PRINTED: 02/17/2017 FORM APPROVED

Health Standards Section		<del></del>		1
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		[ ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN OF CONNECTION		A. BUILDING! _		
	BO0004642	B. WING		01/25/2017
		DRESS, CITY, ST	ATE ZIR CORE	
NAME OF PROVIDER OR SUPPLIE	756 COL	ONIAL DRIVE	ALE, ZIP GODE	
DELTA CLINIC OF BATON F	OHGE INC	OUGE, LA 70	806	
DDEELY (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETE
S 000 Initial Comments		S 000		
Relicensing Surv #LA00044656.	ey with Complaint	; 		
Abbreviations				
AED CDC cm cent DON GB Gov IC Infe ITOP (report) LDH/HSS Health/Health St LEERS Registration Sys LPN MA Med MD Med MD Med MedDir Med ModDir Med N/A Not OfficeMgr OSHA Administration PI QA Qua QAPI Performance Im RN Reg US Ultr S 043 4407 E Survey E. Statement of survey, the dep	Licensed Practical Nurse dical Assistant dical Doctor dical Director applicable Office Manager Occupational Safety & Health Performance Improvement ality Assurance Quality Assurance approvement gistered Nurse asound	\mathref{31/30/15/30/3} \mathref{NN} \square \mathref{N} \quare \mathref{N} \square \mathref{N} \quare \mathref{N} \quar	RECEIVED  MAR 16 2017  HEALTH STANDARDS	
DHH/Health Standards Section	OVER THE PROPERTY OF THE PROPE	IOMATUSE	TITIC	(X6) DATE

administrata

Health S	tandards Section				FORMAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642	B. WING		01/25/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, ST	TATE, ZIP CODE	i i i i i i i i i i i i i i i i i i i
DELTA C	LINIC OF BATON RO	DIGE INC	ONIAL DRIVE OUGE, LA 70		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
S 043	Continued From p	age 1	S 043		
	applicable governi supporting why the but not limited to, record review of in survey. The outpareceive a copy of 1. Display. The deficiencies issue outpatient aborticonspicuous place a. the mosurvey statement of deficiencies issue outpatient of deficiencies issue outpatient aborticosure to the after the outpareceptable plan or within 90 deficiencies over the second or within 90 deficiencies over the secon	ncluding the deficiency, the ng rule, and the evidence or rule was not met including, observations, interviews, and offormation obtained during the tient abortion facility shall the statement of deficiencies. The following statements of d by the department to the confacility must be posted in a secon the licensed premises: sost recent annual licensing of deficiencies; and allow-up and/or complaint survey clencies issued after the annual licensing survey. Closure. Any statement of the department to an ion facility shall be available for public within 30 calendar days attent abortion facility submits and correction to the deficiencies asys of receipt of the statement of the open occurs first.			
	Based on observ failed to display the from the most re- up, and/or complethe licensed prer	met as evidenced by: ation and interview, the facility he statement of deficiencies cent surveys (licensing, follow aint) in a conspicuous place on nises as evidenced by no results from the last survey.		S 043 The LDH license to and hung on the wall direct you enter the building. The hung in the same location.	ly to the left when
	p.m., escorted by evidence to indic	the facility on 01/23/17 at 12:10 y S1OfficeMgr revealed no eate the facility had posted a cop of deficiencies from the most			

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Health S	tandards Section					
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		•	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642		B. WING		01/25/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	TATE, ZIP CODE	
DELTA CI	LINIC OF BATON RO	UGE, INC		NIAL DRIVE DUGE, LA 70		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCY Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S 043	Continued From pa	age 2		S 043		
	complaint) in a con licensed premises.		n the	ļ		
	S1OfficeMgr confir posted copy of the	01/23/17 at 12:10 p. med that the facility statement of deficiency rveys (licensing, fol	had no encies from			
		n a conspicuous loc				
S 055	4409 B Changes ir Info	n Outpatient Abortio	n Facility	S 055		
	the outpatient abor	rmation. Any chang tion facility 's entity s" name, mailing ad	name,			
	telephone number shall be reported in within five calenda	, or any combination n writing to the depa ir days of the chang	n thereof, artment e. Any			
	business as" nam outpatient abortion	the entity name or " le requires a change n facility license and	e to the shall			
	license. C. Change of Key	for the issuance of a Administrative Pers the outpatient abort	onnel. Any			
	key administrative writing to the depa	personnel shall be artment within five ca e. For the purposes	reported in alendar	:		
	Chapter, key adm the administrator	e. I of the pulposes inistrative personne and medical directo n facility shall provid	l includes r, and the			:
	individual's name, defined in this Cha	hire date, and qual	ifications as	=		:

						FORM APPROVED
STA	TEMEN"	andards Section F OF DEFICIENCIES DEF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			BO0004642	B. WING		01/25/2017
NAN	AE OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	
			HOE INC	ONIAL DRIVE		
DE	LTA CI	LINIC OF BATON RC	BATON	ROUGE, LA 7		
PF	(4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC'I (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
	S 055	Continued From p	age 3	S 055		
		Based on record r of Baton Rouge fa (Department of Ho	net as evidenced by: eview and interview Delta Clin iled to ensure the department ospitals) received notification on histrative personnel within 5		S 055 An Organizational Chart and, after Board approval will t Administrative Manual. Se	t was created be placed in the e Exhibit A 03/18/2017
:		calendar days of t practice was evidenthe department has	he change. This deficient enced by no documented proo do been notified of a change in Delta Clinic of Baton Rouge in		The Board of Directors will app quarterly meetings will be held September and December. (	3 in March, June, 03/18/2017
		Findings:		· :	Change of key personnel form for Administrate Director of Nursing or	or and
		provided by S10f	ning Body Meeting minutes, ficeMgr as current, revealed a	: 3. :	2017. Exhibit B	3/18/2017
		(communication of software application webcam), in which was in attendance minutes indicated retirement of S9/	/02/16 via Skype Transmission over the Internet using the ion, typically also viewing by the President /GB member e, as well as S12ADM. The It the topic of discussion was the ADM and the assumption of the ADM.	ne	The Board will establish May effective date for the new added to assume all day-to-and administrative duties of the stablish May	ministrator, day operations
		review revealed of given full authority Women's Clinic of the control of the cont	sition by S12ADM. Further documentation that S12ADM very over daily operations of Delt of Baton Rouge. The docume e President and S12ADM and	a nt	A Key Personnel Change form in for June LPN to position of Clinic Manager.	is going to be sent assume the Exhibit C 03/08/2017
		Board of Directo the President an part. S9ADM for	mentation of the "Annual Meet rs Meeting", dated 05/04/16, w d S9ADM present, revealed in mally announced her retireme S12ADM would be taking her	vith n i nt	With Board approval, function as the Administrator responsible for the day-to-d	LPN will be ay operations of the not present or is

3/18/22017

unable to perform those duties.

Health S	tandards Section					T
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB	CD.	•	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642	E	B. WING		01/25/2017
NAME OF F	PROVIDER OR SUPPLIER	S	TREET ADDR	ESS, CITY, ST	ATE, ZIP CODE	
DELTA C	LINIC OF BATON RO	TITE INIT		IAL DRIVE JGE, LA 70		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI	JLL ON)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S 055	Continued From pa	age 4		S 055		Ì
	the change in adm	ealed no date was provinistrators for the facility ed S9ADM as the reconsignatures noted.	y. The	: 		
	LDH/HSS notificati personnel reveale Form for another of by the corporation	nts provided regarding on of a change in key d a Key Personnel Chaputpatient abortion clinic that did not include a change in administration Rouge.	owned			
	S1OfficeMgr as cu	inizational Chart provid irrent, with administrat vith staff names, reveal ministrator.	ve			. :
	S1OfficeMgr report Administrator of D S1OfficeMgr report absence of S9ADI oversaw the day to S1OfficeMgr indicated designating her to the absence of the S9ADM indicated often at the clinic, position with these years.  In a phone interview.	23/17 at 12:00 p.m. ted S9ADM was the elta Clinic of Baton Rooted she was in charge M, and she (S1OfficeModay operations of the ated she had no docum stand in for the administration that the administrator v and she had been in the understood responsible w 01/25/17 at 11:20 a.	in the gr) facility. hentation strator in or. vas not illities for m.			
	indicated S9ADM actual supervisor. spoken with S9ADM	she reports to S1Office I is the administrator and S7DON reported she DM last month.  ew 1/25/17 at 3:00 p.m. and she thought S1Office	d her had			

Health S	tandards Section				1 01/11/11/11/07/20
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642	B. WING		01/25/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODÉ	
DELTA C	LINIC OF BATON RO	NGE INC	NIAL DRIVE DUGE, LA 70	806	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
S 055	Continued From pa	ige 5	\$ 055		
	was the administra Rouge.	tor of Delta Clinic of Baton	ļ		
	S9ADM reported sitimes over the last S1OfficeMgr with shad been told S12 administrator of thi impression that S1 position of adminishad told her she (Sin key personnel not for both facilities (Dianother owned by she(S9ADM) still had been reported to the administrative dution to aware of any G2016).  In a phone interviee S12ADM, indicated the clinic of Bate in another city. S12 paperwork for chate Abortion Facilities indicated she did reprovide. She reported that no Kareceived for a chate she with the same communication of the control of the	w 01/25/17 at 1:45 p.m. he had come to the clinic a few months of last year to assist ome administrative duties, but ADM was going to be the sclinic, and was under the 2ADM had assumed the trator. She reported S12ADM 12ADM) had faxed a change offication to the state offices Delta Clinic of Baton Rouge and the corporation), but that ad come to Delta Clinic of alp S1OfficeMgr with es. S9ADM reported she was B meetings since last May (of w 01/25/17 at 2:35 p.m. and she was the administrator of the Program Desk 04/29/16, but not have a copy she could arted she had come to the composition of Baton Rouge) go, and that she was on the GB on with the Abortion Program via a supervisor it was ey Personnel Change had beer nge in Administrators for Delta uge to S12ADM from S9ADM.			

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Health S	tandards Section				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642	B. WING		01/25/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE	
		756 COL	ONIAL DRIVE		
DELTA C	LINIC OF BATON RO	UGE, INC BATON R	OUGE, LA 7	0806	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S 107	Continued From pa	age 6	S 107		
S 107	4421 A-B Governin	ig Body	S 107		
	compliance with all local statutes, laws ordinances.  B. The outpatient governing body that for the total operatifacility.  1. The govern least one individual responsibility.  2. The outpatimaintain documen identifying the member of the govern all terms of a name;  b. contact c. address d. terms of terms of terms of the govern adopt bylaws which responsibilities.  4. The governmeet annually and	t information; s; and of membership. hing body shall develop and h address its duties and s. hing body shall, at minimum, I maintain minutes of such menting the discharge of its			
	Based on record r of Baton Rouge fa maintained docun premises identifying of the governing b	net as evidenced by: review and interview Delta Clini ailed to ensure the GB nentation on the licensed ng information for each membe body that included name, on, address, and terms of		S 107 A list of the members Body has been created. It inclu contact information, address a membership. It will be mainta Administrative Policy and Proc Exhibit D	des their names, nd terms of ined in the

membership.

Health S	tandards Section					
	IT OF DEFICIENCIES OF CORRECTION	1 ' '			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642		B. WING		01/25/2017
NAME OF F	PROVIDER OR SUPPLIER	S	TREET ADD	RESS, CITY, S	STATE, ZIP CODE	
DELTA C	LINIC OF BATON RO	LIGE INC		NIAL DRIV JUGE, LA 7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
S 107	Continued From pa	ige 7		S 107		
	Findings:					
	facility's GB, includ Minutes that includ	entation provided relateding the Bylaws, Meeting ed May 2, 2016, and Mocumentation of the Governing Board.	)			
	S1OfficeMgr as cur President of the co Rouge, who would responsibility for the revealed he appoint No date was noted documentation as sat on the GB, and of the GB. No con	and procedure provide rrent revealed the name rporation, Delta Clinic o assume all legal and file Corporation. Further sted S9ADM as administion the document, and to whether or not the properties of the were other metact information, address hip were noted for either M.	e of the f Baton nancial review strator no resident mbers ss, or			
	reported she was s reported the GB co	/25/17 at 1:45 p.mS9/ still a member on the G onsisted of her and the orporation, who lived ou	B. She .			
	reported she was to of Baton Rouge.	5/17 at 2:35 p.m. S12A the administrator of Del S12ADM reported she v s, as well as the Preside	ta Clinic vas a			
	reported she did n contact information Baton Rouge. S10	5/17 at 3:45 p.m. S1Of ot have a list of names n of the GB for Delta Cl OfficeMgr confirmed no ad been received from g the GB.	and inic of			

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Health S	tandards <u>Section</u>						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION			CONSTRUCTION		E SURVEY PLETED
		BO0004642		B. WING		01 <i>l</i> :	25/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	ATE. ZIP CODE		
				NIAL DRIVE			
DELTA C	LINIC OF BATON RO	UGE, INC		OUGE, LA 70			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETE DATE
S 109	Continued From pa	ge 8		S 109			
S 109	4421 - C 1-4 Gover	ning Body		S 109			
	continued compliar state, and loca regulations, and or department rules, governing or relating facilities, abortion or reporting requirement informed consent activity requirement delivering any insuppose health topic, including sexuality or family public elementary or charter school that knowingly providing regarding human for distribution or vor secondary so receives state fund addressed by law abortion procedure 2. designating administrator and of this person to reperations of the factor and delegated allow him/her that the substitution is the substitution of the factor and delegated allow him/her that the substitution is the substitution of the factor and delegated allow him/her that the substitution is director and delegated allow	e outpatient abortine with all applicate with all applicate statutes, laws, redinances, includir regulations, and get outpatient at termination requirements, pats, e.g. presenting truction or prograting but not limited planning, to stude or secondary school at receives state of gany materials or sexuality or familiated to aborting, or any other related to aborting; a person to act a delegating sufficient and medical services administrator	ion facility's able federal, ales, ag a fees, cortion procedures, equirements, with a feet and an any and a feet and an authority to color as the ent authority to call staff, vices provided and medical dimaintaining				

	to the Company				FORWIAPPROVED
	tandards Section T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPLETED
		BO0004642	B. WING		01/25/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DORESS, CITY, ST	TATE, ZIP CODE	
		756 COL	ONIAL DRIVE	:	
DELTA C	LINIC OF BATON RO	UGE, INC BATON F	ROUGE, LA 70	0806	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
		0	S 109		
S 109	Continued From pa	age 9	0 100		
	·			•	
			í		
	interview, the Governments of the compliance with or requirements, prolimited to the Lompleted/certifier policy and procedured by state I deficient practice #3, #4, #5, #6, #8 15 (#1-15) medical sample of 15 b) no documented prohibited activity 2) clear designation authority to manathe facility as evice appointment of the completed of the completed/certified policy and procedured by state I deficient practice #3, #4, #5, #6, #8 15 (#1-15) medical certified later than total sample of 15 b) no documented prohibited activity 2) clear designation authority to manathe facility as evice appointment of the complete interview.	net as evidenced by: tion, record review, and erning Body failed to consibility for ensuring: bortion facility's continued department rules, reporting nibited activity requirements. tice was evidenced by: tion that ITOP reports EERS system were d within 15 days as per their ture, or within 30 days as aw and regulations. This was evidenced by 13(#1, #2, #9, #10, #12, #13, #14, #15) of al records with ITOP reports 30 days after an abortion of a fi, and d policy and procedure of requirements, and on of a person to act as the d delegation of sufficient ge the day-to day operations of the person to act in the osence and their authority.		S 109 A new policy has been be approved by the Board of Destablishing Prohibited Activitian Activities policy number 3108 maintained in the Personnel Perocedure Manual. An in-service policy with be conducted with Exhibit E  A policy dictating the reporting terminations to the State of Lethirty (30) days of the proceduritem and will be approved Policy number 2411. It will be Patient Care Policy Manual. E  The Board will approve be the Acting Administrator were ponsibilities and authority day operations of the clinic in the Administrator,	birectors, les. Prohibited will be olicy and lee reviewing this the staff.  3/18/2017.  If of all pregnancy ouisiana within live has been by the Board. maintained in the fixhibit F  3/18/2017  LPN to whose include day-to-
	facility's continue rules, reporting re requirements. a. Failure to den facility's continue rules, reporting re	ure the outpatient abortion d compliance with department equirements, prohibited activity monstrate the outpatient abortion d compliance with department equirements, prohibited activity is deficient practice was	on t		: : :

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Health S	tandards Section				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642	B. WING		01/25/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE	
DELTA C	LINIC OF BATON RO	UGE, INC	LONIAL DRIVE ROUGE, LA 70		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
S 109	Continued From pa	ge 10	S 109		
	reports submitted to completed/certified policy and procedu required by state la	-			
	revealed, in part "A for each abortion p completed by the a report shall include attending physician be signed by the at submitted to the De	40:1299.35.10 Reports, An individual abortion reporerformed or induced shall be ttending physician The :(25) Signature of the C. All abortion reports shatending physician and epartment of Health and rty days after the date of the			
	"Report of Induced presented on 01/24 S1OfficeMgr as cu Report of induced PHS 16-ab, shall be with appropriate corequired by LSA-R Vital Records Reginduced terminatio written) with approwill be submitted to within 15 days of a revealed no processubmission of the required by facility	ty's Policy & Procedure title Termination of Pregnancy", 4/17 at 2:40 p.m. by rrent, read in part: Policy: termination of pregnancy, for the completed and submitted entificates and consent forms S.40:1299.3510 (25) to the stry. Procedure: The report the of pregnancy from (as priate certificates and consent to the Vital Records of Register the abortion. Further review dure to provide evidence of the ITOP reports in the time policy and time required by the ITOP report.	of the state of th		
		lical record for patient #1 a non-surgical abortion 7/14/	16.		: : :

FORM APPROVED Health Standards Section STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING \_ BO0004642 01/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE, INC BATON ROUGE, LA 70806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 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, I 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.

Health St	tandards Section					
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642	<u></u>	B. WING		01/25/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
DELTA C	LINIC OF BATON RO	UGE, INC		NIAL DRIVE OUGE, LA 70		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED B SC IDENTIFYING INFORI	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETE
S 109	Continued From pa	age 12		S 109		
	revealed she had a Further review of the certification or region which had a printed Review of an ITOP provided by the LD	Preport for Patient DH State Registrar a realed a certification	ion 9/6/16. evealed no ITOP form, #5, and Vital			
	revealed she had a Further review of t certification or region which had a printe Review of an ITOF provided by the LE	Preport for Patient DH State Registrar a vealed a certificatio	tion 9/9/16. revealed no revealed from, H6, and Vital			
	revealed she had 10/04/16. Further revealed no certifi	dical record for pation of a non-surgical abore review of the medication or registration in had a printed d	tion cal record n date on			
	revealed she had Further review of certification or reg which had a printe an ITOP report fo LDH State Regist	dical record for pati a surgical abortion the medical record gistration date on the ed date of 7/22/16. or Patient #9, provic trar and Vital Record cation and registration	07/14/16. revealed no e ITOP form Review of fed by the ds office,			

PRINTED: 02/17/2017 FORM APPROVED Health Standards Section STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ B. WING BO0004642 01/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE, INC BATON ROUGE, LA 70806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 109 Continued From page 13 S 109 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

Health St	tandards Section				FORMAPPROVED
AND BLAN OF CODDECTION IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		BO0004642	B. WING		01/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE	
DELTA CI	LINIC OF BATON RO	LIGE INC	ONIAL DRIVE ROUGE, LA 708	306	
	OUR BLACK ON COME				DECTION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETE
S 109	Continued From pa	ge 14	S 109		
	into the LEERs syst discharged after has She indicated this wafter the procedure printed 2 copies. On medical record, and physician to be sign who had a procedushow how it worked the page was 1/25/printed. S1OfficeMand demonstration manually signed the were taken to post S1OfficeMgr report documentation of treports were maile S1OfficeMgr review Patient #s 1-6, 8-1 confirmed there was ITOP copy from the certification dates the program desk than the 15 days or required by state in S1OfficeMgr report documented evided including the physical report, having bee Registrar and Vita patient's procedure.  B. no documented prohibited activity. Review of the policy activity requirements.	wed the ITOP reports for 0, and 12-15. S1OfficeMgr as no certification date on their e medical record, and the of the ITOP reports provided by showed them all to be later of their policy, and 30 days as egulations and statues, and the could provide no note of required information, cian's signature certifying the opposite provided to the State Statistics within 30 days of the es.	y		

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Health S	Standards Section					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642		B. WING		01/25/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE	
DE: T4.0	N 18110 OF 12 ATOM DO	HOT INC	756 COLO	NIAL DRIVE	Ė	·
DELIAC	LINIC OF BATON RO		BATON RO	OUGE, LA 70	)806	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE!  MUST BE PRECEDE!  SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S 109	Continued From pa	ige 15		S 109		
	any health topic, inchuman sexuality or a public elementary charter school that knowingly providing regarding human s distribution or view secondary school, receives state fund addressed by law reprocedures.  In an interview 01/2 verified there was a facility's manuals the program, materials sexuality or family secondary, or charfunding or any other related to abortion S1OfficeMgr confinal policy and procedures.	family planning, or secondary so receives state fur any materials or exuality or family ing at a public eleor at a charter so ing, or any other related to abortion 25/17 at 3:45 p.m. and policy and pronat addressed any eleor and addressed any planning at a eleor school that refer matter addressed or abortion processed facility did not secondary and processed and addressed and a	to students at chool, or at a nding or media planing for ementary or chool that matter a or abortion  1. S1OfficeMgr cedure in the py prohibited instruction, ing human ementary, aceives state sed by law edures.			
	2)Failure to design administrator in his to manage day-to	s/her absence an	d the authority			
	Review of Govern provided by S10ff dated 05/02/16 via no documentation person to act as a the administrator.	iceMgr, revealed a Skype Transmis regarding the de	a meeting ssion revealed signation of a	:		:
	Review of docum Board of Directors the President and documentation re	Meeting", dated S9ADM present,	05/04/16, with revealed no			·

Health S	tandards Section				FORM APPROVED		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		BO0004642	B. WING		01/25/2017		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
DELTA C	DELTA CLINIC OF BATON ROUGE, INC  756 COLONIAL DRIVE  BATON ROUGE, LA 70806						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE COMPLETE HE APPROPRIATE DATE		
S 109	Continued From pa	ige 16	S 109				
	person to act as ad the administrator.	ministrator in the absence of					
	S1OfficeMgr as cur positions filled in w S9ADM as the Adm revealed no design administrator in the In an interview 01/2 S1OfficeMgr report Administrator of De S1OfficeMgr report absence of S9ADM she (S1OfficeMgr) operations of the fathere was no docur stand in for the administration and she (S1OfficeMgr) with these responsible S9ADM reported soperations of Delta In a phone interviee S4MedDir indicate	nization Chart provided by rrent, with administrative ith staff names, revealed ninistrator. Further review ation of the person to act as absence of the administrator.  23/17 at 12:00 p.m. ted S9ADM was the elta Clinic of Baton Rouge. ted she was in charge in the M (who lived out of town), and oversaw the day to day acility. S1OfficeMgr indicated mentation appointing her to ministrator in the absence of inistrator. S9ADM indicated tor was not often at the clinic, Mgr) had been in this position sibilities understood for years. he oversaw the day to day a Clinic of Baton Rouge.  w 1/25/17 at 3:00 p.m. d she thought S1OfficeMgr ator of Delta Clinic of Baton					
	S9ADM reported s times over the last S1OfficeMgr with s had been told S12 administrator of this impression that S1 position of administrations.	w 01/25/17 at 1:45 p.m. he had come to the clinic a few months of last year to assist some administrative duties, but ADM was going to be the is clinic, and was under the 2ADM had assumed the strator in May of last year eported she did not remember					

Health Standards Section						
	AND PLAN OF CORRECTION   I DENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		BO0004642	B. WING		01/25/2017	
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DELTACLE	NIC OF BATON BO	756 COLO	NIAL DRIVE	≣		
DELIA CLI	NIC OF BATON RO	BATON R	OUGE, LA 7	0806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
S 109 (	Continued From pa	ge 17	S 109			
		designation of a person to act s place in her absence.	1			
E r c t	S12ADM, indicated Delta Clinic of Bato under the corporation of the corporation of the corporation of the corporation of the corporated that she did not corporated the cor	v 01/25/17 at 2:35 p.m. If she was the administrator of a Rouge and of another clinic on, in another city. She st come to the Baton Rouge as ago. S12ADM indicated the to Delta Clinic regularly, here had not been an ignation of someone to act in ministrator).				
	contract with an outsafe and effective rate and effective rate and effective rate and ensuring that the develops, implement assurance and perforogram; and reviewed and procedures related to address programited to, patient comproved practices and external occurrance metal occurrance and external occurrance metal and external occurrance and that a preparedness drills the disaster plan. T	tes that are provided through a side source are provided in a nanner; he outpatient abortion facility hats, monitors, enforces, and um, quarterly, a quality formance improvement (QAPI) aplementing, monitoring, ewing annually written policies ating to communication with hedical director, and medical ablems, including, but not are, cost containment, and isaster plans for both internal rences are developed, tored, enforced, and annually				

premises indicating the date, type of drill,

ΞD

	Standards Section		· · · · · · · · · · · · · · · · · · ·		FORM APPROV
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER;		LE CONSTRUCTION	(X3) DATE SURVEY
		THE STATE OF THE S	A. BUILDING	d:	COMPLETED
		BO0004642	B. WING		01/25/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	1 0112012011
DELTA C	LINIC OF BATON RO		ONIAL DRIV		
	····	BATON R	OUGE, LA	70806	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE COMPLE
S 115	Continued From pa	-	S 115	\$ 115 It is very upsetting	g for this
	participants, and n	naterials;		Administration to believe	- Te-
				who has been employed	
				2004, would report to the	•
	This Rule is not m	et as evidenced by:		we had never developed	a QA Program.
	Based on record re facility's Governing	eview and interview, the Body failed to ensure that the		This employee has since I	been terminated.
	QAPI program was	developed, implemented.	;	However, under her water	ch, apparently, the
	quarterly and the G	ed and reviewed at least BB failed to ensure all		program was not implem	ented, monitored,
	contracted service they were provided	s were evaluated to ensure I in a safe and effective way.	÷	enforced and reviewed a	t least quarterly.
	Finding:	•		A staff meeting will be he	eld and a Quality
	Review of the facili	ty's Policy & Procedure titled "		Assurance Coordinator w	ill be identified.
	Quality Assurance	presented (01/25/17) by		The program, which is att	tached, will be
	S10fficeMgr as be	ing current read in part: The		reviewed and implement	•
	quarterly to advise	ory Group (PAG) will meet the Clinic on professional		Coordinator. See Exhib	it G
	issues, to participa	te in the evaluation of the		A Quality Assurance Com	mittee will be
	Clinic's program ar	nd to assist the Clinic in with other health care		established and will meet	t at least quarterly.
	providers		:	The Quality Assurance ac evaluated by the Governi	
	Indicators Year 201	ent titled "Quality Assurance  6" revealed the areas audited		quarterly.	- 
	surgical abortion);	ne (counseling, pill abortion, Complications (ectopic, pill cal re-aspiration, retained	- - -	This will be established b will be gathered for Janu	y 3/18/2017. Data ary, February and

documented evidence that the facility's Governing DHH/Health Standards Section

tissue, bleeding, missed abortion, infection, other

grievances-employee, occurrences-employee; Logs (refrigerator-lab, medication, cleaning, AED,

Autoclave, in-services). Further review of QA

contracted services provided in the facility.

Review of the facility's Manual revealed no

documents provided revealed no evaluation(s) of

-fail, grievances, occurrences (patient),

findings.

06/15/2017

March 2017 with reporting completed for

Board of Directors meeting later that month

to review the Quality Assurance Committee

QA Committee meeting in June and the

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Health St	andards Section				· · · · · · · · · · · · · · · · · · ·
SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA .		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_	·	;
		BO0004642	B. WING		01/25/2017
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
		756 COLO	NIAL DRIVE		
DELTA CI	INIC OF BATON RO	UGE, INC BATON R	OUGE, LA 708	306	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
\$ 115	Continued From pa	age 18	S 115	Delta Clini	c of Baton Rouge's
	·	T		Board of Director	s met on March 13,
	participants, and m	18(5)1815,	;	2017. A Quality A	·
			í	Coordinator was	<u>'</u>
				Quality Assurance	1 7 7
	This Parks is a second			established. An In	
		et as evidenced by: eview and interview, the			appointed and an
		Body failed to ensure that the	'	Infection Control	; ' '
		s developed, implemented,		:	"
		d and reviewed at least		established.;	
		SB failed to ensure all	}	_, _	) )
		s were evaluated to ensure I in a safe and effective way.			dinator's will ensure
	Finding:	in a sais and shoos to way.	;	appropriate docu	<u>]</u> '
	•		:	,	ding certain aspects
	Review of the facil	ity's Policy & Procedure titled "		· · · · · · · · · · · · · · · · · · ·	ded in the Clinic to
		presented (01/25/17) by sing current read in part: The		maintain strict ei	1
1		ory Group (PAG) will meet		infection control	policies and
1		the Clinic on professional		procedures and	compliance with
1		ate in the evaluation of the		quality assurance	ė guidelines.
		nd to assist the Clinic in			
	maintaining liaisor providers	with other health care	•	Data is co	mpiled daily and is
	providera			· · · · · · · · · · · · · · · · · · ·	veekly, monthly and
	Review of a docur	nent titled "Quality Assurance			ported quarterly.
		16" revealed the areas audited	1	annaday, resort	
		me (counseling, pill abortion, Complications (ectopic, pill	•	Eartha a	urpose of this
		ical re-aspiration, retained		•	<b>,</b>
		nissed abortion, infection, other		Louisiana Depar	<del>{</del>
		ccurrences (patient),		• • •	e, the data available
		yee, occurrences-employee;		for January and	1
		lab, medication, cleaning, AED, ices). Further review of QA	•	compiled and re	1.
		ed revealed no evaluation(s) of		, ,	27, 2017. Data for
		s provided in the facility.	:	March will be co	mpiled and
]	Davidan State 6 19	26.10 \$ A a ( )		completed, read	ly for review by
}		ity's Manual revealed no ince that the facility's Governing	,	Monday, April 3	, 2017.
DHH/Health	Standards Section	area mar me racinty's Governing	;	•	y

If continuation sheet 19 of 41

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STATE FORM

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PAGE 03/05 PRINTED: 02/17/2017 FORM APPROVED

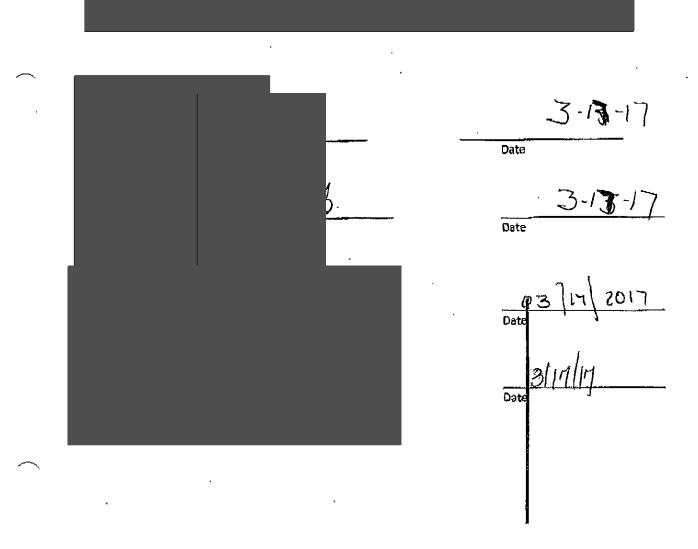
STATEMEN	TANDAROS SECTION  T OF DEFICIENCIES  TO CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
MIND PLAN	OF CORRECTION	INDIALII JOSHI OR HAINDRIN	A, BUILDING:		
` ` ` ` ` ` ` · · · · · · · · · · · · ·		BO0004642	B. WING		01/25/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
DELTA C	LINIC OF BATON RO	JI(a)e INC:	ONIAL DRI\ ROUGE, LA	70806	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO) DEFICIENC	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
S 115	Continued From pa	age 19	S 115		
S 121	QAPI program. In an interview on a S1OfficeMgr indicators were no by the Governing E	ng quarterly reviews of the 01/25/17 at 12:10 p.m., ated that the facility's QAPI treviewed/monitored quarterly 3ody.  g Requirements, Qual &	S 121	It is the intercoordinator and the ensure documentate collected and ready the end of the first month, every month	e Committee to for review by week of the next
	shall have an adm governing body who day-to-day manago operation of the outline administrator shall available and on-susiness hours.  1. Qualification at least 18 years school diplomate. The output designate a personabsence, and sithe qualifications of this Chapter. It is a shall maintain documents of the properties of the statement of the shall maintain documents.	The outpatient abortion facility inistrator designated by the to is responsible for the ement, supervision, and atpatient abortion facility. The be a full-time employee, ite, during the designated ons. The administrator shall be of age and possess a high a or equivalent. Iten abortion facility shall in to act in the administrator's hall ensure this person meets of the administrator pursuant to the outpatient abortion facility umentation on the licensed tying this person and evidence ins.			
	Based on record r failed to have an a by the governing b appointment/desig	net as evidenced by: eview and interview the facility administrator, clearly designate body, and documentation of the gnation of a person to act in the sence. This falled practice was	9 '		
DHH/Health STATE FOR	Standards Section	Λ.	6899	7V6L11	If continuation sheet 20 of 41

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# 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.



## **DELTA CLINIC OF BATON ROUGE**

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

	, Administrator
	Director of Nursing
SIGNING FOR	: <b>n</b>

Date

03/20/20/7

Page 2

PRINTED: 02/17/2017

Health S	Standards Section				FORM APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	·	BO0004642	B. WING		01/25/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE	
DELTA C	LINIC OF BATON RO	UGE. INC	ONIAL DRIV		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S 115	Continued From pa	ige 19	S 115	Deficiency states our Quality	Accuração
	QAPI program.  In an interview on 0	ng quarterly reviews of the 01/25/17 at 12:10 p.m., ted that the facility's QAPI		program failed to ensure cont services were provided in a sa effective manner. As part of our Quality Assuran	racted fe and
	indicators were not reviewed/monitored quarterly by the Governing Body.			contracted services will be evaluated at least annually and their policies, procedur	
S 121	4423 B 1-2 Staffing Respons.	Requirements, Qual &	S 121	and contracts will be reviewed information will be evaluated Governing Board.	by the
	shall have an admi governing body wh day-to-day manage operation of the ou administrator shall	The outpatient abortion facility nistrator designated by the o is responsible for the ament, supervision, and tpatient abortion facility. The be a full-time employee,		doverning board.	06/15/2017
	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				
	shall maintain docu	all maintain documentation on the licensed emises identifying this person and evidence			
	Based on record refailed to have an action by the governing be appointment/design	et as evidenced by: eview and interview the facility dministrator, clearly designated ody, and documentation of the nation of a person to act in the ence. This failed practice was	•	<b>S 121</b> A staff meeting will be establish common knowledge members of the Board of Direct Administrative Staff.	e of the



#### 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 Provider License #: Baton Rouge, IND Agency DBA Name: Address: 756 Colonial Drive \*B Provider CMS ID if applies#: City, State, Zip: Baton Rouge, la 70804 Administrator's Email Address: Telephone Number: 225-924-4442 WHICENO @ gmoul lom Proposed Employee's Email Address Fax Number: 125-924-4465 (if available): WACC NO @ amoul . 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: Name of proposed employee for this position Effective Date of Change: 05/01/2016 Verification Date of Current LA Professional License: NA 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. Signature of Proposed Employee Printed Name of Proposed Employee Segnature of Administrator Printed Name of Administrator 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**

Source as we as we will share the state of t	Y PERSONNEL CHANGE FORM
This form must be signed by the proposed	employee and the administ ator.
Legal Entity Name: Delta Clinic of	Provider License #:
Agency DBA Name: BATON Rouge	07
Address: 754 Colonial Drive & B	Provider CMS ID if applies#:
City, State, Zip: Boston Ronge, la 70806	•
Telephone Number:	Administrator's Email Address:
225.924:4442	WHICE NO @ gmail. Com
Fax Number:	Proposed Employee's Email Address
225. 924. 4445	(if available): WHE DeltaClinic 7568
	WHE DESTACTIONS 1568
Circle the Position that is changing (Please circle only	those appropriate to the Provider Type): ${\stackrel{0}{\circ}}$
Administrator (the person with overall responsibility for	
<b>Director of Nursing</b> (the RN providing leadership of nur	
Medical Director (the physician providing oversight of the CLINIC MANAGER	ne clinical operations – if applicable)
Name of previous employee in this position:	
Name of proposed employee for this position:	
Effective Date of Change: 3 / 1 / /7	
Verification Date of Current LA Professional License:	\$211812016
Please enter the date on which the agency verified the current profess	ional licensure of the proposed employee, if
licensure is a requirement for the position. The date should precede	· · · · · · · · · · · · · · · · · · ·
Attestations of Con	
We hereby certify that the proposed employee listed herei set forth by the Louisiana Department of Health and Hosp	n meets all state and federal requirements
Centers for Medicare and Medicaid Services; and any oth	er regulatory agency applicable to the
Provider Type, to function in the role indicated. We further	
the administrator to ensure that the agency maintains com	pliance with state and federal regulations on
an ongoing basis. DHH Health Standards Section will be	promptly notified of any changes to Key
Personnel.	
	3-8-17
Printed Name of Proposed Employee Signature of Propos	ed Embloyee Date (mm/dd/yy)
	3-8-17
Printed Name of Administrator Signature of Admir	
PLEASE NOTE: This form is used for all Health Standar	de Section licensed providers/suppliers

HSS-ALL-37 (originated 5/05/06, revised 04/08/2016)

specific Provider Type.

Definitions of Key Personnel may be found in the applicable state licensing regulations for the

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FORM APPROVED Health Standards Section STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING BO0004642 01/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE, INC BATON ROUGE, LA 70806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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 S1OfficeMar 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 L.A. Dept of Health)

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DHH/Health Standards Section

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

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

Health Standards Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BO0004642	B. WING		01/25/2017
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u></u>
DELTA CLINIC OF BATON F	OUGE INC. 756 COLO	NIAL DRIVE		
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PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
S 121 Continued From	page 22	S 121		
administrator of to impression that Sposition of administrator of administrator of administrator of the desired specific and administrator of the administra	nis clinic, and was under the 12ADM had assumed the strator. She reported S12ADM S12ADM) had faxed a change notification to the state offices but that she still had come (to ton Rouge) to help. S9ADM ught she was still a member of st meeting was last year, and ag wouldn't be held until May (of W reported she did not pointment of a person to act in s place in her absence.  ew 01/25/17 at 2:35 p.m. ed she was the administrator of ton Rouge and of another clinic 12ADM reported she sent ange in administrators (to ortion Facilities Program Desk cated she did not have a copy. had come to the Baton Rouge in this ago, and that she was on 1 indicated that she did not come			
been a meeting j copy of minutes S12ADM reporte appointment of s (as administrator	gularly. She indicated there had ust last month, and would send a or that meeting to the clinic. If there had not been an omeone to act in her absence of the survey, at 7, no documentation had been 2ADM.			
S 159. 4425 -A Patient I Requirements	· · · · · · · · · · · · · · · · · · ·	S 159		
	sions tient abortion facility shall intain a patient medical record			

(X5) COMPLETE

Health Standards Section STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND FLAN OF CORRECTION IDENTIFICATION NUMBER-COMPLETED A. BUILDING: B00004642 01/25/2017 NAME OF PROVIDER OR SUPPLIER. STREET ADDRESS, CITY, STATE, ZIP CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE INC BATON ROUGE LA 70806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TEACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION! CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**)

S 159 Continued From page 23

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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
- 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) requiations. and/or all applicable state laws. rules, and regulations.
- 4. Safeguards shall be established to project 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 safequards 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.

DHH/Health Standards Section

Health Standards Section FORM APPROVED										
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		BO0004642	B. WING		01/25/2017					
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE						
DELTA CLINIC OF BATON ROUGE, INC 756 COLONIAL DRIVE										
BATON ROUGE, LA 70806										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE					
S 159	Continued From page 24		S 159							
	Records Content", being current, read are established to r	ity's Policy titled "Patient presented by S1OfficeMgr as in part: Policy: Safeguards maintain confidentiality and , water, or other sources of								
	S1OfficeMgr indica estimated number were stored in the f medical records sto patient records. St no safeguards in pl	on 1/23/17 at 12:15 p.m., ted that she could not give an of how many medical records facility. She indicated that all ored in the facility were active ne indicated that the facility had ace to protect the records amage from fire or water.								
S 169	4425 - E-F Patient Requirements	Med Records/Reporting	S 169							
	shall maintain a da receiving a surgica abortion. Patients recorresponding to the This daily patient reperiod of three years. Reporting Requirements abortion reporting requirements abortion reporting requirements, the induced terminant of the forminant abortion federal, state, and deregulations.	ne patient's medical record. Dister shall be retained for a result of a result of a rements and abortion facility shall tation to support that the on facility is compliant with all ents, including, but not limited remination of pregnancy (ITOP) cumentation as required by and local statutes, laws, epartment rules and								
		ent abortion facility shall report all applicable state laws for								

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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 LARS 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

Policy number 2411 will be maintained in the Patient Care Manual. Staff will be inservices 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

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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.

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#### 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.

provided by the LDH State Registrar and Vital Records office, revealed a certification and

registration date of 11/23/16.

DHH/Health Standards Section

Health Standards Section									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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NAME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST.	ATE. ZIP CODE	· · · · · · · · · · · · · · · · · · ·				
DELTA C	DELTA CLINIC OF BATON ROUGE, INC  756 COLONIAL DRIVE BATON ROUGE, LA 70806								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE COMPLETE				
S 169	Continued From pa	~	S 169						
	provided by the LDI	report for Patient #6, H State Registrar and Vital realed a certification and 12/01/16.							
	revealed she had a 10/04/16. Further revealed no certification	ical record for patient #8 a non-surgical abortion review of the medical record ration or registration date on oth had a printed date of							
	revealed she had a Further review of the certification or regist which had a printed Review of an ITOP provided by the LDI	report for Patient #1, H State Registrar and Vital ealed a certification and							
	revealed she had a Further review of th	ical record for patient #10 a surgical abortion 12/09/16. The medical record revealed no stration date on the ITOP form didate of 01/11/17.							
	revealed she had a Further review of th	ical record for patient #12 a non-surgical abortion 7/14/16 ne medical record revealed no stration date on the ITOP form d date of 7/25/16.							
	Patient #13 Review of the medi	ical record for patient #12							

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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

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Health S	Standards Section				FORM APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BO0004642	B. WING	(1)	01/25/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	0112012011
DELTA C	LINIC OF BATON RO	U\3E. 11%G	ONIAL DRIVI OUGE, LA 7		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
S 169	Continued From pa	ge 30	S 169		
	the program desk sthan the 15 days of required by state re S1OfficeMgr report documented evider including the physic report, having been Registrar and Vital patient's procedure		· .		
0 11 7	Improvement Pro	ssurance/Performance abortion facility shall	S 171		
	develop, implement annually review a w	t, enforce, maintain, and ritten QAPI program subject governing body, which puts			
	systems in place to which quality monit improvement activi	effectively identify issues for oring and performance tles are necessary. The QAPI			÷
	identified issues inc monitoring the effe- and making necess	de plans of action to correct cluding, but not limited to, ct of implemented changes cary revisions to the plan of			
	facility shall develop of action designed for which quality me improvement a	ion. The outpatient abortion of and implement a QAPI plan of to effectively identify issues onitoring and performance ctivities are necessary.		S 171 A Board of Directors to held to establish a Quality Assurant and a plan of action for monitand making revisions to the prospective system will be established to address issues designated in Assurance Program. These performed will be reviewed, followed and documented.	ssurance ace Committee itoring changes program. A identify and the Quality olicies and , implemented,
	Daseu Ulliecold le	view and interview, the facility			

FORM APPROVED Health Standards Section STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: BO0004642 B. WING 01/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE, INC BATON ROUGE, LA 70806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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

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<u>Health S</u>	tandards Section					
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
DELTA C	LINIC OF BATON RO	UGE. INC	ONIAL DRIVE OUGE, LA 70			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
S 171	Continued From pa	ge 32	S 171			
	recommendations a	as appropriate.	! !			
	Indicators Year 201 areas of audit: Par abortion, surgical a (ectopic, pill re-asp retained tissue, ble infection, other -fail (patient), grievance occurrences-emplo	ent titled "Quality Assurance 6" revealed the following tient volume (counseling, pill bortion); Complications iration, surgical re-aspiration, eding, missed abortion, , grievances, occurrences is- employee, lyee; Logs (refrigerator-lab, eg, AED, Autoclave, in			:	
	S1OfficeMgr indica system in place to the QAPI Program. collected the numb Assurance Indicate the end of the year	on 1/25/17 at 12:10 p.m., ted that the facility had no identify/address issues through She indicated that she ers monthly for the Quality ors and summed up the total at . She indicated that she had idence that the data collected e QAPI committee.				
	S9ADM indicated t	rview on 01/25/17 at 1:45 p.m., hat the facility had a policy & PI Program and failed to licy and procedure.				
S 173	4427 - A-3 Quality. Improvement Pro	Assurance/Performance	S 173		:	
	quarterly basis the a. processes f the quality of medic received;	of action shall include on a following: for receiving input regarding cal and clinical services for review of patient medical			:	

FORM APPROVED

PRINTED: 02/17/2017 Health Standards Section STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: BO0004642 01/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE, INC BATON ROUGE, LA 70806 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION iD (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 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 **S 173** Our newly established Quality clinical services. Examples may include, but are **Assurance Coordinator and Quality** not limited to: i. review and resolution of patient Assurance Committee will meet at least grievances; and quarterly and the Board of Directors will ii. review and resolution of review the results at least quarterly. patient/employee incidents involving medication and equipment failure: d. a process to review and develop action We do have a system in place to identify plans to resolve all system wide issues identified and address issues through the program. result of the processes above. We will implement these systems with the 3. The QAPI outcomes shall be documented and reported to the administrator in writing for action. new Quality Assurance coordinator. as necessary, for any identified systemic problems. The guarterly review will include: 1. A process for receiving input regarding the quality of medical and clinical services received. This Rule is not met as evidenced by: 2. Process, quarterly, for identifying the risk Based on record review and interview, the facility failed to ensure that the QAPI plan of action factors that affect or may affect the health included a quarterly review of the following: 1) a and safety of patients. process for receiving input regarding the quality 3. Process for review and development of of medical and clinical services received, 2) a process for identifying, on a quarterly basis, the action plans to resolve all system-wide risk factors that affect or may affect the health issues identified. and safety of the patients, 3) a process to review 4. Documentation of outcomes and reporting and develop action plans to resolve all system to administrator, in writing, for action of wide issues identified, and 4) document

Program in place.

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 QAP!

identified systemic problems.

PRINTED: 02/17/2017 FORM APPROVED Health Standards Section STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_\_ B. WING BO0004642 01/25/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE, INC BATON ROUGE, LA 70806 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S 173 Continued From page 34 S 173 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

In a telephone interview on 01/25/17 at 1:45 p.m.,

was reviewed by the QAPI committee.

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STATEMENT	indards Section  OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' ' .		NSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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S 173	Continued From p		S 173				
	implement their pa	API Program and failed to olicy and procedure.		:			
	S4 Office Mar india	01/25/17 at 12:10 p.m., cated that the facility's QAPI ot reviewed/monitored quarts mittee.	erly				
S 221	1 4445 -A 1 - 3 Ge	neral Requirements	, \$ 221				
	designed, construct to protect the hopersonnel, and to 2. The outpost the provisions for Section, unlugations are affect the a criginal design Painting was correct repairing	atient abortion facility shall be ructed, equipped, and mainta nealth and safety of patients, the public at all times. Settlent abortion facility shall mor physical environment under the public at all times. Settlent abortion facility shall mor physical environment under the public at all times. Settlent under the public and the rein. Settlent major the facility is construction. Its, re-tiling floors, installation a roof damage or reroofing a to be major renovations for	med reet r this or that r				
					, 1 1		

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:

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

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 34, 2017.

DHH/Health Standards Section STATE FORM

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S 221	Continued From pa	ige 36		S 221		
	p.m., revealed a ho baseboards. The happroximately 6 cm approximately 2 cm.  In an interview on 0 S10fficeMgr, presereported she was avaindicated it was from being pushed into the same process.	om C on 01/23/17 at 12: ole in 2 of the walls, neal holes were observed to m by 1.5 cm in one wall, m by 4 cm in the other wall. 21/23/17 at 12:30 p.m., ent for the observation, tware of the holes and m the Ultrasound mach the wall. She confirmed allowed for passage of lents.	ar the be be be l, and wall.			
S 243	4447 B Infection Co	ontrol		S 243		
	implement, enforce review, with the app written policies and identifying, reporting and immediately im relative to infections of patients and perspolicies shall address 1. alcohol base 2. use of all typ 3. decontaminate each patient use, in chairs and proced 4. linen cleanin 5. waste manalimited to, the requirement 7. reporting, invarigical infections;	ed hand rub and hand hoes of gloves; ation of equipment betwinduding, but not limited fure room tables; agement including, but rements of Part XXVII of Health/Sanitary Code; tal cleaning; vestigating, and monito	rector, ting, ting, actions iseases the nygiene; ween to, not of LAC			
	<ol><li>sterilization r</li></ol>	procedures and process	ses, if			

Health Standards Section				FORM APPROVED
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S 243 Continued From pa	age 37	S 243		
This Rule is not me Based on record representation procedures that distribution indicators inside serilization procedures that distribution procedures that distribution indicators inside serilization procedures that distribution procedures that distribution indicators inside serilization indicators inside serilization indicators inside serilization indicators inside serilization indicators in identified infection an identified infection control in indicators in identified infection control in indicators in identified infection control in indicators indicators indicators indicators in identified infection control indicators	g procedures and processes; of infection control practices.  The sevidenced by: eview, observation, and by failed to ensure infection d procedures were developed, proced, and monitored related to dures and processes. This was evidenced by policy and d not include using chemical terilization packs. The facility mation related to each load of hits sterilized that would be esterilization parameters were and track data in the event of tion. Findings: ty policy and procedure titled Autoclave Testing-Daily" with r, provided by S1Office nt, revealed in part, instruments n heat sensitive bags, and heat r strips would be placed in each		S 243 Again, this Administrated disbelief regarding the Manawhich stated the physician in not to properly sterilize instrainclude verification of sterilize document appropriately.  This Clinic has always had an control and OSHA program was proper handwashing, proper instruments, and environments cleanliness.  An Infection Control Coordinassigned and an Infection Committee will be established.	ger's claim estructed staff uments, eation, and infection which included ly sterilizing ntal
sterilization proce sensitive indicato	struments before each ss. A Tray Record Card ( heat r) would be placed in each load os and the Tray Record Card	•	Documentation will be collected the Quality Assurance programmer	
would be maintain Clinic for QA purp no procedure to i	ned in an orderly fashion in the poses. Further review revealed nolude a chemical(heat	:	Documentation includes, bu to: Hand washing observation completed quarterly. Exhib	on to be
(also know as per indicator on the o	or inside all heat sensitive bags el packs) and to place an utside of pack wrapped dition to the internally placed		completed quarteny. LAME	03/18/2017

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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 ovole, 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 1723/17 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 or processed sealed peel packs where observed without a chemical indicator inside the peack 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. revealed without a chemical indicator inside the peack 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. sterilization processed sealed peel packs where observed without a chemical indicator inside the peack 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. sterilization package as it was not necessary. She indicated prior to that the practice was to always place an indicator inside each pack to go of indicators for each instrument serilization logs and documents revealed no log of indicators for each pack to estimate and results	indicator. Review of the CDC Sterilization in Hearevealed, in part, in underwent steriliza sterilization proces affixed on the outs the package has be sterilization cycle, it prove sterilization in review revealed a be placed on the in sterilant penetratio An observation 1/2 surgical instrument an outside indicator package had been process. Further of chemical indicator instruments observed sterilization room, a in Room "B with no packs. A total of 30 processed sealed p without a chemical demonstrate the te had reached a tem sterilize the conten in an interview 1/23 S1OfficeMgr, prese the observed findin physicians had inst (to the survey) to s indicator into each not necessary. She practice was to alw each package steri A review of steriliza revealed no log of	C Guideline for Disinfection and althcare Facilities, 2008 adicate that the item (that tion) had been exposed to the s. Chemical indicators are ide of each pack to show that een processed through a but these indicators do not has been achieved. Further chemical indicator also should uside of each pack to verify in.  3/17 at 12:40 p.m. revealed as in sealed peel packs, having in with a color change that the through the sterilization poservation revealed no inside the sealed peel pouch of red as follows: 23 packs in the surgical indicators inside the surgical indicators inside the surgical instruments in peel packs where observed indicator inside the pack to indicator inside the pack to indicator inside the peel pack perature for long enough to its.  3/17 at 12:40 p.m. ent for the observation, verified gs, and reported one of the ructed staff a few months prior stop putting a chemical sterilization package as it was a indicated prior to that the lays place an indicator inside lized. In the load of		needed. Cleaning logs to be monthly by Infection Control Logs are maintained in QA Exhibit I  Sterilization processes, polimaintained in a binder white testing cards and results; clindicators for each instrumautoclave cleaning and maintained control document will be collected as part of	collected of Coordinator. binder. 03/18/2017 cies and logs are ch includes Spore nemical ent pack; intenance. tation and logs the Quality chibit J

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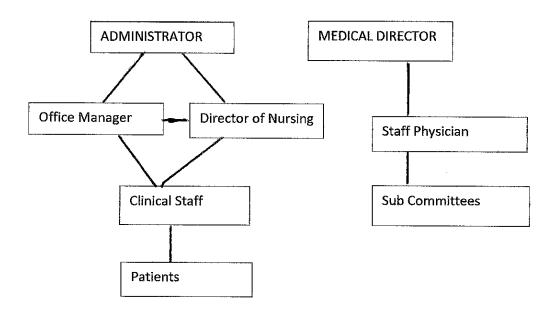
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SUMMARY STAT-SIDENT OF DEPOLISHOES PRECIA  SUMMARY STAT-SIDENT OF DEPOLISHOES (#ACH DEPOLISHOY MUST as PRECEDED BY TILL) TAG  S 243  Of the date, load #, temperature, length (in time), contents, results of the chemical indicator from the tray, or the person processing each load processed, in an in interview 1/24/17 at 2:10 p.m. S10fficeMgr reported process of the facility to keep a log of each load of instruments autoclaved for sterilization. S10fficeMgr indicated there was no record of the date, temperature, length (in time), contents, results of the chemical indicator in the tray, or person processing each load of instruments autoclaved for sterilization. S10fficeMgr 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. S10fficeMgr 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 peal packs of instruments to be sterilized. In a phone interview 1/24/17 at 11:20 a.m. S7DON indicated she was involved with Infection Control for the facility, but was not the IC Coundinator. S7DON indicated she had been in her current position as DON for approximately 2 years. She reported that she worked with S10fficeMgr and S4MedDir in the IC program. She reported staff was instructed by S2MD to stop using chemical indicators inside the seel packs of instruments. When asked which nationally recognized guidalines the facilitys IC policies and procedures were based, specifically starilization procedures, she indicated the were based on "OSHA, and state guidelines." S7DON inclicated 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 breaches, audits charts, sterilization process, and oversees SELEN, S7DON inclicated she gives a report to S10fficeMgr regardi	DELTA CLINIC OF BATON BO	750 001			
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	S4MedDir indicated	there was no one person			

PRINTED: 02/17/2017

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X) PROVIDER DECITION NUMBER  BO0004642  NAME OF PROVIDER OR SUPPLIER  DELTA CLINIC OF BATON ROUGE, INC  STREET ADDRESS, CITY, STATE ZUP CODE  THE COLONIAL DRIVE BATON ROUGE, LA 70806  (KACH DEFICIENCY WIST BE PRECEDED BY PLLL TAG  SEQULATORY OR LSO DEFINITIVE INFORMATION)  S 243  Continued From page 40  designated as the IC coordinator or responsible for the IC program. The Medical Director indicated that the facility dia not have meetings regarding IC, and she did not receive IC reports. Review of a document provided for have meetings regarding IC, and she did not receive IC reports. Review of a document provided for 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 SYDON as the observer. Further review revealed a list of staff repeated bytice, with dates of 225.216 and 8/23/16 with an observation documented compliance before and after contact. S30-ffice was noted as NIA on 8/23/17. It was noted that no physicians were included in the surveillance. No other hand hygiene exicuted in the surveillance documentation was presented. Review of QA indicators for the year 2016 revealed IC related indicators, underlings as follows: Refrigerator-Lab, Refrigerator-Medicine, Cleaning, AED, Autolabre, Inservices. Each category had a "C" for complete for each of the 12 months of 2015. Purcher review revealed no report on hand hygiene, sterilization and storage processes, environmental cleanliness, infections, or any other IC surveillance.	Health 9	Standards Section				FURIM A	ALLKOAFD
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# DELTA CLINIC OF BATON ROUGE, INC. ORGANIZATIONAL CHART

#### **BOARD OF DIRECTORS**



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#### KEY PERSONNEL CHANG

This form must be signed by the proposed employee and the administrator. Legal Entity Name: Delta CLINICOF Provider License #: BATON ROUGE, INC Agency DBA Name: Provider CMS ID if applies#: Address: 756 Colonial Drive \*B City, State, Zip: Baton Rough, la Telephone Number: 225.924.4442 Administrator's Email Address: WHEENO @ gmail-Com Proposed Employee's Email Address 225.924.4465 Fax Number: (if available): Lauren alanek @ as 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: Name of proposed employee for this position Effective Date of Change: 02/13/2017 Verification Date of Current LA Professional License: 0/ 123 12017 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. Signature of Proposed Employee Printed Name of Proposed Employee Signature of Administrator Printed Name of Administrator 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.

# 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.

Policy Number: 3108

#### **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: (<a href="https://leers.oph.dhh.la.gov">https://leers.oph.dhh.la.gov</a>). 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**

- 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>B.Administartive Policies</b>	
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 billin 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** 

**Services Provided** 

**Number of Visits** 

**Payment Sources** 

**Referral Sources** 

**G.Medical Direction** 

**Standing Orders** 

Relationship to Medical Staff

**Admission and Discharge Policies** 

H. Personnel and Staffing

Review of Staff by Type & Number

**Director, Service Personnel** 

Administrative, Supervisory Personnel

**Business personnel** 

Job Descriptions

Salary Schedule

**Performance Evaluation** 

Staffing & Patterns & Policies

To determine quality of services provided

To determined characteristics of population

served, sources of referral and payment services

To provide clear, uniform, safe medical direction

for direct service personnel

To revise as indicated

To employ personnel in sufficient ratio to service

needs

To appropriately & efficiently utilize personnel

To define functions according to educational and

experience qualifications

To determine equitable financial remuneration for

all personnel

To determine level of performance and degree of

competency

To assess adequacy of staff, productivity and

turnover rates

**Educational Program** 

**Clinic Personnel** 

Orientation

License

In-Services

To orient personnel to the CLINIC

To validate current state licensure

To offer opportunities for personnel to increase

their knowledge

**1.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** 

Patient Care Conferences

Satisfaction Surveys

**Chart Audit** 

Grievances

To evaluate appropriateness of services rendered and efficient use of community resources

To coordinate and review the care delivered by each discipline

To determine patient/physician/ referral source

satisfaction with staff and service

To determine if established policies are carried out

in providing services by both staff and contract

personnel

To address all complaints and grievances with

patients and staff

**K.Community Study** 

**Population Characteristics** 

Age groups

Morbidity rate

Mortality rate

Existing community health/ social resources

To determine community needs

Hand Hygiene Observation Form Date: / / Observer

		AFTER contact with blood or body fluids:  □Soap & water □Noncompliant		AFTER contact with blood or body fluids:  □Soap & water □Noncompliant		AFTER contact with blood or body fluids:  □Soap & water □Noncompliant		AFTER contact with blood or body fluids:  □Soap & water □Noncompliant
Observation	BEFORE performing an invasive procedure (e.g. placing an IV, removing an IV):  □ABHR or soap & water and □gloves □Noncompliant	AFTER removing gloves:  []ABHR	BEFORE performing an invasive procedure (e.g. placing an IV, removing an IV):  CABHR or soap & water and Cigloves Civoncompliant	AFTER removing gloves:  [] ABHR	BEFORE performing an invasive procedure (e.g. placing an IV, removing an IV):  □ABFIR or soap & water and □gloves □Noncompliant	AFTER removing gloves: []ABHR   []Soap & water []Noncompliant	BEFORE performing an invasive procedure (e.g. placing an IV, removing an IV):  CABHR or soap & water and Cigloves CNoncompliant	AFTER removing gloves:  [] ABHR
	BEFORE touching the patient:	AFTER touching the patient or contaminated surfaces:  □ABHR □Soap & water  □Noncompliant	BEFORE touching the patient:  [] ABHR	AFTER touching the patient or contaminated surfaces:  □ABHR □Soap & water  □Noncompliant	BEFORE touching the patient:  [] ABHR [] Soap & water  [] Noncompliant	AFTER touching the patient or contaminated surfaces:  □ABHR □Soap & water □Noncompliant	BEFORE touching the patient:  []ABHR	AFTER touching the patient or contaminated surfaces:  □ABHR □Soap & water □Noncompliant
Type of Healthcare Worker	☐ Pre-op nurse ☐ Lab Technician ☐ Scrub ☐ Ultrasound Technician.	□ Recovery K.N. □ Doctor □	<ul> <li>□ Pre-op nurse</li> <li>□ Lab Technician</li> <li>□ Scrub</li> <li>□ Ultrasound Technician</li> <li>□ Recovery R N</li> </ul>	Doctor	☐ Pre-op nurse ☐ Lab Technician ☐ Scrub ☐ Ultrasound Technician ☐ Recovery R N	Doctor	<ul> <li>Pre-op nurse</li> <li>Lab Technician</li> <li>Scrub</li> <li>Ultrasound Technician</li> <li>Recovery R N</li> </ul>	Doctor
L	- Frank		CY	Imal	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~		4	

# EXAM ROOM 5

Date:\_

Dale,						
CLEANING DUTY	MON	TUES	WED	THUR	FRI	
WEEK 1						
Wipe countertop & sink						
Wipe Aspirator Machaine			· - · <u>-</u> · -			
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			į			
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	
Sanderda Lagra	WEEK 1						
	Wipe countertop						
	Wash sink			_			
	Clean exam table						
	Wipe ultrasound mach						
	Clean probes						
	Empty trash						
	Sweep & Mop floors			;			
	WEEK 2						
	Wipe countertop	<u> </u>	<u> </u>	1	<u> </u>		<u> </u>
	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						
<u> </u>	Wipe countertop						
•	Wash sink			-			
	Clean exam table						
	Wipe ultrasound mach						
	Clean probes						
	Sweep & Mop floors						

# QUALITY CONTRL LOG FOR KITCHEN

# 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		<del></del>				
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			<u> </u>			
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

, 20	112	ar i riski malazilar ka ili ja			**************************************	
DAILY CLEANING	والدخرور	TUES	WED	THUR	FRI	
DAILY CLEANING  WEEK 1	MON .					
LOBBY						
RECEPTION AREA						†
LAB ROOM						
KITCHEN & RESTROOMS	***					1
COUNSELING ROOM						
DOCTOR'S OFFICE						<del>-</del>
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	1 1 1 1 1 1					
LOBBY						
RECEPTION AREA						
LAB ROOM						
KITCHEN & RESTROOMS						
COUNSELING ROOM						
DOCTOR'S OFFICE						
VACCU, SWEEP, MOP						
TRASH EMPTIED						
WEEK 4		*				
LOBBY						
RECEPTION AREA						
LAB ROOM			<u></u>			
KITCHEN & RESTROOMS						
COUNSELING ROOM						
DOCTOR'S OFFICE						
L_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 k to to the Autoclave Binder in the Scrub (autoclave) room.

Steam Plus Sterilization Integrator Cards are placed in the autoclave with each loaf of instruments. These car 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	<u>,</u>						
Thu							
Fri				·			The state of the s
Sat							
/Week 2 ≥							
Mon							
Tue							
Wed							
Thu						· · · · · · · · · · · · · · · · · · ·	
Fri				<u> </u>			
Sat				,,			
Week 3							
Mon							
Tue				<del>,</del> ,			
Wed							
Thu				<del></del>	· · · · · · · · · · · · · · · · · · ·		
Fri							
Sat				- <del>p. h </del>			
Week 4							
Mon							
Tue							
Wed			<u> </u>				
Thu							
Fri							
Sat							

#### **POLICY AND PROCEDUR - FORMS**

#### **AUTOCLAVE SPORE TESTING TRAY CARD RESULTS**

MONT	Ή	2016

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

Signature:				

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						The second secon		
Check door seals and gaskets	all many or "The Park"							
Check to make sure gauges and timers are working correctly							-	
Clean exterior autoclave				manager or a second				
Complete a spore indicator test recording all results								14 to 15 to
						N = N White		
Initials								
Year: Month:	Week 1	Week 2	Week 3	Week 4	Week 1	Week 2	Week 3	Week 4
Clean and Scrub interior of autoclave, including all loading trays					}			
Run cycle with Vinegar to clean internal pumps		A contract of the second of th						
Check door seals and gaskets								
Check to make sure gauges and timers are working correctly								
Clean exterior autoclave		3					- The state of the	
Complete a spore indicator test recording all results				į				
				,				
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 I	Date	Date Mailed	Initials	Results	Date Rec'd	Initials	Daily Cleaning Initials	Comments
Mon								
Tue								
Wed							······································	
Thu							F-77-11-11-11-11-11-11-11-11-11-11-11-11-	
Sat								
Week 2					1	-		
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 – F	Performs skill with competently knowledge.						
B - 1	Needs Review and Reinforcement						
C -	Needs Training						
D - I	N/A Employee:	··				· · · · · · · · · · · · · · · · · · ·	
		·····		<u> </u>			
	SKILL	A	В	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						
Emp	loyee Signature	Γ	Date_				
Prec	eptor Signature	[	)ate_				

### **POLICY AND PROCEDURE - FORMS**

### **QUALITY ASSURANCE**

### SKILLS OBSERVATIONS – SCRUB ROOM COMPETENCY

A	Performs skill with competently knowledge.					
	Needs Review and Reinforcement					
	Needs Training					
D –	N/A Employee Name:		<i>.</i>			and the second s
	SKILL	Α	В	С	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.					A 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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.					
Emp	loyee Signature	Date <sub>-</sub>		***************************************		1884-18-18-18-18-18-18-18-18-18-18-18-18-18-
Prec	eptor Signature	)ate				

FORMAPPROVED

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		BO0004642	B, WING			R
NAME OF	PROVIDER OR SUPPLIER		<del></del>		06/	20/2017
DELTA C	LINIC OF BATON RO	UGE, INC. 756 CO	LONIAL DRIV ROUGE, LA 7			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF (	CORPECTION	1 00
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFÉRENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPI COMPI DAT
{\$ 000}	Initial Comments	· · · · · · · · · · · · · · · · · · ·	(S 000)			
	#LA45116	rith a Complaint LA 45116 e cited for Complaint		Reviewed		
	Abbreviations:			<u></u>		
	DON Dire GB Governi	ninistrator ector of Nursing ing Body				
	LDH/HSS Lou Health/Health Stand LEERS Loui	isiana Electronic Event		8/11/8017		
	N/A Not appl	nsed Practical Nurse		<u> </u>		
	QAPI Performance Improv	Quality Assurance				
(S 055) 4	1409 B Changes in C nfo	Outpatient Abortion Facility	<b>(</b> S 055)			
t.	ne outpatient abortio doing business as" r elephone number, or	ation. Any change regarding n facility 's entity name, name, mailing address, rany combination thereof,	9			
s v c	shall be reported in within five calendar da within five calendar da hange regarding the susiness as" name re	riting to the department ays of the change. Any entity name or "doing equires a change to the				
o re lie	utpatient abortion fac equire a \$25 fee for t cense.	cility license and shall the issuance of an amended ministrative Personnel, Any				
ke w	hange regarding the ey administrative per riting to the departm	outpatient abortion facility's sonnel shall be reported in ent within five calendar				
1621th Sta RATORY DI	ndards Section RECTOR'S OR PROVIDER.	SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	. (2	(6) DATE

)17 ED

STATEMENT OF DEFICIENCIES	(X1) PROVIDERIOUS			FOR	MAPPROVE
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TPLE CONSTRUCTION NG:		E SURVEY
	B00004642	B. WING_			R
NAME OF PROVIDER OR SUPPLIER	SIRERTA			j j	20/2017
DELTA CLINIC OF BATON RO	OUGE, INC 756 COL	ONIAL DRI	(, STATE, ZIP CODE VE		
(X4) ID SUMMARY ST. PREFIX (EACH DEFICIENCE	VALUE OF DEFICIENCIES	ROUGE, LA	** * * * * * * * * * * * * * * * *		
TAG REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
days of the change. Chapter, key admin the administrator an	For the purposes of this istrative personnel includes and medical director, and the acility shall provide the	{\$ 055}	DEFICIENCY		
within 5 calendar days administrative person.  Findings:  During the entrance condition 10:10 AM, SF1Administrative person.  Findings:  During the entrance condition 10:10 AM, SF1Administrative person.  Personal interview and 10:10:10 AM, SF1Administrative interview and 10:10:10 AM, SF1Administrative interview and 10:10:10 AM, was appointed as the facetive 05/01/2017 SP	in writing to the department of a change in key nel.  Inference on 06/19/2017 at strator (ADM) introduced administrator and the active administrator on lards Section's (HSS) on 06/19/17 indicated urrent administrator, review of records on SF1ADM stated she cility's administrator in the active administrator.	i t	S 055  The current administration the mistaken notion that previous Administrator has submitted the Change of Personnel Form when the changed to the current Administrator.  Upon notification by the L Department of Health survithe discrepancy, we immediate the form to LDF of the Change of Key Persond the fax delivery notice extrached. Completed 06/26 fee EXHIBIT A.	the ad Key position  ouislana veyors of diately I. A copy onnel form	

If continuation sheet 2 of 15

### MEMORY TRANSMISSION REPORT

TIME

:06-20-117 10:57

FAX NO.1

: 2259244465

NAME

FILE NO.

: 619

DATE

: 06.20 10:55

TO

: **23** 3423073

DOCUMENT PAGES

START TIME

: 06.20 10:55

END TIME

: 06.20 10:57

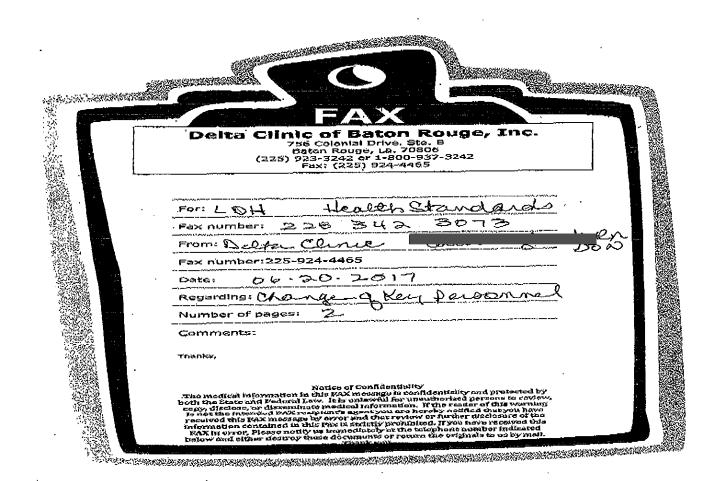
PAGES SENT

2

STATUS

0K

SUCCESSFUL TX NOTICE



### MEMORY TRANSMISSION REPORT

TIME

:07-27-'17 13:06

FAX NO.1

: 2259244465

NAME

FILE NO.

888

DATE

07.27 13:05

TO

: **8** 3420157

DOCUMENT PAGES

START TIME

07.27 13:05

BND TIME

07.27 13:06

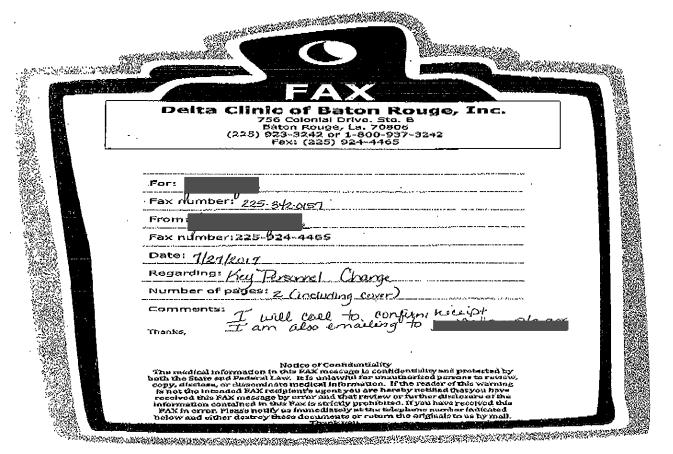
PAGES SENT

2

STATUS

OK

SUCCESSFUL TX NOTICE





### Delta Clinic of Baton Rouge, Inc. 756 Colonial Drive, Ste. B

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

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For:
Fax number: 225.342.0157
From:
Fax number:225-924-4465
Date: 7/27/2017
Regarding: Key Personnel Charge
Number of pages: 2 (including Cover)
Comments: I will call to confun thereight Thanks, I am also emailing to
Notice of Confidentiality  The 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

NO.6202

08/08/2017/TUE 09:22AM

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.

### DEPARTMENT OF HEALTH

### Health Standards Section

### KEY PERSONNEL CHANGE FORM

This form must be signed by the proposed	
Legal Entity Name: Delta Chrus.	Provider License #:
Agency DBA Name: Baton Roug, un	0.7
Address: 756 Colonial Dring & B	Provider CMS ID if applies#:
City, State, Zip: Baton Rouge, la 70804	
Talanhana Number	Administrator's Email Address:
225 924 444Z	-K'
Fax Number:	Proposed Employee's Email Address
225.924. 4465	(if available): deltachine 756 @gmail av
Circle the Position that is changing (Please circle only	y those appropriate to the Provider Type):
Administrator (the person with overall responsibility for	or the day-to-day administrative operations)
Director of Nursing (the RN providing leadership of m	rsing services — if applicable)
Medical Director (the physician providing oversight of	the clinical operations – if applicable)
Other:	
Name of previous employee in this position:	
Name of proposed employee for this position:	
Effective Date of Change: OS/01/2017	
Verification Date of Current LA Professional Licens	e: 12/31/2014
Please enter the date on which the agency verified the current profe licensure is a requirement for the position. The date should precede	essional licensure of the proposed employee, if
Attestations of Co	
We hereby certify that the proposed employee listed here set forth by the Louisiana Department of Health and Ho	ospitals (DHH), Health Standards Section; the
Conters for Medicare and Medicaid Services: and any o	ther regulatory agency applicable to the
Provider Type to function in the role indicated. We fur	ther understand that it is the responsibility of
the administrator to ensure that the agency maintains co	impliance with state and rederal regulations of
an ongoing basis. DHH Health Standards Section will b	be promptly notified of any changes to Key
Personnel.	
1	10000
	nosed Employee Date (mm/dd/yy)
Printed Name of Proposed Employee Signature of Pro	posed employee Date (minute))
	1. admin 6/20/17
Printed Name of Administrator LSignature of Ad	
PLEASE NOTE: This form is used for all Health Stan	dards Section licensed providers/suppliers.
I was a see one of the country and the formal in the country	icable state licensing regulations for the
Definitions of Key Personnel may be found in the apple specific Provider Type.	100010 3tttto 11001101112 108 mm

HSS-ALL-37 (originated 5/05/06, revised 04/08/2016)

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/

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DCBR Key personnel change form

3 messages

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

Thu, Jul 27, 1:39 PM

I received it-thank you.

Subject: DCBR Key personnel change form

[Quoted text hidden]

Thu, Jul 27, 1:42 PM

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

Health \$	Standards Section				I. CIUM	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3:	(X3) DATE	E SURVEY PLETED
·		BO0004642	B. WING	,		R 20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY,	STATE, ZIP CODE		
DELTA C	CLINIC OF BATON RO	oge. Inc	ONIAL DRIV ROUGE, LA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
<b>(</b> \$ 055 <b>)</b>	Continued From pa	ge 2	(S 055)		<u></u>	
	SF5ADM, effective of confirmed she was responsible for notificative the HSS - All -37 Kedated 05/01/2017 at SF1ADM as the admosfo1/2017. SF2DO SF5ADM faxed the everified there was not sent.  The State Office About DH/HSS, on 6/20/1 had not received any the Abortion Program provider of the provider.	DN stated she thought change to the department and of fax confirmation that it was ortion Program Desk at 7, confirmed that State Office written notification nor had n Desk been informed by the				
	ensuring the continued compliance state, and local state, and local state, and ordinate and	ody shall be responsible for: outpatient abortion facility's e with all applicable federal, statutes, laws, rules,	(S 109)			

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If continuation sheet 3 of 15

2259244465 WINUL

T-929 P0002/0004 F-990 FAUL VI/VO

RECEIVED 08/09/2017 12:10PM 5048962302 08-09-17 12:11 FROM-

WHOC 2259244465

T-927 P0011/0027 F-975 FORMATHUVELI

Health S	tandards Section TOF DEFICENCIES	O(1) PROVIDER/SUPPLIERICLIA	(X2) SSULTIPLE	E CONSTRUCTION	DOS DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	INCHTHICATION NUMBER:	A BUILDING:		
				·	05/20/2017
		BD0094642	e' AMO		1 darana
NAME OF F	ROVIDER OR SUPPLIER			STATE, ZIPCODE	1
· ·	LINIC OF BATON RO		NIAL DRIV		
DELIAC			OUGE, LA 7	BOYAROERS IN AN OF CORRECT	TON COMPLETE
(XA) KI PREFIX YAG	CACH CONTENT	TEMPORY OF DEFICIENCIES  A WITCH OF DEFICIENCIES  TEMPORY OF DEFICIENCIES	PREFIX YAG	(RICH CORRECTIVE ACTION SHOULD CRUSS REFERENCED TO THE APPRICACHENCY)	
(S 109)		•	{\$ 109}	,	
	regarding human for distribution or was condary as receives state fund addressed by law abortion procedure.  2. designating administrator and this person to operations of the factor and delegation allow himmer nursing personnel to each patient;  4. evaluating	e person to act as the delegating sufficient authority to manage the day-to-day		S 109 In an effort to comply wit regulations regarding the day window to submit painformation into the LEEF and complete the Induce Termination of Pregnance (ITOP), we have created procedures, forms and uplan-Do-Check-Act forms	thirty (30) tient IS program d y Report policies, tilized the
	This Rule is not met as evidenced by: Based on record review and interviews, the governing body falled 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.			Angela Adkins, Administration Assistant will be responsively reviewing the LEERS Log weekly to ensure the ITC submitted within the third window.  Procedure initiated 06/2	rative lible for lat least OP forms are lity (30) day
	Patient Care - Vill Form No. 2411 m	wider's Policy and Procedure: al Records Reporting. Policy ad in part: ance with LDH (Louisiana		See EXHIBIT B.	
DHHIHE	Standards Section		6010	78.5C 4 7 2	the desire to the state of the

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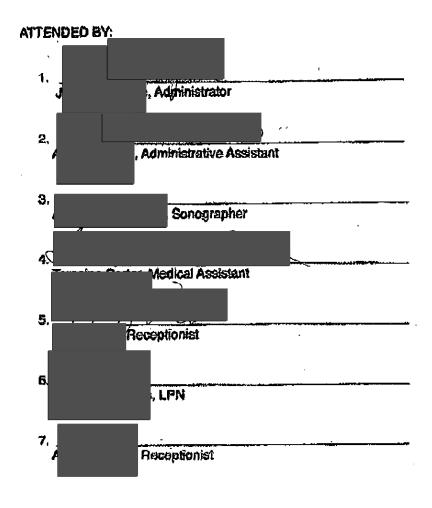
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the construction sheet 4 of 15

TOPIC: LEERS



DATE: JUNE 21, 2017



### 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.

Policy Number 2309

### QUALITY ASSURANCE LEERS LOG

		<del></del>			
	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.	Write policy, create log and Complete log and print reports.	As each page of the Log is complete, check to ensure the reports have been completed within the thirty (30) day window	Continue with process.	Signature QA Coordinator:  Date:
IDENITEY	PLAN	00	CHECK	ACT	
<del></del>	7	€ .	4	រេ	

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

DATE RECEIVED: LOT NUMBER OF BC EXPIRATION DATE:	DATE RECEIVED: LOT NUMBER OF BOX: EXPIRATION DATE:			PHYSICIAN:	AN:		
DATE	PATIENT'S NAME	CHART NUMBER	LOT NUMBER	MINOR	INITIALS	LEERS	LEERS
						Date Entered	Date Certifie
							:
·			,				
QA Audito	QA Auditor (Print name, Sign):				Date:		,
OA Audite	OA Auditor (Print name, Sign) :				Date:	is	

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

	100								
Weeks	Pt's Name	Chart #	Minor	Rh	Specimens				LEERS
					Sent to Stericycle	Sent to AML	Report Rec'd	Date Entered	Date Certified
				· · · · · · · · · · · · · · · · · · ·					
		`							
				:					
QA Audito	QA Auditor (Print name, Sign):			Ę		Date:			
OA Andito	Ob Anditor (Print name Sign)					Dafe.			
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FORMAPPROVED

Health	Standards Section				FOR	MAPPROVED
STATEME AND PLAI	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
		BO0004642	B. WING		06	R / <b>20/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DORESS, CITY S	STATE, ZIP CODE	1 00	120/2011
DELTA C	CLINIC OF BATON RO	UGE, INC 756 COL	ONIAL DRIVI	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{\$ 109}	Continued From page	ge 4	(S 109)		<u>'</u>	<del> </del>
	Department of Heal "Report of Induced" Performed in Louisia completed for each performed. The orig LDH, must be signed performed the servic submitted to LDH wi termination. Procedure: Effective of Induced Terminatic completed online in termination.	th) regulations, a vital record fermination of Pregnancy ana" (ITOP) is to be pregnancy termination inal report, the one sent to d by the physician who se The report must be thin thirty (30) days of the August 29, 2011 the "Report on of Pregnancy" is to be he LEERS system using the d by LDH. This form is to be	(3 109)			
t La FFF Ca	n part "C. All abortion the attending physicial coulsiana Department after the date of the a Patient #F3 Review of Patient #F3 Pregnancy (ITOP) reports of Termination of the Date Certified	i's Induced Termination of ort revealed Patient #F3's FPregnancy was 03/30/17				
R P D ar Pr Dr an	regnancy (ITOP) replate of Termination of all the Date Certified atlent #F7 eview of Patient #F7! egnancy (ITOP) repo	s Induced Termination of ort revealed Patient #F7's Pregnancy was 04/13/17				

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If continuation sheet 5 of 15

STATEMEN	Standards Section  NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		VIII		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
			A. BUILDING:		}	
		BO0004642	B. WING			R 20/2017
AME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S		1 00/	<u> </u>
SELTAC	I INIC OF DATON DO	770000	ONIAL DRIVI			
JELIA O	LINIC OF BATON RC		ROUGE, LA 7			
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID I	PROVIDER'S PLAN OF C	ORRECTION	(X5
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI		COMP
		, , , , , , , , , , , , , , , , , , ,		DEFICIENCY		
{\$ 109}	Continued From pa	age 5	(S 109)			
ļ						
	Patient #F9					
ľ	Review of Patient #	F9's Induced Termination of				
	Date of Tormination	report revealed Patient #F9's n of Pregnancy was 03/28/17				
	and the Date Certifi	ied was 05/01/2017.	j			
	Site the pate certifi	120 Was 00/01/2017.				
	During an interview	on 06/20/2017 at 3:55 PM,				
1	SF1Administrator (A	ADM) and SF2Director of				
	Nursing (DON) revi	ewed the ITOP reports for				ŀ
1.	Patients #F3, #F6, #	#F7, and #F9. Both verified				
	that the blooker did	not ensure compliance with	1			
	for Patients #F3 #F	ments when the ITOP reports 6, #F7, and #F9 were not				
	submitted to LEERS	S (Louisiana Electronic Event				
	Registration System	i) within thirty (30) days after	į į			
] 1	the date of the abor	tion.				i
S 159) 4	4425 -A Patient Med Requirements	d. Records/Reporting	{S 159}			
	•					
/	<ol> <li>General Provisio</li> </ol>					
	1. The outpatier	nt abortion facility shall		•		
		ain a patient medical record				
	•	nedical record shall be:				
		ly and accurately				
d	locumented; and	y tiva accurates,	[			
]	<ul> <li>b. readily av</li> </ul>	vailable and systematically	]	•	į	
0	organized to facilitate	e the gathering of				
-	information.	A — handra a da asiste da esta			į	
	o. The outpatient with editor	t abortion facility shall ensure acy and confidentiality of				
] ~	patient medical r	ecords, including information				
in	a computerized me	edical record system, in				
ſ	accordance with	the Health Insurance				
P	ortability and Accou	intability Act (HIPAA)				
r <i>e</i>	egulations, and/	or all applicable state laws,				
	iles, and regulations	or all abblicable grate laws,			1	

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If continuation sheet 6 of 15

	Standards Section				FORM	APPROVED
	CHO FEMA OF COURSE HOM I TORN HEICHTON NUMBER:		ŀ	PLE CONSTRUCTION 3:	(X3) DATE	SURVEY
		BO0004642	B. WING			₹ 20/2 <b>017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
DELTA (	CLINIC OF BATON RO	OGE, INC	ONIAL DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
{S 159}	Continued From pa	ge 6	{S 159}			
	the patient medical and/or breach o	shall be established to protect records from loss or damage of confidentiality in accordance tate laws, rules, and				
	interviews, the facilit were established to records from loss or	on, record review and by failed to ensure safeguards protect the patient medical damage and/or breach of ordance with all applicable		Regarding our new chart room, fireproof door was hung on 06/23/2017. The door will be locked at all tir with the key maintained in the business office front desk to eliminate patient access. The painting has been complet	nes	
	Patient Record Cont SF1ADM and SF2D0 read in part: Safegua	and Procedure Patient Care ents was presented by ON on 6/20/2017. The policy ards are established to lity and protection from fire, ees of damage.		with a third coat of paint. We are awaiting ICC Certification approve the painting. We antice this inspection and approval with will be september 9, 2017	ipate	N
	store patient medical SF1Administrator (Al 6/19/2017. The locat room was verified to	oset which the facility used to I records was conducted with DM) at 10:25 AM on ion of the medical records be in a hall across from a y the facility for medicated				
· · [	utilized this hallway to was also observed th	s observed that patients of access the restrooms. It that the door of the medical field a doorknob which only				

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If continuation sheet 7 of 15

<u>Health</u>	Standards Section				FOK	MAPPROVED
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 3:	(X3) DAT CON	E SURVEY APLETED
		BO0004642	B, WING			R /20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	, STATE, ZIP CODE	1 00	
DELTA (	CLINIC OF BATON RO	UGE, INC 756 COL	ONIAL DRIV	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{S 159}	Continued From pa	ge 7	{S 159}			
	locked from within to the doorknob had no from outside the roo	he medical records room and o keyhole to unlock the door orn.				
	room was painted o 2017 with a Fire Ref was currently walting	re Retardant door which was and be installed on				
İ	medical records room completely covered a paint. SF1ADM con- walls at the top near boards and around a switches. S1ADM ve	about the areas of the m which had not been with the white fire retardant firmed the areas included the the ceiling, near the base electrical boxes and light rified the medical records etely painted with the Fire				
	which she explained painting of the medic of paint was labeled a Retardant / Resistant An observation of the	manufacture's label on the noted in part, under the				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	retards a particular fir things, on (i) the amo the sole responsibility that Ff 88 has been a the application directi Thickness: All surfac applied should be ins	The amount by which Ff 88 to will depend, among other unt of Ff 88 applied It is of the applicator to ensure pplied in accordance with ons to which Ff 88 have been pected by an ICC certified that Ff 88 has been properly				

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If continuation sheet 8 of 15

<u>Health</u>	Standards Section				FORM	AFFKUVEL	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER;			PLE CONSTRUCTION	(X3) DATE	SURVEY	
			A. BOILDIN	G:	R		
 		BO0004642	B. WING _	<del></del>		0/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY	, STATE, ZIP CODE			
DELTA (	CLINIC OF BATON RO	OGE. ING	ONIAL DRI	•			
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
{S 159}	Continued From pa	ge 8	(S 159)	7940000		***	
	applied in the required When asked if the purpose in the provider had not obtain any such profession application of the Ff provider's medical records the medical records the medical records on 6/20/2017 at 10:1 the facility staff had medical records roof door if it was locked and the door was undays when patients and the door was undays when patients and the contration Friday (6/23/2017 Retardant door.  During an interview of 6/20/2017 at 10:45 A that the doorknob on was a bedroom style be locked from within explained that she st in the room early last medical records were room on Thursday 6/present in the hall an outside and across from edical records room that facility staff was in the facility staff was in t	red uniform thickness, provider had received an C certified professional to been properly applied in the ckness, SF1ADM said the tained any such inspection by all to ensure proper 88 paint used in the ecord room.  15 AM, SF2DON verified that room only locked from within room. During this interview 15 AM, SF1ADM confirmed no key or device to unlock them from the outside of the from the inside of the room able to be locked on clinic were across the hall from them. SF2DON and SF1ADM actor would be in the facility of to install the new Fire with SF3Receptionist verified the medical records room door knob which could only the room. SF3Receptionist verified arted putting patient records week and said patient eplaced in the unlocked 15/17 when patients were dwaiting room located om the door of the unlocked on SF3Receptionist verified not always present or in line all records room where	(5.159)				

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If continuation sheet 9 of 15

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WHCC 2259244465

T-927 P0019/6027 F-975 FORMAPPROVED

	TAY EMENT OF DEPICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDENCIA PLENCIA (CENTRICATION MUMBER:  BOSON4642		PYS) MULTIPA BYNDYNG	E CONSTRUCTION	COMPLETED	
			B. Wing		06/20/2017	
	PROVIDER OR SUPPLIER	INGE INC. 756 COLO	dress, City, DNIAL DRIV OUGE, LA	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DESKUENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREFOX TAG	PROVIDERS PLAN OF CORRECT (ENCH CORRECTIVE ACTION SHOU CROSS REFERENCES TO THE APPRI DEFICIENCY)	ION (X6) LO BE COMPLET PRIME DATE	
	Requirements  E. Other Reports, shall maintain a dail receiving a surgical abortion. Patients in corresponding to the This daily patient to period of three years. I. The outpatient abortion reporting requirements, the induced tenderal, state, a ordinances, and de regulations.  2. The outpatient abortion in accordance with a condance with a condance with a condance with a condance with a canal knowledged on record refailed to ensure that documentation to excompliance with the compliance with the compli	Med Records/Reporting  The outpatient abortion facility ity patient roster of all patients for chemically induced hay be identified be patient's medical record, ester shall be retained for a sirements ent abortion facility shall estion to support that the infacility is compliant with all ents, including, but not limited mination of pregnancy (ITOP) umentation as required by and local statutes, laws, partment rules and ent abortion facility shall report all applicable state laws for crimes against a child that limited to:  Ty;  ledge of a juvenile	(S 169) (S 169)	S 169  We have initiated processe ensure that the Clinic is in compliance with the state requiring ITOP reports white completed and certified with days. We created a form a initiated a policy and proceed ensure the documentation completed timely. All approximates a serviced on the and procedure. Angela Adl Administrative Assistant with responsible for reviewing the Log at least weekly to ensure the thirty (30) day window Established 06/21/2017.  See EXHIBIT B	statute ich will be ithin thirty nd edure to is being copriate e policy kins, ill be the LEERS	

ii contrastion sheet 10 of 15

STATEME	Standards Section  NT OF DEFICIENCIES	(X1) PROVIDERIES INC.			1 ON	IAPPROVE
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		E CONSTRUCTION		E SURVEY PLETED
		PO200 to to		VIII		R
NAME OF	PROVIDER OR SUPPLIER	BO0004642	B, WING		1 '	20/2017
				STATE, ZIP CODE		
DELTA C	LINIC OF BATON RO		ONIAL DRIVI OUGE, LA 7			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	10	PROVIDER'S PLAN OF CO	ORRECTION	(٧5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	IN SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
(S 169)	Continued From pa	ge 10	{S 169}			
	days after the date of #F3, #F6, #F7, and sampled patients.	of the abortion for 4 (Patients F#9) of 9 (Patients #1 - #9)			•	
	Findings:					
	in part "C. All abortic the attending physici	:1061.21 Reports, revealed, ons reports shall be signed by ian and submitted to the nt of Health within thirty days abortion"				
	≺regnancy (HOP) re	3's Induced Termination of port revealed Patient #F3's of Pregnancy was 03/30/17 d was 05/01/2017.				
F F D	'regnancy (ITO₽) rei	5's Induced Termination of bort revealed Patient #F6's if Pregnancy was 03/28/17 if was 05/01/2017.				
R P D	regnancy (ITOP) rep	's Induced Termination of port revealed Patient #F7's f Pregnancy was 04/13/17 was 05/15/2017.				
P. R. P.	atient #F9 eview of Patient #F9 regnancy (ITOP) rep	's Induced Termination of ort revealed Patient #F9's Frequency was 03/28/17				
Sh	uring an interview on 1Administrator (ADI dards Section	06/20/2017 at 3:55 PM, M) and SF2Director of				

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WHCC 2259244465

T-927 P0021/0027 F-975

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	TEMENT OF DEFICIENCES (X1) PROVIDER SUPPLERICUS (X1) PROVIDER SUPPLERI		PARTICIPAL (EZG) PARTICIPAL A	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 08/20/2017	
		BO0004642	e. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY,	STATE, 24 CODE		
DELTA C	LINIC OF BATON RO	DESC. IMA.	NIAL DRIV			
		BAJONR	OUGE, LA		7	
(X4) (Q PREFIX TAG	TEACH DEFICIENCY	Tement of Deficiencies I must be preceded by full BC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREST IN (ENCH DORRESTIVE AUTHORISHOUL CROSS-REFERENCED TO THE APPROX DEFICIENCY)	DBE [	COMPLETE DATE
(8 169)	Continued From pa	ge 11	(S 169)			 
	Patients #F3, #F6, and that the provider diction requires for Patients #F3, #F submitted to LEER: Registration System termination.  4427 A-1 Quality As improvement Pro  A. The outpatient develop, implement annually review a warm to approval by the grant systems in piace to which quality monital improvement activity program shall inclusive identified issues incomorkoning the effect and making necess action.  1. Plans of Actificality shall develop of action designed for which quality monitality monitality mich quality monitality mich quality monitality mich quality monitality mich grant making necess action designed for which quality monitality monitality mich quality monitality mich quality monitality mich quality monitality mich quality quality quality quality quality quality quality quality quality	ewed the ITOP reports for #F7, and #F9. Both verified I not ensure compliance with ments when the ITOP reports 6, #F7, and #F9 were not 5 (Louistana Electronic Event 6) Within thirty (30) days of the esturance/Performance abortion facility shall abortion facility shall enforce, maintain, and effectively identify issues for aring and performance ies are necessary. The QAPI be plane of action to correct buding, but not limited to, at of implemented changes any revisions to the plan of and implement a QAPI plan ito effectively identify issues mitoring and performance shuttes are necessary.	{S 171}	A system has been created monitor the timey reporting Angela Adkins, Administrati Assistant will be responsible reviewing the LEERS Log at weekly to ensure the ITOP is have been submitted within thirty (30) day window. A form and policy and procedure been created. Staff has in-serviced. In addition to monitoring ti reporting of the ITOP, a system implemented to monitoring of the ITOP, a system implemented to monitoring to the implemented to monitoring to the implemented to monitoring to the implemented to monitoring to the implemented to monitoring the receipt of pathology report products of conception. Powritten and forms created. Teresina Carter, medical as receives the reports and with the receipt, a follow-up of reports not retimely. She has been in-ser Recording data entry began	g of ITO ve a for least forms in the edure as been mely tem has itor the is for licies Ms isistant ill be and ceived viced.	
	Based on record per outpatient abortion	new and interview, the facility falled to put a ffectively monitor the effect of		06/21/2017. See EXHIBIT B		

Hooms wellen short 12 of 15

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DHI-Weith Standards Section STATE FORM

Health 9	Standards Section				FURIN	V 11/0450
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		BO0004642	B. WING			R 2 <b>0/2017</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY.	STATE, ZIP CODE		
DELTA C	LINIC OF BATON RO	UGE, INC 756 COL	ONIAL DRIV	Æ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  EFIX (EACH CORRECTIVE ACTION SHOULD BE		
{S 171}	Continued From pa	ge 12	{S 171}			
	necessary revisions to ensure compliant requiring ITOP (Indu Pregnancy) reports physician and subm Department of Heal date of the abortion and F#9) of 9 (Patie patients.	es, identify issues, and make to the plan of action by failing the with the state statute used Termination of to be signed by the attending litted to the Louisiana th within thirty days after the for 4 (Patients #F3, #F6, #F7, ents #F1 - #F9) sampled				
·	in part "C. All abortion the attending physic	:1061.21 Reports, revealed, ons reports shall be signed by ian and submitted to the ont of Health within thirty days abortion"				
	Pregnancy (ITOP) re	F3's Induced Termination of eport revealed Patient #F3's of Pregnancy was 03/30/17 ed was 05/01/2017.				
	Pregnancy (ITOP) re	6's Induced Termination of eport revealed Patient #F6's of Pregnancy was 03/28/17 ed was 05/01/2017.			,	
	Pregnancy (ITOP) re	7's Induced Termination of port revealed Patient #F7's of Pregnancy was 04/13/17 d was 05/15/2017.				
1		9's Induced Termination of port revealed Patient #F9's	ļ			

STATE FORM

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If continuation sheet 13 of 15

Health Stan	idards Section				, 4, 4,,	- •
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		BO0004642	B. WING			₹ 20/2017
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
DELTA CLIM	IO OE BATON BOI	756 001	ONIAL DRIV			
DELIA CLIN	IC OF BATON ROU	JUE. INC.	OUGE, LA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{\$ 171} Co	ontinued From pag	ge 13	{S 171}			
Da	ite of Termination	of Pregnancy was 03/28/17 ed was 05/01/2017,				
SF Nu SF Da be be dual LEI System par Improve SF2 be improve of the report of the subject of the	rsing (DON) on 6. 2DON stated that ta Compiled, which compiled and the collected, such as arterly, or annually ERS (Louisiana Estem) was listed of collected monthly the first of the Quality As provement (QAPI) inpliance with the 2DON stated that the QA (Quality As plemented March 2DON stated that ponsible for review the ITOP (Induced orts. When asked the ITOP (Induced orts. When asked the ITOP (Induced orts. When asked the ITOP) (Induced orts. When asked the ITOP) (Induced orts. When asked the ITOP) (Induced orts. When asked the ITOP) (Induced orts. When asked the ITOP) (Induced orts. When asked the ITOP) (Induced orts. When asked the ITOP) (Induced orts. When asked the ITOP) (Induced that the longuistic of ITOP) (Induced that ITOP) (In	ADM) and SF2Director of /20/2017 at 3:55 PM. It she created the form titled the listed all data that should a time frame that data should a time frame that data should s daily, weekly, monthly, y. S2DON confirmed that electronic Event Registration on the form and data was to y. SF2DON verified this was assurance and Performance and Performance of Program to ensure ITOP reporting requirements. She considered this form to ssurance) Chart and it was				

STATE FORM

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If continuation sheet 14 of 15

Health Standards Section STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		F CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		1				R	
	, , , , , , , , , , , , , , , , , , ,	BO0004642	B. WING			20/201	
VAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
DELTA Ç	LINIC OF BATON RO		ONIAL DRIVE				
		BATON	ROUGE, LA 7	0806			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC	CORRECTION	(X COMP	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DA	
(\$ 171 <sub>}</sub>	Continued From pa	age 14	{\$ 171}		· · · ·	<u> </u>	
		porting requirements was	10 11 13				
	effective because the	here were no identified issues					
	and all ITOP report	s were submitted as per the					
1	requirements. She	stated that the facility should					
	no aware is there w	ere issues or problems.					
	SF1ADM and SF2D	OON reviewed the ITOP					
J	reports for Patients	#F3, #F6, #F7, and #F9					
	Both Veritied that the	e provider did not ensure reporting requirements when				1	
	the ITOP reports for	reporting requirements when Patients #F3, #F6, #F7, and					
	#F9 were not submi	itted to LEERS (Louisiana					
	Electronic Event Re	gistration System) within thirty					
	(30) days of the term Sevealed that the or	mination. SF1Administrator ovider created a QAPI					
i	Program, approved	by the governing body, but					
įt	here was no system	n in place to effectively	ļ				
1	nonitor and identify equirements.	issues with the reporting					
'	ogunernents.						
	•				j		
					ļ		
T T			1				

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If continuation sheet 15 of 15

PRINTED: 10/04/2018 FORM APPROVED

Health Standards Section

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
711012711	or contraction	BERTHOWNSER	A. BUILDING:			
		BO0004642	B. WING		11/0	7/2017
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
DELTA CL	INIC OF BATON ROUGE	, INC 756 COLON BATON RO	IIAL DRIVE UGE, LA 7080	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{S 000}	Initial Comments		{S 000}			
	An onsite revisit was deficiencies cited on 0 from this survey have #LA46736 was also in	conducted for all previous 06/20/2017. All deficiencies been corrected. Complaint exestigated during this deficiencies were cited for				

DHH/Health Standards Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

11/28/17

John Bel Edwards GOVERNOR



### 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 <u>compliance</u> with licensing standards.

Enclosed for your completion and prompt response is the <u>STATE FORM</u> (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, <u>Required Components for the Plan of Correction</u>, 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 <u>SIGNIFICANT FINDINGS</u> 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.