FORMAPPROVED

| STATEME                        | Standards Section  NT OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MIR TIO  | LE CONSTRUCTION  | 222.5                          | APPRO                 |
|--------------------------------|--|--|---------------|--|--------------------------------|-----------------------|
| AND PLAN                       | OF CORRECTION  | IDENTIFICATION NUMBER:   |               | :  | COM                            | E SURVEY<br>PLETED    |
|                                |  | BO0004642  | B, WING       |  |                                | R<br>2 <b>0/201</b> 1 |
| NAME OF                        | PROVIDER OR SUPPLIER   |  | DORESS OTV    | STATE, ZIP CODE  | 1 06/                          | 201201                |
| DELTA C                        | CLINIC OF BATON RO   | UGE, INC 756 COL   | ONIAL DRIV    | E  |                                |                       |
| (X4) ID                        | SUMMARY STA  | TEMENT OF DEFICIENCIES   | iD            | PROVIDER'S PLAN OF (                                     | CORRECTION                     |                       |
| PREFIX<br>TAG                  | REGULATORY OR L  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG | (EACH CORRECTIVE ACT) CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X)<br>COMPI<br>DAT   |
| {S 000}                        | Initial Comments   |  | (5 000)       |  | ·············                  |                       |
|                                | Follow Up Survey w<br>No deficiencies wer<br>#LA45116<br>Abbreviations;  | vith a Complaint LA 45116<br>e cited for Complaint   |               | Reviewed   |                                |                       |
|                                | DON Dire GB Governi ITOP Indu LDH/HSS Lou  | iced termination of pregnancy islana Department of   | }             | <u>&amp;</u>   |                                |                       |
|                                | Health/Health Stand LEERS Lou Registration System LPN Lice N/A Not app.  | ards Section<br>isiana Electronic Event<br>insed Practical Nurse<br>licable<br>Assurance<br>Quality Assurance  |               | 1/2017   |                                |                       |
| <b>(</b> \$ 055)               |  | ed Nurse  Outpatient Abortion Facility   | {\$ 055}      | 3,   |                                |                       |
| ti<br>s<br>v<br>o              | ne outpatient abortion doing business as relephone number, or shall be reported in within five calendar distange regarding the business as rame noutpatient abortion far | ation. Any change regarding in facility 's entity name, name, mailing address, any combination thereof, writing to the department ays of the change. Any entity name or "doing equires a change to the cility license and shall the issuance of an amended |               |  |                                |                       |
| C<br>c<br>k<br>w<br>Health Sta | Change of Key Adr<br>hange regarding the<br>ey administrative per<br>riting to the departm   | ministrative Personnel. Any outpatient abortion facility's sonnel shall be reported in ent within five calendar  |               |  |                                |                       |
| RATORY DI                      | RECTOR'S OR PROVIDER   | /SUPPLIER REPRESENTATIVE'S SIGNA   | ATURE         | TITLE  | . (2                           | ®) DATE               |

)17 ED

| TAG CROSS-REPERFUCED TO THE ADDITION OF THE AD   | 0745       | Standards Section       |                               |              |                                   | PRIMIE    | U: 07/10/20 |
|--|------------|-------------------------|-------------------------------|--------------|-----------------------------------|-----------|-------------|
| A BUNDING:  BO0004642  NAME OF PROVIDER OR SUPPLER  STREET ADDRESS CITY. STATE, ZIP CODE  DELTA CLINIC OF BATON ROUGE, INC  SCOLONIAL DRIVE  BATON ROUGE, LA 70806  PREPARATE PROVIDER OR SUPPLER  SAMMARY STATEMENT OF DEPORTURES BATON ROUGE, LA 70806  PREPARATE PROVIDER OR SUMMARY STATEMENT OF DEPORTURES BATON ROUGE, LA 70806  [SO 059] 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 outputient abortion facility shall provide the individual's name, hire date, and qualifications as defined in this Chapter.  Findings:  During the entrance conference on 06/19/2017 at 10:10 AM, SF1Administrator (ADM) introduced herself as the facility administrator and explained she became the active administrator on 05/01/2017.  Roview of Health Standards Section's (HSS) liconsing software (POPS) on 06/19/17 indicated that SFSADM was the current administrator.  During an interview and review of records on 08/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator.  During an interview and review of records on 08/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator on 08/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator on 08/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator on 08/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator on 08/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator on 08/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator on 08/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility administrator on 08/01/2017.  During this interview on 06/20/2017 at   | AND PLA    | ENT OF DEFICIENCIES     | (X1) PROVIDER/SUBDITION       |              |                                   | FOR       | MAPPROV     |
| MANE OF PROVIDEA OR SUPPLIER  STREET ADDRESS, GITY, STATE, 219 CODE  THE CALINIC OF BATON ROUGE, INC  SUMMARY STATEMENT OF DEFICIENCIES TAG  CODES REFERENCES TO THE APPROPRIATE OFFICIENCY  AND THE APPROPRIATE OFFICIENCY  AND THE APPROPRIATE OFFICIENCY  SOSS REFERENCES TO THE APPROPRIATE OFFICIENCY  CODES REFERENCES  TO THE APPROPRIATE OFFICIENCY  AND THE APPROPRIATE OFFICIE   | ,          | AN OF CORRECTION        | IDENTIFICATION NUMBER         | (X2) MUL     | TIPLE CONSTRUCTION                | I (Va) PA | C CUDYEN    |
| MAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  756 COLONIAL DRIVE  BATON ROUGE, INC  SUMMAY STYNEMENT OF DEPICIENCES  PREPAY  TAG  OD 10  SUMMAY STYNEMENT OF DEPICIENCES  FREQULATIONY ON LIST REPRECEDED BY PULL  REQUILATIONY ON LIST REPRECEDED BY PULL  AND THE CONTROL OF THE APPROPRIATE  OD 10  OD 10  CONTROL OF THE APPROPRIATE  OD 10  CONTROL OF THE APPROPRIATE  OD 10  OD 10  CONTROL OF THE APPROPRIATE  OD 10  OD 10  PREPAY  TAG  CONTROL OF THE APPROPRIATE  OD 10  OD 10  PREPAY  TAG  CONTROL OF THE APPROPRIATE  OD 10  OD 10  OD 10  CONTROL OF THE APPROPRIATE  OD 10  O   |            |                         |                               | A. BUILO     | ING:                              |           |             |
| STREET ADDRESS, CITY, STATE, 2IP CODE  DELTA CLINIC OF BATON ROUGE, INC  TAG COLONIAL DRIVE BATON ROUGE, INC  SUMMARY STATEMENT OF DEPOCIENCE OF THE ATTEMPT OF DEPOCIENCE OF THE ATTEMPT OF DEPOCIENCE OF THE ATTEMPT OF THE ATTEMPT OF DEPOCIENCE OF THE ATTEMPT OF   |            |                         | Done                          | i            | <del>-</del>                      |           | , _,        |
| DELTA CLINIC OF BATON ROUGE, INC  756 COLONIAL DRIVE BATON ROUGE, LA 70806  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCY MUST BE PRECEDED BY FULL TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCY MUST BE PRECEDED BY FULL TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCY MUST BE PRECEDED BY FULL TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCY MUST BE PRECEDED BY FULL TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCY TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCISE FERON DEPICIENCY TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCISE TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCY TAG  SUMMARY STATEMENT OF DEPICIENCISES FERON DEPICIENCY TAG  SOSSI-REFERENCES OF CORRECTION FERON DEPICIENCY TAG  SOSSI-REFERENCE ACTION SHOULD BE CROSS-REFERENCES OF CORRECTION FERCIX DEPICENCY TAG  (\$ 055)  The CURRENT TAG  SOSSI-REFERENCE CATION SHOULD BE CROSS-REFERENCE OF CORRECTION FERCIX DEPICENCY TAG  (\$ 055)  The CURRENT TAG  SOSSI-REFERENCE CORRECTION FEACURE ACTION SHOULD BE CROSS-REFERENCE OF CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE OF | NAME OF    | DEAL                    | DU0004642                     | B. WING      |                                   |           | R           |
| Summary stylement of periclescies   Summary stylement   Summary styl     | HOWL OF    | PROVIDER OR SUPPLIER    |                               | ADDOMAN      |                                   | 06/       | 20/2017     |
| SUMMARY STATEMENT OF DEPICIENCES   SUMMARY STATEMENT OF DEPICENCIES   FREQUENCY MUST BE PRECEDED BY FULL   FACE OWNERS PLAN OF CORRECTION   FACE OWNERS REGULATORY OR SES DEMTHYING INFORMATION)   PREFIX   PROVIDERS PLAN OF CORRECTION SHOULD BE CAROS-REFERENCED TO THE APPROPRIATE   CAROS-REFERENCE     | DELTA (    | CLINIC OF BATON BOL     | 750 001                       | ADDKESS' CIJ | TY, STATE, ZIP CODE               | -         |             |
| TAGE  TAGE TAGE  |            | DATON KUL               | JGE, INC 756 CO               | LONIAL DE    | RIVE                              |           |             |
| REGULATORY OR LSG DEMIFICATION INFORMATION)  (S 055)  Continued From page 1  days of the change. For the purposes of this Chapter, key administrative personnel includes the administrator and medical director, and the outpatient abortion facility shall provide the individual's name, hire date, and qualifications as defined in this Chapter.  This Rule is not met as evidenced by: Based on record review and staff interview, the facility failed for 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 on 05/01/2017.  Review of Health Standards Section's (HSS) ilconsing software (POPS) on 06/19/17 indicated that SF5ADM was the current administrator and explained she became the active administrator on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator and effective 05/01/2017. SF1ADM confirmed that she did not notify the department in writing within 5 calendar days when she became administrator on 06/07/2017.  During this innerview on 06/20/2017 at 10:05 AM, SF3ADM stated she was appointed as the facility's administrator on 05/07/2017.  During this innerview on 06/20/2017 at 10:05 AM, SF3ADM stated she was appointed as the facility's administrator on 05/07/2017.  During this innerview on 06/20/2017 at 10:05 AM, SF3ADM stated she was appointed as the facility's administrator on 05/07/2017.  During this innerview on 06/20/2017 at 10:05 AM, SF3ADM stated she was appointed as the facility's administrator on 05/07/2017.  During this innerview on 06/20/2017 at 10:05 AM, SF3ADM stated she was appointed as the facility's administrator on 05/07/2017.   |            | SUMMARY STAT            | EMENT OF DEFICIENCE           | ROUGE, LA    | 70806                             |           |             |
| (\$ 0.55)  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 falled 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 SF3ADM 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 on 06/20/2017. SF1ADM confirmed that she did not notify the department in writing within 5 calendar days when she became administrator on 06/01/2017.  During this interview on 06/20/2017 at 10:05 AM, Mb Standards Section  Standards Section  Continued From page 1  (\$ 0.65)  Considered Active Administration was of the mistaken notion that the previous 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 Louislana 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.  This standards Section   |            | (EACH DEFICIENCY        | MUST BE PRECEDED BY FULL      |              | PROVIDER'S PLAN OF COURSE         |           | <del></del> |
| (\$ 0.55)  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 outputient 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 falled for perport 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 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 and explained she became the active administrator on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator and 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.  Mit Standards Section  Graph Standards Section  (\$ 0.505  The current administration was of the mistaken notion that the previous 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 Louislana Department of Health surveyors of the discrepancy, we immediately submitted the form to IDH. A copy of the Change of Key Personnel form and the fax delivery notice is attached. Completed 06/20/2017.  See EXHIBIT A.   | ,,,,,,,    | THEODERIORI OR ES       | C IDENTIFYING INFORMATION)    |              |                                   |           | (X5)        |
| 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.  Roview 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 of 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.  Mh Standards Section  Mh Standards Section  Modern Standards Section (Indicated that SF5ADM when she became administrator and sea delivery notice is attached. Completed 06/20/2017.  | (S Orm     |                         |                               | 1/10         | THE APPROX                        | PRIATE    | DATE        |
| 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 falled to report in myting 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.  Roview of Health Standards Section's (HSS) licensing software (POPS) on 06/19/17 indicated that SFSADM was the current administrator.  During an interview and review of records on 06/20/2017 at 10:05 AM, 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.  Ith Standards Section  Mh Standards Section  Amount of the charge of the purpose of the change of Key Personnel form and the fax delivery notice is attached. Completed 06/20/2017. See EXHIBIT A.  Ith Standards Section  | (0.000)    | Continued From pag      | e 1                           | 12.4         | DEFICIENCY)                       | _         |             |
| 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 falled 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.  Roview 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 of officitive 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,  This Standards Section   | į          | days of the change      | <b></b> - (1                  | (8 055)      |                                   |           |             |
| 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 falled 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.  Roview 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 of officitive 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,  This Standards Section   |            | Chanter key adminis     | For the purposes of this      |              |                                   |           |             |
| 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 falled 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 necords on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator on 05/01/2017.  During this interview and review of ecords on 06/20/2017 at 10:05 AM, 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, this Standards Section  |            | the administrator and   | strative personnel includes   |              |                                   |           |             |
| 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 06/19/12 indicated that SFSADM 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 on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated 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, SF1ADM stated she was appointed as the facility's administrator on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator on 05/01/2017.  |            | Outpatient shortion to  | rnedical director, and the    |              |                                   |           |             |
| 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 on 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 she did not notify the department in writing within 5 calendar days when she became administrator.  During this interview on 06/20/2017 at 10:05 AM,  During this interview on 06/20/2017 at 10:05 AM,   |            | individual's name him   | College Shall provide the     |              |                                   |           |             |
| This Rule is not met as evidenced by: Based on record review and staff interview, the facility falled 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 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 she did not notify the department in writing within 5 calendar days when she became administrator.  During this interview on 06/20/2017 at 10:05 AM,  During this interview on 06/20/2017 at 10:05 AM,  |            | defined in this Chante  | e date, and qualifications as | İ            |                                   |           |             |
| facility falled 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 confirmed that she did not notify the department in writing within, 5 calendar days when she became administrator.  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section   |            | and mile of table       | · i                           | 1            |                                   | ]         |             |
| 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 on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section  Both Standards Section  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 Louislana 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.  See EXHIBIT A.   |            |                         |                               |              |                                   |           |             |
| 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 on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section  Both Standards Section  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 Louislana 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.  See EXHIBIT A.   |            |                         | į                             |              |                                   |           |             |
| 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  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section   |            |                         |                               |              | 1 .                               |           |             |
| facility falled 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 on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM, Interview on 06/20/2017 at 10:05 AM, SF1ADM confirmed that she did not notify the department in writing within, 5 calendar days when she became administrator.  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 Louislana 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.  See EXHIBIT A.  | }          | •                       |                               |              |                                   | .         |             |
| 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, 18/16 Slandards Section   |            |                         |                               | •            |                                   | ľ         |             |
| 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.  During this interview on 06/20/2017 at 10:05 AM, IBM Slandards Section   |            | his Rule is not met a   | S evidenced by:               |              |                                   |           |             |
| 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, Ith Standards Section   | ,          | くろろの ひし しゃじいしし プラバック    | area = af a t are 1 a f       |              | 5 055                             |           |             |
| 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.  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section   |            |                         |                               |              |                                   |           |             |
| 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 5 calendar days when she became administrator.  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section  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 Louislana 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.   | W          | ithin 5 calendar days   | of a change in key            | ·            | The current administration was    | of        |             |
| 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  During this interview on 06/20/2017 at 10:05 AM, introduced submitted the Change of Key Personnel Form when the position changed to the current Administrator.  Upon notification by the Louislana Department of Health surveyors of the discrepancy, we immediately submitted the form to LDH. A copy of the Change of Key Personnel Form when the position changed to the current Administrator.  Upon notification by the Louislana Department of Health surveyors of the discrepancy, we immediately submitted the form to LDH. A copy of the Change of Key Personnel Form when the position changed to the current administrator.  Upon notification by the Louislana Department of Health surveyors of the discrepancy, we immediately submitted the form to LDH. A copy of the Change of Key Personnel Form when the position changed to the current administrator.  Upon notification by the Louislana 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 factor.  Upon notification by the Louislana 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 factor.  Upon notification by the Louislana submitted the form to LDH. A copy of the Change of Key Personnel form and the factor and the fac   | a          | dministrative personne  | el                            |              | the mistaken notion that the      | - 1       |             |
| 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, Ith Standards Section   |            |                         |                               |              | Drevious Administrator had        | 1         |             |
| 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 on 05/01/2017.  See EXHIBIT A.  Personnel Form when the position changed to the current Administrator.  Upon notification by the Louislana 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.   |            | naings;                 | ĺ                             |              | Submitted the Cha                 | }         | ſ           |
| 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  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section  |            |                         |                               | {            | Submitted the Change of Key       |           | ł           |
| 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 on 05/01/2017. SF1ADM confirmed that she did not notify the department in writing within 5 calendar days when she became administrator  During this interview on 06/20/2017 at 10:05 AM, Ith Standards Section   | n.         | rein Al .               |                               |              | Personnel Form when the position  | on        | ĺ           |
| 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, Ith Standards Section  Administrator.  Upon notification by the Louislana 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.   | 100        | ung the entrance con    | nference on 06/19/2017 at     |              | changed to the current            |           |             |
| 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, Ith Standards Section   |            |                         |                               | -            | Administrator                     | 1         |             |
| 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 at 10:05 AM, SF1ADM stated she was appointed as the facility's administrator on 05/01/2017. SF1ADM confirmed that 5 calendar days when she became administrator.  During this interview on 06/20/2017 at 10:05 AM,  During this interview on 06/20/2017 at 10:05 AM,  During this interview on 06/20/2017 at 10:05 AM,  Ith Standards Section  |            |                         |                               | }            |                                   |           | 1           |
| 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 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, Ith Standards Section  | 1 44.1     | PIGNICA SHE DECAMA N    | he active administrator on    | 1            | Open notification by the Louisiar | 1a        | Ĭ           |
| 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, lith Standards Section  | 00/        | 01/2017.                |                               |              | Department of Health surveyors    | of        | - 1         |
| 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, Ith Standards Section   | Rev        | VIAW of Honlib on       | -                             |              | the discrepancy, we immediately   | , [       | 1           |
| 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, and of the Change of Key Personnel form and the fax delivery notice is attached. Completed 06/20/2017. See EXHIBIT A.  | lice       | nsing coffusion (Dona   | irds Section's (HSS)          | 1            | Submitted the form to LDU A see   |           | ı           |
| 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, lith Standards Section   |            |                         |                               | 1            | of the Change of Karra            | yς        | }           |
| 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, Ith Standards Section   |            | cor or rolly was the Ch | rrent administrator,          |              | or the change of key Personnel fo | orm       | 1           |
| 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, Ith Standards Section   | Dur        | ing an interview and    |                               | {            | and the fax delivery notice is    |           | ł           |
| was appointed as the facility's administrator effective 05/01/2017. SF1ADM confirmed that she did not notify the department in writing within on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM,   | 06/2       | 20/2017 of 10:05 ANA    | eview of records on           | 1            | attached. Completed 06/20/2017    | ,         | - 1         |
| 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,   | was        | appointed as the feet   | SF1ADM stated she             |              | See EXHIBIT A.                    | ·         | 1           |
| 5 calendar days when she became administrator on 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM,   | effec      | ctive 05/01/2017 em     | ity's administrator           |              |                                   | - 1       | 1           |
| On 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM,   |            |                         |                               |              |                                   |           | 1           |
| On 05/01/2017.  During this interview on 06/20/2017 at 10:05 AM,   |            |                         | hooses within                 | .            |                                   | 1         | 1           |
| During this interview on 06/20/2017 at 10:05 AM,   |            |                         | uecame administrator          |              | ·                                 |           | ]           |
|  |            |                         |                               |              |                                   |           | ł           |
|  | Durin      | ng this interview on ne | 1/20/2017 -+ 15 -             |              |                                   |           | - 1         |
| DRM  | th Standar | ds Section              | 720/2017 at 10:05 AM,         | 1            |                                   | -         |             |
|  | DRM        | (10) 1                  |                               |              |                                   | 1         | 1           |

H/H **ATE** 

7V6L12

If continuation sheet 2 of 15

### MEMORY TRANSMISSION REPORT

TIME

:06-20-'17 10:57

FAX NO.1

: 2259244465

NAMB

FILE NO.

: 619

DATE

: 06.20 10:55

ΤO

: **23** 3423073

DOCUMENT PAGES

START TIME

; 06,20 10:55

RND TIME

: 06.20 10:57

PAGES SENT

; 2

STATUS

; OK

SUCCESSFUL TX NOTICE

Delta Clinic of 756 Colonial Drive. Sta. B Batan Rouge, La. 70806 (225) 923-3242 or 1-800-937-9242 Fax: (225) 924-4465 Health Stand For: L DH Fax number: ユュモ きょう From: Delta Clinic ट्रे ब्ट्ट Fax number: 225-924-4465 06.20.201 Regarding: Change 9 Number of pages: Comments: Thanky, 

### 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

2

START TIME

07.27 13:05

END TIME

07.27 13:06

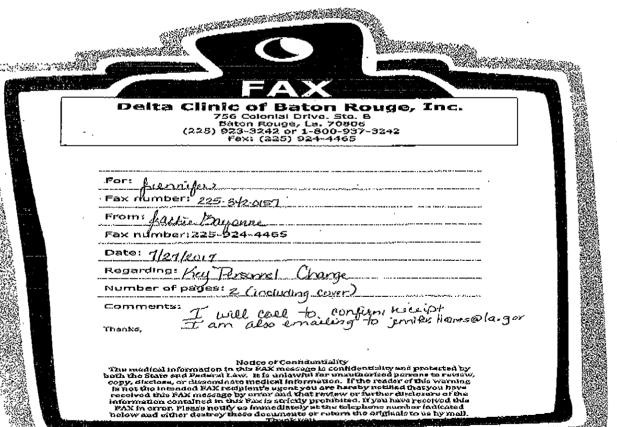
PAGES SENT

:

STATUS

OK

SUCCESSFUL TX NOTICE





### 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: Lennifer

Fax number: 225-34.0157

From: Latin Myonne

Fax number:225-924-4465

Date: 1/21/2017

Regarding: Ley Tersame Charge

Number of pages: 2 (including cover)

Comments:

I will last to Confuni kice of Image

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.

### DEPARTMENT OF HEALTH

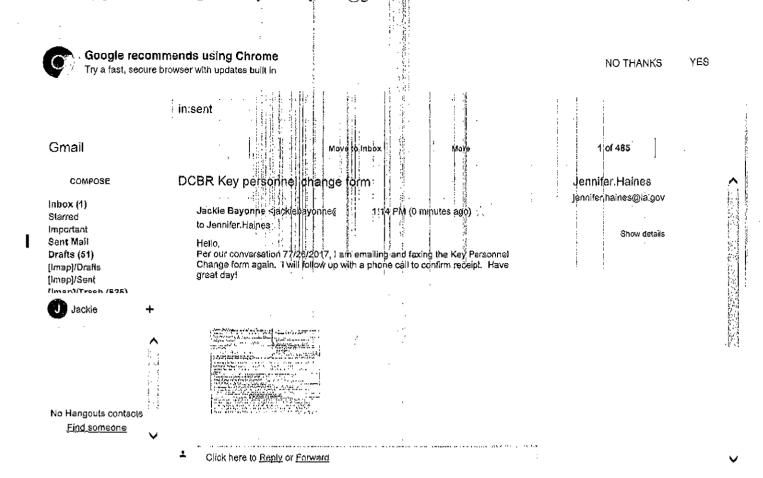
### Health Standards Section

### KEY PERSONNEL CHANGE FORM

This form must be signed by the proposed employee and the administrator. Legal Entity Name: Delta Chris Provider License #: Agency DBA Name: Baton Roud inc Address: 756 Colonial Drive & B Provider CMS ID if applies#: City, State, Zip: Baton Rouce Administrator's Email Address: Telephone Number: iackiebumnea amail. com Proposed Employee's Email Address Fax Number: (if available): 225.924. 4465 delta chine 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 BAYDAN & Effective Date of Change: OS 101 12017 Verification Date of Current LA Professional License: 12 /31/20( 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. léignature 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.

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/





### Jackie Bayonne <jackiebayonne@gmail.com>

### DCBR Key personnel change form

3 messages

Jackie Bayonne <jackiebayonne@gmail.com>

To: <Jennifer.Haines@la.gov>

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

Jennifer Haines (LDH) < Jennifer. Haines@la.gov> To: Jackie Bayonne <jackiebayonne@gmail.com>

Thu, Jul 27, 1:39 PM

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

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

| Health S                 | Standards Section  |  |                         |  | 1-01-140  | , (( ) ( ) ( ) ( ) ( )   |
|--------------------------|--|--|-------------------------|--|-----------|--------------------------|
|                          | NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                         | PLE CONSTRUCTION<br>3:   | (X3) DATE | SURVEY<br>PLETED         |
|                          |  | BO0004642  | B. WING                 | ,  |           | R<br>20 <u>/2017</u>     |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | ODRESS, CITY,           | STATE, ZIP CODE  |           |                          |
| DELTA C                  | LINIC OF BATON RO  | DIATE INI.   | ONIAL DRIV<br>ROUGE, LA |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDENCY) | D BE      | (X8)<br>COMPLETE<br>DATE |
| <b>(\$ 055)</b>          | Continued From pa  | ge 2   | (S 055)                 |  |           | 1 1 5                    |
|                          | SF2DON verified th SF5ADM, effective confirmed she was responsible for notif of the administrative the HSS - All -37 Ke dated 05/01/2017 at SF1ADM as the adm 05/01/2017. SF2DO SF5ADM faxed the verified there was no sent.  The State Office About DH/HSS, on 6/20/1 had not received any the Abortion Program provider of the provider. | at SF1ADM replaced 05/01/2017. SF2DON aware that the facility was ying the department in writing change. SF2DON presented by Personnel Change Form and confirmed it documented ministrator effective DN stated she thought change to the department and of fax confirmation that it was prior Program Desk at 7, confirmed that State Office y written notification nor had on Desk been informed by the |                         |  |           |                          |
|                          | ensuring the continued compliance state, and local state, and local state, and ordidepartment rules, governing or relating facilities, abortion or reporting requirement informed consent activity requirements delivering any instrated in the late topic, including sexuality or family plantic elementary or                            | ody shall be responsible for: outpatient abortion facility's e with all applicable federal, statutes, laws, rules, nances, including regulations, and fees; to outpatient abortion   | (S 109)                 |  |           |                          |

DHH/Health Standards Section

STATE FORM

6899

7V6L12

If continuation sheet 3 of 15

T-927 P0011/0027 F-975 FORMALTHUVELL

WHOC 2259244465

| NAME OF PR<br>DELTA CLI<br>(X4) NO<br>PREFIX<br>YAG<br>(S 109) | REGULATORY OR L Continued From pa   | UGE, INC BATON RO<br>TRAMENT OF DEFICIENCES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTETING RECRMATION  | a' mang                            | STATE, ZEPCODE<br>E  | COMPLETED  R 05/20/2017  ON (M2) 10 BS COMPLETE                                |
|--|---|--|------------------------------------|--|--|
| DELTA CLI<br>OCA) NO<br>PREFIX<br>YAG<br>(S 109)               | INIC OF BATON RO  SUMMARY STA  (EACH DEFICENCY REGULATORY OR L  Continued From pa   | STREET ADE  TEMENT OF DEFICIENCIES  WHIST BE PRECEDED BY FUAL SC IDENTFYING MECRIMATION  | NIAL DRIVI<br>DUGE, LA 7<br>PREFIX | 0806 PROVIDERS PLAN OF CORRECTION SHOW   | ION (VIA)  |
| DELTA CLI<br>OKA) NO<br>PREFIX<br>YAG<br>(S 109)               | INIC OF BATON RO  SUMMARY STA  (EACH DEFICENCY REGULATORY OR L  Continued From pa   | STREET ADE  TEMENT OF DEFICIENCIES  WHIST BE PRECEDED BY FUAL SC IDENTFYING MECRIMATION  | NIAL DRIVI<br>DUGE, LA 7<br>PREFIX | 0806 PROVIDERS PLAN OF CORRECTION SHOW   | ION (VIA)  |
| OCA) NO PROFIX YAS   | INIC OF BATON RO  SUMMARY STA  (EACH DEFICENCY REGULATORY OR L  Continued From pa   | UGE, INC BATON RO<br>TRAMENT OF DEFICIENCES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTETING RECRMATION  | NIAL DŘÍVÍ<br>DUGE, LA 7<br>PREFIX | 0806 PROVIDERS PLAN OF CORRECTION SHOW   | ON INS   |
| OCA) NO PROFIX YAS   | INIC OF BATON RO  SUMMARY STA  (EACH DEFICENCY REGULATORY OR L  Continued From pa   | TIPLE INC BATON ROTE OF DEFICIENCIES A MUST BE PRECEDED BY FUAL SC DENTETING MECRIMATION   | PREFIX                             | 9806 PROVIDERS PLAN OF CORRECTION SHOW   | ON COMPLETE  |
| (S 109)  | SUMMARY STA<br>(EACH DEFICENCY<br>REGULATORY OR L<br>Continued From Da<br>Irrawingly providing  | ATRIMENT OF DEFICIENCIES<br>SCHOENTETRIGHT METORMATION   | ID<br>PREFIX                       | PROVIDERS FLAN OF CORRECT  | ON COMPLETE  |
| (S 109)  | REGULATORY OR L Continued From pa   | PC IDENALATING WARDENWYLKHI<br>A WITZI BE BUGGEDED BA LYAT   | PREFIX                             | Lancia conspondina ACTION SHOU   | PBE COMPANIE   |
|  | knowinaly providilly  | e a c  |                                    | OPPICIENCY)  | PRIATE DATE  |
| [1   | knowinaly providing   |  | (জ 109)                            | ,  |  |
|  | regarding human for distribution or y or secondary so receives state fund addressed by law abortion procedure 2. designating administrator and this person to operations of the first allow himfler allow himfler to each patient; 4. evaluating disorborts personned | e person to act as the<br>delegating sufficient authority to<br>manage the day-to-day  |                                    | S 109 In an effort to comply with regulations regarding the day window to submit partinformation into the LEER and complete the Induced Termination of Pregnancy (ITOP), we have created procedures, forms and utility and the submit of the sub | thirty (30)<br>tient<br>S program<br>d<br>y Report<br>policies,<br>cilized the |
|  | Based on record of geverning body to abortion facility's of applicable state in reporting required for reporting required for reviewed.  Findings:  | net as evidenced by: review and interviews, the led to ensure the outpatient continued compliance with all catures, rules, and regulations rements for 4 (F3, F8, F7 and F9) sampled patient records |                                    | Plan-Do-Check-Act formal Angela Adkins, Administr Assistant will be responsively reviewing the LEERS Log weekly to ensure the ITC submitted within the thiwindow.  Procedure initiated 06/2 See EXHIBIT B.   | rative<br>ible for<br>at least<br>OP forms are<br>rty (30) day                 |
|  | Patient Care - Vit  | vider's Policy and Procedure:<br>al Records Reporting. Policy<br>ad In part<br>ance with LDH (Louisiana  |                                    |  |  |

7V5L12

the deliveration sheet 4 of 15

STATE FORM

TOPIC: LEERS

PRESENTED BY: JACKIE BAYONNE, ADMINISTRATOR

DATE: JUNE 21, 2017

| ATTENDE | D BY | ۰ |
|---------|------|---|
|---------|------|---|

| 1. | Jachie Bayonne, Administrator           |
|----|---|
| 2, | Angela Addins, Administrative Assistant |
| 3. | Aldreicka Armstead, Sonographer         |
| 45 | Teresina Certer, Medical Assistant      |
| 5. | Mary Webb Receptionist                  |
| 6. | Shan Tina Banks, LPN                    |
| ·  | Shen ura panks, Lith                    |

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.

Policy Number 2309

### QUALITY ASSURANCE LEERS LOG

| Y Need a way to ensure LEERS reports are entered into the system within the thirty (30) day window. | 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: Thuillill Monthfilled  Date: L.   2   1   1   1   1   1   1   1   1   1 |
|---|--|--|--|------------------------|---|
| IDENITEY  | PLAN   | 8  | CHECK  | ACT                    |   |
| <del>ਜ</del> ਼  | 7  | m  | 4  | ហ                      |   |

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

| DATE RECEIVED: _<br>LOT NUMBER OF<br>EXPIRATION DATE | DATE RECEIVED: LOT NUMBER OF BOX: EXPIRATION DATE: |              |            | PHYSICIAN: | AN:            |              |               |
|--|--|--------------|------------|------------|----------------|--------------|---------------|
|  |  |              |            |            |                |              |               |
| DATE   | PATIENT'S NAME                                     | CHART NUMBER | LOT NUMBER | MINOR      | MINOR INITIALS | LEERS        | LEERS         |
|  |  |              |            |            |                | Date Entered | Date Certifie |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
| ·  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
|  |  |              |            |            |                |              |               |
| QA Audit   | QA Auditor (Print name, Sign) :                    |              |            |            | Date:          |              | ,             |
| OA Audit   | 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    | Sent to | Report | Date    | Date      |
|           |                                 |         |       |    | Stericycle | AML     | Rec'd  | Entered | Certified |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
|           |                                 |         |       |    |            |         |        |         |           |
| QA Audito | QA Auditor (Print name, Sign) : |         |       |    | 1          | Date:   |        |         |           |
| QA Auditc | QA Auditor (Print name, Sign) : |         |       |    |            | Date:   |        |         |           |

| Health                   | Standards Section   |   |                     |  | FOR                                     | MAPPROVED                |
|--------------------------|---|---|---------------------|--|---|--------------------------|
| STATEME                  | ENT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | I                   | PLE CONSTRUCTION   |   | E SURVEY                 |
|                          |   | BO0004642   | B. WING             |  | 1                                       | R<br>/20/2017            |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY.       | STATE, ZIP CODE  | , |                          |
| DELTA (                  | CLINIC OF BATON RO  | UGE, INC 756 COL  | ONIAL DRIV          | /E   |   |                          |
| (X4) ID<br>PREFIX<br>TAG | 1 (EAUH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                               | (X5)<br>COMPLETE<br>DATE |
| {\$ 109}                 | Continued From page   | je 4  | {S 109}             |  |   |                          |
|                          | Performed in Louisia completed for each performed. The origin LDH, must be signed performed the service submitted to LDH wittermination.  Procedure: Effective of Induced Terminatio completed online in tweb address provide completed within third procedure.  Review of LARS 40; | pregnancy termination in all report, the one sent to do 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 the LEERS system using the doby LDH. This form is to be |                     |  |   |                          |
| [                        | ne attending physicia   | in and submitted to the   |                     |  |   |                          |
| F<br>  F<br>  C          | Review of Patient #F3<br>Pregnancy (ITOP) rep   | 's Induced Termination of<br>ort revealed Patient #F3's<br>Pregnancy was 03/30/17<br>was 05/01/2017.  |                     |  |   |                          |
| R<br>P<br>D              | regnancy (ITOP) rep   | s Induced Termination of<br>ort revealed Patient #F6's<br>Pregnancy was 03/28/17<br>Was 05/01/2017.   |                     |  |   |                          |
| Ri<br>Pi<br>Da<br>ar     | egnancy (ITOP) repo   | s Induced Termination of<br>ort revealed Patient #F7's<br>Pregnancy was 04/13/17<br>was 05/15/2017.   |                     |  |   |                          |

DHH/

**STATE FORM** 

6899

7V6l.12

If continuation sheet 5 of 15

| Health                   | Standards Section   |  |                     |   | FUR                        | MAPPROVI               |
|--------------------------|---|--|---------------------|---|----------------------------|------------------------|
|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  |                            | E SURVEY               |
| ,                        |   | BO0004642  | B. WING             | <u> </u>  | 06                         | R<br>/20/ <b>2017</b>  |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET A   | ADDRESS, CITY, S    |   | 1 00                       | <u> </u>               |
| DELTAC                   | CLINIC OF BATON RO  |  | ONIAL DRIVE         |   |                            |                        |
| DELIA                    | CINIC OF BATON RO   |  | ROUGE, LA 7         |   |                            |                        |
| (X4) ID<br>PREFIX<br>TAG | I (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>APPROPRIATE | (X5)<br>COMPLE<br>DATE |
| (5 109)                  | Continued From pa   | ge 5   | (S 109)             |   |                            |                        |
|                          | Pregnancy (ITOP) in Date of Termination and the Date Certific During an Interview SF1Administrator (A Nursing (DON) revise Patients #F3, #F6, # that the provider did all reporting requirer for Patients #F3, #F6 submitted to LEERS   | on 06/20/2017 at 3:55 PM, ADM) and SF2Director of ewed the ITOP reports for F7, and #F9. Both verified not ensure compliance with ments when the ITOP reports 6, #F7, and #F9 were not (Louisiana Electronic Event) within thirty (30) days after  |                     |   |                            |                        |
| (5 159)                  |   | . Records/Reporting  | {S 159}             |   |                            |                        |
| i F                      | A. General Provision  1. The outpatient establish and mainta on each patient.  2. The patient ma. completed documented; and b. readily avorganized to facilitate information.  3. The outpatient compliance with privatient medical reportability and Accounterized meaccordance with portability and Accounterized meaccordance with the cortability and the cortability and the cortability | at abortion facility shall in a patient medical record shall be: ledical record shall be: ledical record shall be: ledical record shall be: ledical record systematically the gathering of abortion facility shall ensure acy and confidentiality of accords, including information edical record system, in the Health Insurance intability Act (HIPAA) or all applicable state laws, |                     |   |                            |                        |

7V6L12

If continuation sheet 6 of 15

|                          | Standards Section  |   |                     |  | FORMARINOVEL                 |
|--------------------------|--|---|---------------------|--|------------------------------|
|                          | NY OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION (   | X3) DATE SURVEY<br>COMPLETED |
| <br>                     |  | BO0004642   | B. WING             |  | R<br>06/20/2017              |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY,        | STATE, ZIP CODE  |                              |
| DELTAC                   | LINIC OF BATON ROI   | 750.001   | NIAL DRI            | •  |                              |
| 52217, 0                 |  | BATON R   | OUGE, LA            | 70806  |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)   | BE COMPLETE                  |
| {S 159}                  | Continued From page  | ge 6  | {S 159}             |  |                              |
|                          | the patient medical:   | shall be established to protect<br>records from loss or damage<br>f confidentiality in accordance<br>ate laws, rules, and   | i -                 |  |                              |
|                          | interviews, the facilit<br>were established to<br>records from loss or                         | on, record review and<br>y failed to ensure safeguards<br>protect the patient medical<br>damage and/or breach of<br>ordance with all applicable                               | ·                   | S 159 Regarding our new chart room, t fireproof door was hung on 06/23/2017. The door will be locked at all tim with the key maintained in the business office front desk to                     |                              |
|                          | Patient Record Conti   | and Procedure Patient Care<br>ents was presented by<br>DN on 6/20/2017. The policy  |                     | eliminate patient access.  The painting has been complete with a third coat of paint.  We are awaiting ICC Certification approve the painting. We anticipate the painting approver the painting. | n to<br>pate                 |
|                          | read in part: Safegua  | ards are established to lity and protection from fire,  |                     | this inspection and approval wit<br>six weeks (6) which will be<br>September 9, 2017   | hin                          |
|                          | store patient medical<br>SF1Administrator (Al<br>8/19/2017. The locati<br>room was verified to | pset which the facility used to<br>records was conducted with<br>DM) at 10:25 AM on<br>ion of the medical records<br>be in a hall across from a<br>the facility for medicated | ·                   |  |                              |
| ' -   t<br>  V<br>  r    | utilized this hallway to<br>was also observed th   | s observed that patients access the restrooms. It at the door of the medical ed a doorknob which only   |                     |  |                              |

6033

7V6L12

If continuation sheet 7 of 15

|                          | GF PROVIDER OR SUPPLIER  A CLINIC OF BATON ROUGE, INC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  locked from within the medical records room the doorknob had no keyhole to unlock the d from outside the room.  SF1ADM explained that the medical records room was painted on June 2, 2017 and June 2017 with a Fire Retardant Paint and the pro was currently waiting on the arrival and installation of the Fire Retardant door which is 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 retards paint. SF1ADM confirmed the areas included walls at the top near the ceiling, near the bas boards and around electrical boxes and light switches. S1ADM verified the medical record room was not completely painted with the Fire Retardant Paint.  SF1ADM presented an opened bucket of pain which she explained was the paint used for the painting of the medical records room. The bur of paint was labeled as Ff 88 (Fire Free 88, FRetardant / Resistant Coating).  An observation of the manufacture's label on bucket of Ff 88 paint, noted in part, under the Application instructions:  Fire Safety: in part The amount by which Ff retards a particular fire will depend, among of things, on (i) the amount of Ff 88 applied It the sole responsibility of the applicator to ensu   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPI<br>A. BUILDING | (X3) DATE SURVEY COMPLETED  |         |                         |
|--------------------------|--|---|-----------------------------|---|---------|-------------------------|
|                          |  | BO0004642   | B. WING                     |   | 06/20/2 | 017                     |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AC   | DRESS, CITY,                | STATE, ZIP CODE   |         |                         |
| DELTA (                  | CLINIC OF BATON RO   |   | ONIAL DRIV                  |   |         |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FIRE   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE C | (X5)<br>DMPLETE<br>DATE |
| {S 159}                  | Continued From pa  | ge 7  | {S 159}                     |   |         | -                       |
|                          | the doorknob had n   | o keyhole to unlock the door  |                             |   |         |                         |
|                          | room was painted of 2017 with a Fire Ref was currently walting installation of the Fire supposed to arrive a   | n June 2, 2017 and June 3, tardant Paint and the provider g on the arrival and e Retardant door which was and be installed on                                     |                             |   |         |                         |
|                          | medical records rook completely covered paint. SF1ADM con walls at the top near boards and around eswitches. S1ADM veroom was not completely completely covered to the completely covered to the completely covered to the covered to t | 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 |                             |   |         |                         |
|                          | which she explained painting of the medic of paint was labeled a Retardant / Resistan An observation of the bucket of Ff 88 paint,   | was the paint used for the al records room. The bucket as Ff 88 (Fire Free 88, Fire t Coating). I manufacture's label on the noted in part, under the             |                             |   |         |                         |
|                          | retards a particular fir<br>things, on (i) the amo<br>the sole responsibility<br>that Ff 88 has been a<br>the application directi<br>Thickness: All surfac<br>applied should be ins  | te will depend, among other unt of Ff 88 applied It is of the applicator to ensure pplied in accordance with  |                             |   |         |                         |

DHH/Health Standards Section

**STATE FORM** 

6699

7V6L12

If continuation sheet 8 of 15

T-923 P0022/0028 F-963 HORMAPPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DAT COM  BO0004642    B. WING   | <u>ealth S</u> |         |                |   | <u> </u>   | Standards Section  | Health S |
|---|----------------|---------|----------------|---|--|--|----------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  T56 COLONIAL DRIVE  BATON ROUGE, INC  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (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   |                |         |                | OLIA<br>ER;   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;   |  | 1        |
| DELTA CLINIC OF BATON ROUGE, INC  To COLONIAL DRIVE BATON ROUGE, LA 70806  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (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  |                |         | B. WING        |   | BO0004642  |  |          |
| DELTA CLINIC OF BATON ROUGE, INC  T56 COLONIAL DRIVE BATON ROUGE, LA 70806  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (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   | ME OF I        | ZIPCOD  | ORESS, CITY, S | FREET AD  | STREET   | PROVIDER OR SUPPLIEF   | NAME OF  |
| PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    {S 159}   Continued From page 8   (S 159)   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   | LTA C          | ;       |                |   | 20E. INC   | LINIC OF BATON RO  | DELTA C  |
| 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   | REFIX          | (EACH ( | PREFIX         | L<br>N)   | MUST BE PRECEDED BY FULL   | (EACH DEFICIENC  | PREFIX   |
| 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  | 159}           | •       | (S 159)        |   | je 8   | Continued From pa  | {S 159}  |
| 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. | in pontion     |         | {S 159}        | to in the he he ion by ed that within view med book the le commic m the DM cility onist cords derected fied | ed uniform thickness, provider had received an accertified professional to been properly applied in the ckness, SF1ADM said the ained 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 5 AM, SF1ADM confirmed no key or device to unlock the from the inside of the from the inside of the room able to be locked on clinic ever across the hall from the inside of the from the inside of the from the inside of the room able to be locked on clinic ever across the hall from the inside of the room able to be locked on the facility of the facility of the medical records room door knob which could only the room. SF3Receptionist on the room. SF3Receptionist explaced in the unlocked explaced in the unlocked of the door of the unlocked on | applied in the requivalent asked if the Inspection by an IC verify that Ff 88 has required uniform the provider had not of any such profession application of the Ferovider's medical records the medical records the medical records roof and the door was understand the door was understand the technological records roof and the door was understand the door.  Ouring an interview of 20/2017 at 10:45 that the doorknob of the room early last the room early last the room early last the room early last the room on Thursday of the records room at facility staff was fight of the medical records room at facility staff was fight at the fight a |          |

DHH/Health Standards Section

STATE FORM

4238

7V6L12

If continuation sheet 9 of 15

2259244465

T-929 P0003/0004 F-990

RECEIVED 08/09/2017 12:10PM 5048962302 08-09-17 12:12 FR00-

WHCC 2259244465

T-927 F0019/6027 F-975 FORMAPPROVED

Health Standards Section STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (QENTIFICATION NUMBER: COS) DATE SLARVEY CONTRIBLE CONSTRUCTION COMPLETED A. BUILDING: 06/20/2017 B. WING B00004642 NAME OF PROMILER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIPCODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE, INC BATON ROUGE, LA 70806 PROVIDER'S PLAN OF CORRECTION
[EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY] (XS) COMPLETE DATE SIMMARY STATEMENT OF DESICIENCIES (EACH DESIGNEY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION (X4) ID PREFIX TAG id Prefix Tag (\$ 189) Continued From page 9 (\$ 16<del>9</del>) 5 169 15 169) 4425 - E-F Patient Med Records/Reporting (8 169) We have initiated processes to Requirements ensure that the Clinic is in E. Other Reports. The outpetient abortion facility compliance with the state statute shall maintain a daily patient roster of all patients requiring ITOP reports which will be receiving a surgical or chemically induced abortion. Patients may be identified completed and certified within thirty corresponding to the patient's medical record. days. We created a form and This daily patient roster shall be retained for a period of three years initiated a policy and procedure to F. Reporting Requirements ensure the documentation is being 1. The outpatient abortion facility shall completed timely. All appropriate maintain documentation to support that the outpatient aboution facility is compliant with all staff was in-serviced on the policy reporting requirements, including, but not limited and procedure. Angela Adkins. to, the Induced termination of pregnancy (ITOP) form and other documentation as required by Administrative Assistant will be state, and local statutes, laws, responsible for reviewing the LEERS ordinances, and department rules and Log at least weekly to ensure the regulations. 2. The outpatient abortion facility shall report ITOP forms are submitted within the in accordance with all applicable state laws for thirty (30) day window the reporting of crimes against a child that include but are not limited to: Established 06/21/2017. a. rape: See EXHIBIT R b. sexual battery: o. incest and d. camal 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 eigned by the attending physician and submitted to the Louislana Department of Health within thirty

is contractable sheet 10 of 15

6803

7V6L12

DHWHeath Stamonds Section

STATE FORM

| 1   | Health             | Standards Section   |  |                              |   | FORM      | MAPPROVE                 | ) |
|-----|--------------------|---|--|------------------------------|---|-----------|--------------------------|---|
|     | STATEME<br>AND PLA | ENT OF DEFICIENCIES<br>N OF CORRECTION                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER;  | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION  |           | E SURVEY<br>IPLETED      | _ |
| Į   |                    |   | BO0004642  | B, WING                      |   |           | R                        |   |
| l   | NAME OF            | PROVIDER OR SUPPLIER  | STREET A   | ODRESS CITY O                | BTATE, ZIP CODE   | 1 06/     | 20/2017                  | _ |
|     | DELTA (            | CLINIC OF BATON ROL   | JGE, INC 756 COL   | ONIAL DRIVI                  | E   |           |                          |   |
| ــا | (X4) ID            | SUMMARY STA   | BATON F  | ROUGE, LA 7                  | <del></del>   |           |                          |   |
|     | PRÉFIX<br>TAG      | T LEACH DEFICIENCY  | MUST BE PRECEDED BY FULL<br>C IDENTIFYING INFORMATION)   | PREFIX<br>TAG                | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |   |
|     | {S 169}            | Continued From pag  | ge 10  | {S 169}                      |   |           |                          | - |
|     |                    | days after the date of #F3, #F6, #F7, and I sampled patients. | of the abortion for 4 (Patients<br>F#9) of 9 (Patients #1 - #9)  |                              |   | <b>N</b>  |                          |   |
|     | Findings:          |   |  |                              |   |           |                          |   |
|     |                    | the attending physicia  | 1061.21 Reports, revealed, ns reports shall be signed by an and submitted to the nt of Health within thirty days abortion" |                              |   |           |                          |   |
|     |                    | Pregnancy (ITOP) rea  | 3's Induced Termination of port revealed Patient #F3's f Pregnancy was 03/30/17 f was 05/01/2017.                          |                              |   |           |                          |   |
|     | [<br>  1           | Pregnancy (ITOP) rep  | i's Induced Termination of<br>ort revealed Patient #F6's<br>Pregnancy was 03/28/17<br>was 05/01/2017                       |                              |   |           |                          | 1 |
|     | F<br>  F<br>  C    | 'regnancy (ITOP) rep  | 's Induced Termination of ort revealed Patient #F7's Pregnancy was 04/13/17 was 05/15/2017.                                |                              |   |           |                          |   |
|     | R<br>P<br>D        | regnancy (ITOP) repo  | s Induced Termination of or revealed Patient #F9's Pregnancy was 03/28/17 was 05/01/2017.                                  |                              |   |           |                          |   |
|     | D                  | uring an interview on<br>F1Administrator (ADN                 | 06/20/2017 at 3:55 PM,<br>A) and SE2Director of  |                              |   |           |                          |   |

DHH/Health Standards Section

STATE FORM

6899

7V6L12

If continuation sheet 11 of 15

WITH

RECEIVED 08/09/2017 12:10PM 5048962302 08-89-17 12:12 FBOM-

#HCC 22592<del>444</del>65

T-927 P0021/0027 F-975

Health Standards Section (M3) DATE SURVEY COMPLETED STATEMENT OF DEFENERACIES AND PLAN OF COPRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: DOWN MALTIPLE CONSTRUCTION A. BUILDING: 08/20/2017 BO0004642 M. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 24 CODE 756 COLONIAL DRIVE DELTA CLINIC OF BATON ROUGE INC BATON ROUGE, LA 70866 PROMDER'S PLAN OF CORRECTION (Kd) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PREFIX TAG PREFIX TAG (EACH DERCHENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING (NEORMATION) (BYCH DORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (8 169) Continued From page 11 (S 169) Nursing (DON) reviewed the ITOP reports for Patients 7F3, #F8, #F7, and #F9. Both verified S 171 that the provider did not ensure compliance with A system has been created to all reporting requirements when the ITOP reports monitor the timey reporting of ITOP. for Patients #F3, #F6, #F7, and #F9 were not submitted to LEERS (Louislana Electronic Event Angela Adkins, Administrative Registration System) within thirty (20) days of the Assistant will be responsible for termination. reviewing the LEERS Log at least (S 171) weekly to ensure the ITOP forms **(\$ 171)** 4427 A-1 Quality Assurance/Performance improvement Pro have been submitted within the A. The outpatient abortion facility shall thirty (30) day window. develop, implement, enforce, maintain, and A form and policy and procedure annually review a written OAPI program subject have been created. Staff has been to approval by the governing body, which puts systems in place to effectively identify issues for in-serviced. which quality monitoring and performance In addition to monitoring timely improvement activities are necessary. The QAPI reporting of the ITOP, a system has program shall include plans of action to correct identified issues including, but not limited to, been implemented to monitor the monitoring the effect of implemented changes receipt of pathology reports for and making necessary revisions to the plan of action. products of conception. Policies 1. Plans of Action. The autoation abortion written and forms created. Ms facility shall develop and implement a QAPI plan Teresina Carter, medical assistant of action designed to effectively identify issues for which quality monitoring and performance receives the reports and will be improvement activities are necessary. responsible for weekly, documenting the receipt, and follow-up of reports not received timely. She has been in-serviced. Recording data entry began This Rule is not met as evidenced by: 06/21/2017. Based on record review and interview, the outpatient abortion facility falled to put a See EXHIBIT B system in place to effectively manitor the effect of

DHI-I/Health Standards Section STATE FORM

96**9** 

7V8L12

HOMEWOELN SLOWE 12 of 15

13A

| STATEME                  | Standards Section<br>INT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;  |                              | E CONSTRUCTION  | (X3) DATE | SURVEY<br>PLETED           |
|--------------------------|--|---|------------------------------|---|-----------|----------------------------|
|                          |  | BO0004642   | B. WING                      |   |           | ₹<br>2 <mark>0/2017</mark> |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S               | STATE, ZIP CODE   | ·         |                            |
| DELTA                    | CLINIC OF BATON RO   | 750 001 0   | ONIAL DRIVE                  | •   |           |                            |
| DEE!/                    | ,  | BATON R   | OUGE, LA 7                   | 0806  | _         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PR <b>E</b> FIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY) | O BE      | (X5)<br>COMPLETE<br>DATE   |
|                          | implemented chang 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.  Findings:  Review of LA RS 40 in part "C. All abortion the attending physic Louisiana Department after the date of the Patient #F3 Review of Patient #F9 Pregnancy (ITOP) reduced the Date Certification and the D | les, identify issues, and make to the plan of action by failing be 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, ints #F1 - #F9) sampled  1061.21 Reports, revealed, ons reports shall be signed by ian and submitted to the ent of Health within thirty days abortion"  13's Induced Termination of eport revealed Patient #F3's of Pregnancy was 03/30/17 and was 05/01/2017.  16's Induced Termination of eport revealed Patient #F6's of Pregnancy was 03/28/17 and was 05/01/2017.  17's Induced Termination of eport revealed Patient #F7's of Pregnancy was 04/13/17 and was 05/15/2017. | {S 171}                      |   |           |                            |
|                          |  | 9's Induced Termination of port revealed Patient #F9's  |                              |   |           |                            |

6099

7V6L12

If continuation sheet 13 of 15

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                             | CONSTRUCTION   | COM     | E SURVEY<br>PLETEO       |
|--------------------------|--|--|-----------------------------|--|---------|--------------------------|
| <u>,</u>                 |  | BO0004642  | B. WING                     |  |         | R<br>2 <u>0/2017</u>     |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S              | TATE, ZIP CODE   |         |                          |
| DELTA C                  | CLINIC OF BATON RO   | JUE. INC.  | ONIAL DRIVE<br>ROUGE, LA 70 |  |         |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETE<br>DATE |
| <b>(S 171)</b>           | ' `  | of Pregnancy was 03/28/17  | {S 171}                     |  |         |                          |
|                          | Nursing (DON) on 6 SF2DON stated that Data Compiled, which be compiled and the be collected, such a quarterly, or annually LEERS (Louisiana E System) was listed to be collected monthly part of the Quality As Improvement (QAPI compliance with the SF2DON stated that   | 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 so daily, weekly, monthly, y. S2DON confirmed that electronic Event Registration on the form and data was to y. SF2DON verified this was a surance and Performance and Performance of Program to ensure TTOP reporting requirements. If she considered this form to ssurance of Chart and it was |                             |  |         |                          |
|                          | responsible for revier identifying any issues of the ITOP (Induced reports. When aske have identified any is not being certified with of abortions, SF1ADI (SF1ADM) reviewed would have identified explained that she lost to ensure that ITOP (the regulatory require no patients since 3/1 submitted within 30 certified identified within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified any in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 30 certified in the regulatory require no patients since 3/1 submitted within 3/ | SF1Administrator was wing all patient records and s with the timely certification of Termination of Pregnancy) d if the QAPI program should saues with the ITOP reports thin 30 days after the dates M replied yes because she every patient record and I a problem. SF1ADM oked at every patient record reports were certified as per ement and stated there were 8/2017 that were not lays as required. SF2DON ent action plan of SF1ADM                               |                             |  |         |                          |

6899

7V6L12

If continuation sheet, 14 of 15

| <u>Health</u>            | Standards Section  |  |                     |   | FORM                              | IAPPRC                      |
|--------------------------|--|--|---------------------|---|-----------------------------------|-----------------------------|
| AND PLAI                 | NT OF DEFICIENCIES<br>N OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  |                                   | E SURVEY<br>PLETED          |
|                          |  | BO0004642  | B. WING             |   |                                   | R<br>20/2 <mark>01</mark> 7 |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  |                     | STATE, ZIP CODE   | 1 00/                             | 20/201                      |
| DELTA (                  | CLINIC OF BATON RO   |  | ONIAL DRIV          |   |                                   |                             |
|                          |  | BATON F  | ROUGE, LA 7         |   |                                   |                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | COMP<br>DA                  |
| (\$ 171)                 | Continued From pa  | ge 14  | {\$ 171}            | 77 - 11 - 11  |                                   |                             |
|                          | compliance with repeffective because the and all ITOP reports requirements. She be aware is there with standard | porting requirements was here were no identified issues a were submitted as per the stated that the facility should be issues or problems.  ON reviewed the ITOP #F3, #F6, #F7, and #F9. Be provider did not ensure reporting requirements when Patients #F3, #F6, #F7, and ted to LEERS (Louisiana gistration System) within thirty hination. SF1Administrator ovider created a QAPI by the governing body, but in place to effectively issues with the reporting |                     |   |                                   |                             |

7V6L12

If continuation sheet 45 of 15

6889