Health Standards Section

FORM APPROVED

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments Follow Up Survey with a Complaint LA 45116 No deficiencies were cited for Complaint #LA45116 Abbreviations: ADM Administrator DON Director of Nursing GB Governing Body ITOP Induced termination of pregnancy LDH/HSS Louisiana Department of Health/Health Standards Section LEERS Louisiana Electronic Event Registration System LPN Licensed Practical Nurse N/A Not applicable QA Quality Assurance QAPI Quality Assurance Performance Improvement RN Registered Nurse	{S 000}	Reviewed 8/11/2017 [illegible] RN	
{S 055}	4409 B Changes in Outpatient Abortion Facility Info B. Change of Information. Any change regarding the outpatient abortion facility 's entity name, "doing business as" name, mailing address, telephone number, or any combination thereof, shall be reported in writing to the department within five calendar days of the change. Any change regarding the entity name or "doing business as" name requires a change to the outpatient abortion facility license and shall require a $25 fee for the issuance of an amended license. C. Change of Key Administrative Personnel. Any change regarding the outpatient abortion facility's key administrative personnel shall be reported in writing to the department within five calendar	{S 055}		

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PRINTED: 07/10/2017
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{S 056}	Continued From page 1 days of the change. For the purposes of this Chapter, key administrative personnel includes the administrator and medical director, and the outpatient abortion facility shall provide the individual's name, hire date, and qualifications as defined in this Chapter. This Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to report in writing to the department within 5 calendar days of a change in key administrative personnel. Findings: During the entrance conference on 06/19/2017 at 10:10 AM, SF1Administrator (ADM) introduced herself as the facility's administrator and explained she became the active administrator on 05/01/2017. Review of Health Standards Section's (HSS) licensing software (POPS) on 06/19/17 indicated that SF5ADM was the current administrator. During an interview and review of records on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator effective 05/01/2017. SF1ADM confirmed that she did not notify the department in writing within 5 calendar days when she became administrator on 05/01/2017. During this interview on 06/20/2017 at 10:05 AM,	{S 055}	**S 055** The current administration was of the mistaken notion that the previous Administrator had submitted the Change of Key Personnel Form when the position changed to the current Administrator. Upon notification by the Louisiana Department of Health surveyors of the discrepancy, we immediately submitted the form to LDH. A copy of the Change of Key Personnel form and the fax delivery notice is attached. Completed 06/20/2017. See EXHIBIT A.	

MEMORY TRANSMISSION REPORT

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

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

*** SUCCESSFUL TX NOTICE ***

FAX

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

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

Thanks,

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

MEMORY TRANSMISSION REPORT

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

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

*** SUCCESSFUL TX NOTICE ***

FAX

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

For: Jennifer
Fax number: 225-342-0157
From: Jackie Dupenne
Fax number: 225-924-4465
Date: 7/27/2017
Regarding: Key Personnel Change
Number of pages: 2 (including cover)
Comments: I will call to confirm receipt
I am also emailing to jennifer.haines@la.gov
Thanks,

Notice of Confidentiality
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Thank you.

FAX

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

For: Jennifer

Fax number: 225-342-0157

From: Jackie Bayonne

Fax number: 225-924-4465

Date: 7/27/2017

Regarding: Key Personnel Change

Number of pages: 2 (including cover)

Comments: I will call to confirm receipt
I am also emailing to jennifer.Haines@la.gov

Thanks,

DEPARTMENT OF HEALTH

Health Standards Section

KEY PERSONNEL CHANGE FORM

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

Legal Entity Name: Delta Clinic OP **Agency DBA Name:** Baton Rouge, LLC	**Provider License #:** 07
Address: 756 Colonial Drive A B **City, State, Zip:** Baton Rouge, La 70804	**Provider CMS ID if applies#:**
Telephone Number: 225 924. 4442	**Administrator's Email Address:** Kjackiebayonne@gmail.com
Fax Number: 225. 924. 4465	**Proposed Employee's Email Address (if available):** deltaclinic756@gmail.com

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

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

Name of previous employee in this position: LUNA KAWASH
Name of proposed employee for this position: JACKIE BAYONNE
Effective Date of Change: 09/01/2017

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

Attestations of Compliance

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

Printed Name of Proposed Employee	Signature of Proposed Employee	Date (mm/dd/yy)
JACKIE BAYONNE	Jackie Bayonne	11/20/17
Printed Name of Administrator	**Signature of Administrator**	**Date (mm/dd/yy)**
LUNA KAWASH	Lauren Glover RN, DON for Luna Kawash, Admr	6/20/17

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.

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/

in:sent

Gmail

Move to Inbox More 1 of 485

COMPOSE

Inbox (1)
Starred
Important
Sent Mail
Drafts (51)
[Imap]/Drafts
[Imap]/Sent
[Imap]/Trash (525)

Jackie +

No Hangouts contacts
Find someone

DCBR Key personnel change form

Jackie Bayonne <jackiebayonne@ 1:14 PM (0 minutes ago)
to Jennifer.Haines

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

Jennifer.Haines
jennifer.haines@la.gov
Show details

Click here to Reply or Forward

Gmail

Jackie Bayonne <jackiebayonne@gmail.com>

DCBR Key personnel change form

3 messages

Jackie Bayonne <jackiebayonne@gmail.com> Thu, Jul 27, 1:14 PM
To: <Jennifer.Haines@la.gov>

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

Jennifer Haines (LDH) <Jennifer.Haines@la.gov> Thu, Jul 27, 1:39 PM
To: Jackie Bayonne <jackiebayonne@gmail.com>

I received it-thank you.

From: Jackie Bayonne [mailto:jackiebayonne@gmail.com]
Sent: Thursday, July 27, 2017 1:14 PM
To: Jennifer Haines (LDH)
Subject: DCBR Key personnel change form

[Quoted text hidden]

Jackie Bayonne <jackiebayonne@gmail.com> Thu, Jul 27, 1:42 PM
To: Jennifer Haines (LDH) <Jennifer.Haines@la.gov>

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

Health Standards Section

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

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

TOPIC: LEERS

PRESENTED BY: JACKIE BAYONNE, ADMINISTRATOR

DATE: JUNE 21, 2017

ATTENDED BY:

1. _____
Jackie Bayonne, Administrator

2. _____
Angela Adkins, Administrative Assistant

3. _____
Aldreicka Armstead, Sonographer

4. _____
Teresina Carter, Medical Assistant

5. _____
Mary Webb, Receptionist

6. _____
Shan Tina Banks, LPN

7. _____
Ashley Landry, Receptionist

POLICY AND PROCEDURE

PATIENT CARE

LEERS LOG

POLICY

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

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

PROCEDURE

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

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

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

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

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

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

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

QUALITY ASSURANCE
LEERS LOG

1	IDENITFY	Need a way to ensure LEERS reports are entered into the system within the thirty (30) day window.
2	PLAN	A. Create a log to track LEERS input. B. Document the day the information is entered into the system. C. Notify physician they may certify each entry. D. Print each LEERS E. Document the certification date on the log.
3	DO	Write policy, create log and Complete log and print reports.
4	CHECK	As each page of the Log is complete, check to ensure the reports have been completed within the thirty (30) day window
5	ACT	Continue with process.
		Signature QA Coordinator: Administrator Date: 12/2/17

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

DATE RECEIVED: _____ PHYSICIAN: _____

LOT NUMBER OF BOX: _____

EXPIRATION DATE: _____

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

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

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

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

DATE: _____ PHYSICIAN: _____

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

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

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

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

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

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 159}	Continued From page 8 applied in the required uniform thickness. When asked if the provider had received an inspection by an ICC certified professional to verify that Ff 88 has been properly applied in the required uniform thickness, SF1ADM said the provider had not obtained any such inspection by any such professional to ensure proper application of the Ff 88 paint used in the provider's medical record room. On 6/20/2017 at 10:15 AM, SF2DON verified that the medical records room only locked from within the medical records room. During this interview on 6/20/2017 at 10:15 AM, SF1ADM confirmed the facility staff had no key or device to unlock the medical records room from the outside of the door if it was locked from the inside of the room and the door was unable to be locked on clinic days when patients were across the hall from the medical records room. SF2DON and SF1ADM stated that the contractor would be in the facility on Friday (6/23/2017) to install the new Fire Retardant door. During an interview with SF3Receptionist on 6/20/2017 at 10:45 AM, SF3Receptionist verified that the doorknob on the medical records room was a bedroom style door knob which could only be locked from within the room. SF3Receptionist explained that she started putting patient records in the room early last week and said patient medical records were placed in the unlocked room on Thursday 6/15/17 when patients were present in the hall and waiting room located outside and across from the door of the unlocked medical records room. SF3Receptionist verified that facility staff was not always present or in line of sight of the medical records room where patient records were stored.	{S 159}		

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

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

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

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	BO0004642	A. BUILDING: _____ B. WING _____	R 08/20/2017

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{S 171}	Continued From page 12 implemented changes, identify issues, and make necessary revisions to the plan of action by failing to ensure compliance with the state statute requiring ITOP (Induced Termination of Pregnancy) reports to be signed by the attending physician and submitted to the Louisiana Department of Health within thirty days after the date of the abortion for 4 (Patients #F3, #F6, #F7, and F#9) of 9 (Patients #F1 - #F9) sampled patients. Findings: Review of LA RS 40:1061.21 Reports, revealed, in part "C. All abortions reports shall be signed by the attending physician and submitted to the Louisiana Department of Health within thirty days after the date of the abortion..." Patient #F3 Review of Patient #F3's Induced Termination of Pregnancy (ITOP) report revealed Patient #F3's Date of Termination of Pregnancy was 03/30/17 and the Date Certified was 05/01/2017. Patient #F6 Review of Patient #F6's Induced Termination of Pregnancy (ITOP) report revealed Patient #F6's Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 05/01/2017. Patient #F7 Review of Patient #F7's Induced Termination of Pregnancy (ITOP) report revealed Patient #F7's Date of Termination of Pregnancy was 04/13/17 and the Date Certified was 05/15/2017. Patient #F9 Review of Patient #F9's Induced Termination of Pregnancy (ITOP) report revealed Patient #F9's	{S 171}		

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{S 171}	Continued From page 13 Date of Termination of Pregnancy was 03/28/17 and the Date Certified was 06/01/2017. An interview was conducted with SF1Administrator (ADM) and SF2Director of Nursing (DON) on 6/20/2017 at 3:55 PM. SF2DON stated that she created the form titled Data Compiled, which listed all data that should be compiled and the time frame that data should be collected, such as daily, weekly, monthly, quarterly, or annually. S2DON confirmed that LEERS (Louisiana Electronic Event Registration System) was listed on the form and data was to be collected monthly. SF2DON verified this was part of the Quality Assurance and Performance Improvement (QAPI) Program to ensure compliance with the ITOP reporting requirements. SF2DON stated that she considered this form to be the QA (Quality Assurance) Chart and it was implemented March 20, 2017. SF2DON stated that SF1Administrator was responsible for reviewing all patient records and identifying any issues with the timely certification of the ITOP (Induced Termination of Pregnancy) reports. When asked if the QAPI program should have identified any issues with the ITOP reports not being certified within 30 days after the dates of abortions, SF1ADM replied yes because she (SF1ADM) reviewed every patient record and would have identified a problem. SF1ADM explained that she looked at every patient record to ensure that ITOP reports were certified as per the regulatory requirement and stated there were no patients since 3/18/2017 that were not submitted within 30 days as required. SF2DON agreed that the current action plan of SF1ADM reviewing every patient record to ensure	{S 171}		

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