STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9004	A. BUILDING _____ B. WING _____	12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRTH CONTROL CARE CENTER	872 E SAHARA AVE, LAS VEGAS, NEVADA ,89104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual permit survey conducted at your facility on 12/11/19. This State Permit Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Outpatient Facilities. Five patient records and nine employee records were reviewed. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		
0140 SS= F	NAC 449.999448 (1) - Professional standards of practice - NAC 449.999448 In addition to the guidelines established pursuant to NAC 449.999441, the holder of a permit to operate an outpatient facility shall establish guidelines and maintain policies for the outpatient facility which: 1. Ensure the health, safety and well-being of patients of the outpatient facility; Inspector Comments: Based on observation, document review, record review and interview, the facility failed to maintain professional standards of practice by ensuring: 1) Medications were stored in a secure manner; 2) Follow-up calls were made to 1 of 4 surgical patients within 24-48 hours, per facility policy (Patient #2); and 3) Filters for the transvaginal ultrasound probes were changed per manufacturer instructions. Findings include: 1) Medications Storage: On 12/11/19 at 9:15 AM, the facility crash cart was unlocked. The medications and needles for the crash cart were located on top of the crash cart. The crash cart had a lock on it. The crash cart was located in a room at the end of the facility's main hallway. The two procedure rooms were across from the room. The door to the room was open. There was an unnamed person sitting alone in the room at the time of observation. There was also a working desk in the room. The Administrator	0140	The Surgical Tech will ensure the facilities crash cart will be secured via a locked medication room, that is locked at all times. The leadership staff and physicians will have a key and access to the locked medication room. Staff had training on securing the crash carton Thursday January 2, 2020. In addition, all syringes, needles and medications will be kept in a drawer/cabinet that can be locked in surgery rooms one and two for patient safety and needle security. Staff assigned to respective surgery room shall be responsible to ensure drawers and cabinets are locked. Patients will be accompanied by staff at all times in Surgery Room. Other medication in the common area will be moved to a locked cabinet within the common area. All staff will have access to the locked cabinet. The leadership staff will ensure the cabinet is locked at all times. The refrigerator in the common area will have a lock installed on January 8, 2020. The facility will implement the Medication and Needle Security Policy effective December 23, 2019. The policy is attached. All staff had training on this policy on	01/02/2020

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	indicated an unawareness of who the person in the room was and they were probably a student in training. Employees and patients were observed passing the room going to and/or from procedure rooms. Some of the medications on the crash cart included: Midazolam, Naloxone, nitroglycerin, romazicon, Labetalol, flumazenil, ephedrine, atropine and Metoprolol Tartrate. There were needles and syringes on top of the crash cart. On 12/11/19 in the morning, the interim Infection Prevention and Control Manager confirmed the cart was unlocked and verbalized the cart was unlocked during the day for convenience. There was no indication of where the medications on top of the crash cart were stored at the end of the day. On 12/11/19 at 9:20 AM, unsecured medications, syringes and needles were observed as follows: -Surgery Room 1 drawers, included medications such as misoprostol 200 milligrams (mg), BD needles, catheters, IV start syringes and needles. -Surgery Room 2 drawers, included medications, syringes and BD Insyte Autoguard Winged IV catheters. On 12/11/19 at 9:20 AM, the interim Infection Prevention and Control Manager confirmed the observation and reported patients were left in the rooms alone to dress and undress for procedures. On 12/11/19 at 9:50 AM, the refrigerator in the facility common area (pathway to procedure rooms) was unlocked. The refrigerator contained Methylergonovic, Vasostrict, Anti D Bland. On 12/11/19 at 9:50 AM, the interim Infection Prevention and Control Manager confirmed the observation and explained the refrigerator was always unlocked. On 12/11/19 in the afternoon, the Administrator confirmed there was no facility policy for crash cart or medication and needle security. There was a facility policy for the security of narcotics. 2) Patient Follow-Up Calls: Patient #2 (P2) P2 was admitted on 12/3/19 for a surgical procedure. The facility document titled May We Call You? documented patients had a choice of giving permission for facility contact with the patient 24 to 48 hours after the surgical procedure, to ask questions and check on patient well being. P2 signed the May We		January 2, 2020. The GUS G10VP Wall-Mounted Disinfection Soak Station for Transvaginal and Transrectal Ultrasound Probe (GUS) filter change log is now in place and located in the common area. The medical assistant responsible for changing and documenting the filter changes, will circle the date of when the filter was changed, initial and sign the log. The manufacturers instructions for use indicates the filter to be changed every six months. All staff that reprocesses the transvaginal ultrasound probes had training on this filter change log on December 26, 2019. A policy was modified to facilitate documentation of post procedural follow up calls in the event team members were unable to reach the patient during the initial follow up call. The back office Lead Medical Assistant will continue to monitor for compliance with follow up calls on a monthly basis. All staff underwent follow up training on this procedure and the new policy on December 26, 2019.	

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	Call You? document on 12/3/19, giving the facility permission to make contact 24 to 48 hours after their procedure. An initial follow-up call was placed to the patient on 12/5/19. There was no answer and a voicemail message was left. There was no documented second contact attempt. On 12/11/19 at 10:23 AM, the interim Infection Prevention and Control Manager confirmed no second call attempt was made. The interim Infection Prevention and Control Manager explained the follow-up call process. Surgery patients filled out a form (May We Call You?) if they were agreeable to a call 24 to 48 hours after a surgical procedure, or the patient could decline. If the patient gave permission, all were called. If there was no answer, the facility would leave a voicemail message. Two attempts were made by either phone call, text or email. A note was placed in the patient's chart regarding tried and successful follow-up attempts. 3) Ultrasound Probe Filter Changes: The GUS G10VP Wall-Mounted Disinfection Soak Station for Transvaginal and Transrectal Ultrasound Probes Operator's Manual (undated), documented the patented filter had a six-month life in normal everyday use. On 12/11/19 in the morning, a small blue sign was attached to the transvaginal ultrasound probe machine in a procedure room, that indicated to replace filter on 2/20/20. There was no filter change log located on the machine and no filter change log could be provided by the facility. On 12/11/19 in the morning, a Medical Assistant responsible for changing and documenting the filter changes, explained the process, reporting the change was documented in red on the scope or probe log and highlighted. The Medical Assistant could not locate documentation of a filter change after 2/18/19, expressing they documented it but could not find that documentation. On 12/11/19 at 2:49 PM, the interim Infection Prevention and Control Manager indicated the facility changed the ultrasound filters based on manufacturer instructions. Severity: 2 Scope: 3			