure compliance with all reporting requirements when the ITOP reports for Patients #F3, #F6, #F7, and #F9 were not submitted to LEERS (Louisiana Electronic Event Registration System) within thirty (30) days of the termination.	(S 169)		
(S 171)	4427 A-1 Quality Assurance/Performance Improvement Pro A. The outpatient abortion facility shall develop, implement, enforce, maintain, and annually review a written QAPI program subject to approval by the governing body, which puts systems in place to effectively identify issues for which quality monitoring and performance improvement activities are necessary. The QAPI program shall include plans of action to correct identified issues including, but not limited to, monitoring the effect of implemented changes and making necessary revisions to the plan of action. 1. Plans of Action. The outpatient abortion facility shall develop and implement a QAPI plan of action designed to effectively identify issues for which quality monitoring and performance improvement activities are necessary. This Rule is not met as evidenced by: Based on record review and interview, the outpatient abortion facility failed to put a system in place to effectively monitor the effect of	(S 171)	S 171 A system has been created to monitor the timey reporting of ITOP. Angela Adkins, Administrative Assistant will be responsible for reviewing the LEERS Log at least weekly to ensure the ITOP forms have been submitted within the thirty (30) day window. A form and policy and procedure have been created. Staff has been in-serviced. In addition to monitoring timely reporting of the ITOP, a system has been implemented to monitor the receipt of pathology reports for products of conception. Policies written and forms created. Ms Teresina Carter, medical assistant receives the reports and will be responsible for weekly, documenting the receipt, and follow-up of reports not received timely. She has been in-serviced. Recording data entry began 06/21/2017. See EXHIBIT B	

13A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 171}	Continued From page 12 implemented changes, identify issues, and make necessary revisions to the plan of action by failing to ensure compliance with the state statute requiring ITOP (Induced Termination of Pregnancy) reports to be signed by the attending physician and submitted to the Louisiana Department of Health within thirty days after the date of the abortion for 4 (Patients #F3, #F6, #F7, and F#9) of 9 (Patients #F1 - #F9) sampled patients. Findings: Review of LA RS 40:1061.21 Reports, revealed, in part "C. All abortions reports shall be signed by the attending physician and submitted to the Louisiana Department of Health within thirty days after the date of the abortion..." Patient #F3 Review of Patient #F3's Induced Termination of Pregnancy (ITOP) report revealed Patient #F3's Date of Termination of Pregnancy was 03/30/17 and the Date Certified was 05/01/2017. Patient #F6 Review of Patient #F6's Induced Termination of Pregnancy (ITOP) report revealed Patient #F6's Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 05/01/2017. Patient #F7 Review of Patient #F7's Induced Termination of Pregnancy (ITOP) report revealed Patient #F7's Date of Termination of Pregnancy was 04/13/17 and the Date Certified was 05/15/2017. Patient #F9 Review of Patient #F9's Induced Termination of Pregnancy (ITOP) report revealed Patient #F9's	{S 171}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 171}	Continued From page 13 Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 05/01/2017. An interview was conducted with SF1Administrator (ADM) and SF2Director of Nursing (DON) on 6/20/2017 at 3:55 PM. SF2DON stated that she created the form titled Data Compiled, which listed all data that should be compiled and the time frame that data should be collected, such as daily, weekly, monthly, quarterly, or annually. S2DON confirmed that LEERS (Louisiana Electronic Event Registration System) was listed on the form and data was to be collected monthly. SF2DON verified this was part of the Quality Assurance and Performance Improvement (QAPI) Program to ensure compliance with the ITOP reporting requirements. SF2DON stated that she considered this form to be the QA (Quality Assurance) Chart and it was implemented March 20, 2017. SF2DON stated that SF1Administrator was responsible for reviewing all patient records and identifying any issues with the timely certification of the ITOP (Induced Termination of Pregnancy) reports. When asked if the QAPI program should have identified any issues with the ITOP reports not being certified within 30 days after the dates of abortions, SF1ADM replied yes because she (SF1ADM) reviewed every patient record and would have identified a problem. SF1ADM explained that she looked at every patient record to ensure that ITOP reports were certified as per the regulatory requirement and stated there were no patients since 3/18/2017 that were not submitted within 30 days as required. SF2DON agreed that the current action plan of SF1ADM reviewing every patient record to ensure	{S 171}		

Health Standards Section

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 171}	Continued From page 14 compliance with reporting requirements was effective because there were no identified issues and all ITOP reports were submitted as per the requirements. She stated that the facility should be aware is there were issues or problems. SF1ADM and SF2DON reviewed the ITOP reports for Patients #F3, #F6, #F7, and #F9. Both verified that the provider did not ensure compliance with all reporting requirements when the ITOP reports for Patients #F3, #F6, #F7, and #F9 were not submitted to LEERS (Louisiana Electronic Event Registration System) within thirty (30) days of the termination. SF1Administrator revealed that the provider created a QAPI Program, approved by the governing body, but there was no system in place to effectively monitor and identify issues with the reporting requirements.	{S 171}		

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	A. BUILDING: _____ B. WING _____	R 11/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA CLINIC OF BATON ROUGE, INC	756 COLONIAL DRIVE BATON ROUGE, LA 70806

(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
{S 000}	Initial Comments An onsite revisit was conducted for all previous deficiencies cited on 06/20/2017. All deficiencies from this survey have been corrected. Complaint #LA46736 was also investigated during this onsite survey and no deficiencies were cited for the complaint.	{S 000}		

DHH/Health Standards Section

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

11/28/17

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Health Standards Section

IMPORTANT NOTICE- PLEASE READ CAREFULLY

DATE: 07/10/2017

TO: Administrator
Delta Clinic Of Baton Rouge, Inc.
756 Colonial Drive
Baton Rouge, LA 70806

FROM: HEALTH STANDARDS SECTION

RE: ANNUAL LICENSING SURVEY FOLLOW UP AND COMPLAINT SURVEY RESULTS

On 06/20/2017, a survey was conducted at your facility by the Louisiana Department of Health, Health Standards Section, to determine if your facility was in compliance with licensing standards established by the State of Louisiana. This survey found deficiencies in your facility whereby corrections are required to assure compliance with licensing standards.

Enclosed for your completion and prompt response is the STATE FORM (STATEMENT OF DEFICIENCIES (SOD) AND PLAN OF CORRECTION (PoC)). A PoC for the deficiencies must be submitted within 10 working days after your receipt of the STATE FORM. In the column "Completion Date," enter a projected date of correction. An explicit date must be shown. This date may not exceed 60 days from the completion of the survey. **Please refer to the enclosed memorandum, Required Components for the Plan of Correction, for guidance in developing your PoC.** Failure to submit an **acceptable** PoC by the date indicated **below** may result in the imposition of specified remedies. The STATE FORM must be **signed and dated by the administrator** or other authorized official as indicated. The **SIGNIFICANT FINDINGS** form, if enclosed, does not require a PoC, but the facility is expected to sign, date, and return the form.

You have one opportunity to question citations of deficient practice through an Informal Dispute Resolution process. To be given such an opportunity you must send your written request, specifying the deficient practice(s) that you are disputing and why you are questioning these, to: DHH/Health Standards Section, Attention IDR Program Manager, P.O. Box 3767, Baton Rouge, LA 70821-3767. The request must be made within 10 calendar days of receipt of your STATE FORM. Again, this is an informal dispute resolution and it is not necessary for your attorney to be present, however, if you wish for your attorney to be included in the informal dispute resolution, please advise this office. Please refer to the enclosed memorandum, **Informal Dispute Resolution Process**, for further information.

Please provide this PoC by 07/23/2017. **Mail the completed original and properly signed/dated PoC to: Health Standards Section, Attention Program Manager, P.O. Box 3767, Baton Rouge, Louisiana 70821-3767 OR email the PoC to Jennifer.Haines@la.gov.**