## Division of Public and Behavioral Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING	(X3) DATE SURVEY COMPLETED	
		9004	В. \	VING	12/11/2019	
NAME OF PRO	OVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODI	E	
BIRTH CONTR	ROL CARE CENTER		872	E SAHARA AVE, LAS VEGAS, NEVADA	,89104	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REG	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL ULATORY FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
0000	Initial Comments		0000			
	Deficiencies was g an annual permit s facility on 12/11/19 Survey was conduc Nevada Administra 449, Outpatient Fa records and nine e reviewed. The findi any investigation b and Behavioral He construed as prohil investigations, action relief that may be a	cted in accordance with tive Code (NAC) Chapter cilities. Five patient mployee records were ngs and conclusions of y the Division of Public alth shall not be biting any criminal or civil ons or other claims for vailable to any party deral, state, or local				
0140 SS= F	addition to the guid pursuant to NAC 4 a permit to operate shall establish guid policies for the out Ensure the health, patients of the outp	ce - NAC 449.999448 In lelines established 49.999441, the holder of an outpatient facility lelines and maintain patient facility which: 1. safety and well-being of batient facility;	0140	The Surgical Tech will ensure crash cart will be secured via a medication room, that is locked The leadership staff and physic have a key and access to the I medication room. Staff had tra securing the crash carton Thur 2, 2020.	a locked d at all times. cians will ocked aining on rsday January	01/02/202 0
	maintain profession by ensuring: 1) Me a secure manner; 2 made to 1 of 4 surg hours, per facility p Filters for the trans probes were chang	hent review, record w, the facility failed to hal standards of practice dications were stored in 2) Follow-up calls were gical patients within 24-48 bolicy (Patient #2); and 3) vaginal ultrasound jed per manufacturer		In addition, all syringes, needle medications will be kept in a di that can be locked in surgery r and two for patient safety and security. Staff assigned to resp surgery room shall be respons drawers and cabinets are lock will be accompanied by staff at Surgery Room.	rawer/cabinet ooms one needle bective ible to ensure ed. Patients	<b>CO</b> .
	AM, the facility crast The medications and cart were located of The crash cart had cart was located in	gs include: 1) ge: On 12/11/19 at 9:15 sh cart was unlocked. Ind needles for the crash in top of the crash cart. a lock on it. The crash a room at the end of the ray. The two procedure		Other medication in the commo be moved to a locked cabinet of common area. All staff will hav the locked cabinet. The leader ensure the cabinet is locked at The refrigerator in the common have a lock installed on Janua	within the ve access to ship staff will all times.	erica
	rooms were across to the room was op unnamed person s the time of observa	from the room. The door		The facility will implement the l and Needle Security Policy effective December 23, 2019. The polic All staff had training on this po	Medication ective y is attached.	ite Lif

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER	Name: TIFFANY COLLINS	Title: Administrator	Date: 01/02/2020
		Theory Contractor	2410. 01/02/2020
REPRESENTATIVE'S SIGNATURE			

## Division of Public and Behavioral Health

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING	(X3) DAT COMPLE	E SURVEY TED
		9004	В.	WING	12	/11/2019
NAME OF PRO	OVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	<b>!</b>	
BIRTH CONTR	ROL CARE CENTER		87	2 E SAHARA AVE, LAS VEGAS, NEVADA ,89	104	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REG	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL GULATORY FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	indicated an unawa person in the room probably a student and patients were room going to and/ rooms. Some of th crash cart included nitroglycerin, roma flumazenil, ephedr Metoprolol Tartrate and syringes on to 12/11/19 in the mo Infection Preventio confirmed the cart verbalized the cart day for convenience indication of where of the crash cart w the day. On 12/11/ unsecured medication needles were obse Room 1 drawers, it such as misoproste BD needles, cathe needlesSurgery included medication Insyte Autoguard W 12/11/19 at 9:20 A Prevention and Co the observation an left in the rooms al for procedures. On refrigerator in the f (pathway to proced unlocked. The refri Methylergonovic, V On 12/11/19 at 9:55 Infection Preventio confirmed the obse the refrigerator wa 12/11/19 in the after confirmed there wa crash cart or media security. There wa security of narcotic Calls: Patient #2 (F 12/3/19 for a surgin document titled Ma documented patier permission for faci patient 24 to 48 ho procedure, to ask of	areness of who the was and they were in training. Employees observed passing the or from procedure e medications on the l: Midazolam, Naloxone, zicon, Labetalol, ine, atropine and a. There were needles p of the crash cart. On rning, the interim n and Control Manager was unlocked during the e. There was no the medications on top ere stored at the end of 19 at 9:20 AM, tions, syringes and erved as follows: -Surgery ncluded medications of 200 milligrams (mg), ters, IV start syringes and Room 2 drawers, ns, syringes and BD Vinged IV catheters. On M, the interim Infection ntrol Manager confirmed d reported patients were one to dress and undress 12/11/19 at 9:50 AM, the acility common area dure rooms) was gerator contained //asostrict, Anti D Bland. 0 AM, the interim n and Control Manager ervation and explained s always unlocked. On ernoon, the Administrator as no facility policy for cation and needle s a facility policy for cation and needle s a facility policy for the facility contact with the urs after the surgical questions and check on P2 signed the May We		January 2, 2020. The GUS G10VP Wall-Mounted I Soak Station for Transvaginal and Transrectal Ultrasound Probe (GU change log is now in place and lo the common area. The medical as responsible for changing and doc the filter changes, will circle the da when the filter was changed, initia the log. The manufacturers instru- use indicates the filter to be chang- six months. All staff that reprocess transvaginal ultrasound probes had on this filter change log on Decem- 2019. A policy was modified to facilitate documentation of post procedural calls in the event team members of unable to reach the patient during follow up call. The back office Lea Assistant will continue to monitor compliance with follow up calls or monthly basis. All staff underwent training on this procedure and the policy on December 26, 2019.	JS) filter cated in ssistant umenting ate of al and sign ctions for ged every ses the ad training nber 26, follow up were the initial do Medical for a follow up new	SS ericans ited Life
STATE FORM		Event ID:	GUPZ11	Facility ID:		Page 2 of 3

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:	_IA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DA COMPLE	TE SURVEY ETED
		9004		B. WING 12/		2/11/2019
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BIRTH CONT	ROL CARE CENTER			872 E SAHARA AVE, LAS VEGAS, NEVA	DA ,89104	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REC OR LSC IDENTI	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL BULATORY FYING INFORMATION) nt on 12/3/19, giving the	ID PREF TAG		I SHOULD BE	(X5) COMPLETION DATE
	facility permission hours after their pr up call was placed There was no answ message was left. documented secor 12/11/19 at 10:23. Prevention and Co no second call atter interim Infection Pr Manager explained process. Surgery p (May We Call You to a call 24 to 48 h procedure, or the p the patient gave pe If there was no ans leave a voicemail n were made by eith email. A note was chart regarding trie up attempts. 3) Ult Changes: The GU Disinfection Soak and Transrectal UI Operator's Manual the patented filter I normal everyday u morning, a small b the transvaginal ul in a procedure roo replace filter on 2/2 change log located filter change log co facility. On 12/11/1 Medical Assistant and documenting t explained the proc was documented i probe log and high Assistant could no a filter change after they documented i documentation. Or the interim Infection	to make contact 24 to 48 ocedure. An initial follow- to the patient on 12/5/19. wer and a voicemail There was no nd contact attempt. On AM, the interim Infection ontrol Manager confirmed empt was made. The revention and Control d the follow-up call oatients filled out a form ?) if they were agreeable ours after a surgical oatient could decline. If ermission, all were called. swer, the facility would message. Two attempts er phone call, text or placed in the patient's ed and successful follow- rasound Probe Filter S G10VP Wall-Mounted Station for Transvaginal trasound Probes (undated), documented had a six-month life in se. On 12/11/19 in the lue sign was attached to trasound probe machine m, that indicated to 20/20. There was no filter d on the machine and no puld be provided by the 9 in the morning, a responsible for changing the filter changes, ess, reporting the change n red on the scope or lighted. The Medical t locate documentation of r 2/18/19, expressing t but could not find that 12/11/19 at 2:49 PM, n Prevention and Control the facility changed the ased on manufacturer			Am Ur for	SS ericans iteo r Life
					IU	

## Division of Public and Behavioral Health

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING	(X3) DAT COMPLE	TE SURVEY ETED
		7982	B. W	/ING	11	/20/2018
NAME OF PRO	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	I	
SAFE AND SC	DUND FOR WOMEN, INC		313 <sup>,</sup>	I LA CANADA #110, LAS VEGAS, NEVA	DA ,89169	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REC	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL GULATORY IFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
0000	Initial Comments		0000			
	Deficiencies was g State Re-permittin your facility on 11/ 11/20/18, in accord Administrative Coo Outpatient Facilitie reviewed and six e reviewed. The find any investigation b and Behavioral He construed as prohi investigations, acti relief that may be a under applicable fe	hts: This Statement of generated as a result of a g Survey conducted in 20/18 and completed on dance with Nevada de (NAC), Chapter 449, es. Five patient files were employee files were lings and conclusions of by the Division of Public eath shall not be ibiting any criminal or civil ions or other claims for available to any party ederal, state, or local g regulatory deficiencies				
0140 SS= F	addition to the guid pursuant to NAC 4 a permit to operate shall establish guid policies for the out Ensure the health, patients of the out Inspector Commer and interview, the medications and n in a room where p care. Findings incl AM, a patient was getting a blood dra The staff member out of the room lea room. The followin needles were unse one bottle of Misop (mg) -one bottle of bottle of Metronida of Ondansetron 8 x1 needles -one bo -one box of 20 gau 22 gauge needles. AM, the Manager medications and n aware the medicat	ice - NAC 449.999448 In delines established 49.999441, the holder of e an outpatient facility delines and maintain patient facility which: 1. safety and well-being of patient facility; hts: Based on observation facility failed to ensure eedles were kept locked atients were receiving ude: On 11/20/18, 10:30 sitting in the lab room aw from a staff member. drawing the blood walked aving the patient in the	0140	Are plan of correction for unloc and needles is to lock cabinet. The cabinet will be lock every t member steps out of the room. The way it will be monitored is the cabinet to get medication a out and locking it ones we have need never to leave unlock. The office manager will manag correction. The correction was done 11/26 We will make sure all areas wh medication and needles are at locked or not in a patient room.	ime a staff by unlocking nd needles e what we e the plan of /18. ere will be	12/07/201 8 erican iteo Life

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: CRAIG HARTMAN	Title: Medical Director	Date: 12/07/2018
STATE FORM	Event ID: 85HJ11	Facility ID:	Page 1 of 1

#### Division of Public and Behavioral Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		LIA		MULTIPLE CONSTRUCTION	(X3) DAT COMPLE	E SURVEY TED
		7982	7982 B. WING 11/17/201				
NAME OF PRO	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SAFE AND SC	DUND FOR WOMEN, INC			3131	LA CANADA #110, LAS VEGAS, NEVADA ,8	9169	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REG	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL GULATORY FYING INFORMATION)	ID PREF TAC	-IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
0000	Deficiencies was g State Permit Surve facility on 11/07/17 11/17/17, in accord Administrative Cod Outpatient Facilitie reviewed and seve reviewed. The find any investigation b and Behavioral He construed as prohi investigations, acti relief that may be a under applicable fe	le (NAC), Chapter 449, s. Five patient files were in employee files were ings and conclusions of y the Division of Public	0	000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: CRAIG HARTMAN, DO	Title: Medical Director	Date: 12/12/2017
STATE FORM	Event ID: WXLD11	Facility ID:	Page 1 of 4

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIE         AND PLAN OF CORRECTION       IDENTIFICATION NUMBE			) MULTIPLE CONSTRUCTION BUILDING	(X3) DA COMPLI	TE SURVEY ETED	
	7982	B. V	B. WING		11/17/2017	
AME OF PROVIDER OR SUPPL	ER	STE	REET ADDRESS, CITY, STATE, ZIP COD	E		
AFE AND SOUND FOR WOMEN	INC	313	1 LA CANADA #110, LAS VEGAS, NEVA	ADA ,89169		
ÌDÍ (EACH DEFICIEI PREFIX	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
0131NAC 449.999 managing pro The person d Must have co the prevention development and communi ensure that th and control of diseases for t Complies with and local laws guidelines ad permit pursua (3) Is reviewe outpatient fac contract with a at the facility a thereafter, or pursuant to su 449.999447.Inspector Cor review, intervi facility failed t Officer compli control and pr communicable Findings inclu Officer. On 14 records revea licensed healt employee cor control and pr all clinical em lacked docum specialized tr prevention. R Officer's job of employee's re oversight and program for in	ENTIFYING INFORMATION) 446 (2) - Overseeing and gram - NAC 449.999446 2. scribed in subsection 1: (a) hpleted specialized training in and control of the and transmission of infections able diseases; and (b) Shall e program for the prevention infections and communicable e outpatient facility: (1) all applicable federal, state ; (2) Is consistent with the pted by the holder of the at to NAC 449.999441; and I with all employees of the ity and all persons under the outpatient facility who work nd have exposure to patients within the first 10 days of nd every 12 months hore often if required bsection 2 of NAC ments: Based on record aw and document review, the o ensure the Infection Control ted specialized training on avention of infections and diseases (Employee #4). de: Employee #4 was hired on ledical Staff, Infection Control (07/17, review of personnel) ed the employee is not a horare professional. The pleted the same infection evention training provided to loyees. The employee's file ented evidence of a ining in infection control and view of the Infection Control escription revealed the sponsibilities did not include management of the facility's fection control and verity: 2 Scope: 1	0131	<ul> <li>1) Our infection control officer additional training requested in deficiency.</li> <li>2) We reviewed the deficiency compliance consultants. They the required training on an and the time of our annual staff tra</li> <li>3) Our compliance consultants a log book documenting annua our infection control officer.</li> <li>4) Our infection control officer for attending the required train Medical Director, Clinic Director compliance consultant will cor monitor all staff requirements and maintain a log book as no 5) The required training was c December 7, 2017.</li> <li>6) The certificate of training ar educational training completed will be scanned and attached.</li> </ul>	h the with our will provide hual basis at ining. s will maintain al training for is responsible ing. The or, and titnually for training ited above. ompleted on ad log of d on 12/7/17		



#### Division of Public and Behavioral Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		_IA		MULTIPLE CONSTRUCTION JILDING	(X3) DATE SURVEY COMPLETED	
			/17/2017				
NAME OF PRO	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SAFE AND SC	DUND FOR WOMEN, INC			3131	LA CANADA #110, LAS VEGAS, NEVADA ,8	9169	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REG	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL SULATORY FYING INFORMATION)	ID PREF TAC	ΞIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
0140 SS= F	addition to the guid pursuant to NAC 4 a permit to operate shall establish guid policies for the out Ensure the health, patients of the out Inspector Commer observation, intervi- review, the facility emergency medica Findings include: C morning, emergency stored in an uprigh compartments. The have a locking med was on top of the r hallway across from room, operating roo The medications in Albuterol, Atropine Epinephrine, Fluma Nitrostat, The Phys the emergency me the nurses' station	cé - NAC 449.999448 In delines established 49.999441, the holder of e an outpatient facility delines and maintain patient facility which: 1. safety and well-being of patient facility; hts: Based on iew and document failed to ensure ations were secured. On 11/07/17, in the cy medications were t plastic box with e storage unit did not chanism. The storage unit burses' station, in the n the pre-procedure om, and recovery room. icluded: Amiodarone, , Dexamethasone,	0	140	<ol> <li>Emergency medicines have beer relocated to our emergency crash c</li> <li>Our facility Policy and Procedure states that emergency medicines wis stored in our crash cart. All employed briefed on the proper storage and maintenance of emergency medicat 12/7/17.</li> <li>The Quarterly Quality Assurance Committee will inspect all emergency medications and ensure expiration of have not expired. A log of the Quart Quality Assurance Committee inspec check lists is maintained in our Polic Procedures manual book.</li> <li>The Medical Director relocated the emergency medications to the crash and will maintain the quarterly log b medication inspection.</li> <li>The corrective action was complet 12/7/17.</li> </ol>	art kit. manual ill be ees were cions on cy dates erly ection cy and be cy and he n cart ook of	12/07/201 7



Page 3 of 4

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		7982	B. WING		NG	11/17/2017	
NAME OF PRO	NAME OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SAFE AND SC	OUND FOR WOMEN, INC		:	3131	LA CANADA #110, LAS VEGAS, NEVADA ,8	9169	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REG	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL ULATORY FYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
0142 SS= D	addition to the guid pursuant to NAC 4 a permit to operate shall establish guid policies for the out Require each perso outpatient facility o outpatient facility to tuberculosis in acc 441A.375. Inspector Commen review, interview an facility failed to ens completed the initia (TB) Skin Test with (Employee #7). Fin #7 was hired on 11 Practice Registered of personnel record TB Skin Test was a and read on 09/13/ The 2nd-Step TB S administered on 10 10/20/17, with neg was completed mo the 1st-Step. Revie on Employee TB T revealed the policy	ce - NAC 449.999448 In lelines established 49.999441, the holder of an outpatient facility lelines and maintain patient facility which: 3. on employed by the r under contract with the o have a skin test for ordance with NAC ts: Based on record ind document review, the sure 1 of 7 employees al 2-Step Tuberculosis in the required timeframe idings include: Employee /01/17, as Advanced d Nurse (APRN). Review ds revealed the 1st-Step administered on 09/12/16 16, with negative result. Skin Test was /18/17 and read on ative result. The 2nd-Step re than 12 months after iew of the facility's policy esting (undated) did not include the nts of NAC 441A.375. On cal Staff Manager	014	42	<ol> <li>Employee #7 has received her 2 test. Step 1 was read on 10/20/17. 3 was read on 10/27/17.</li> <li>There was no deficient practice. Employee #7 was up to date with he testing. The documentation for this attached.</li> <li>A log book of employee TB test of has been created to ensure all emp remain up to date.</li> <li>The Clinic Director will review the employee TB test log book at the tir annual employee training and at the initial hire of any new employee.</li> <li>Employee #7 had appropriate TB as of 10/27/17. Documentation of st attached.</li> </ol>	Step 2 er TB s lates loyees ene of time of testing	12/07/201 7



#### Division of Public and Behavioral Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		LIA		MULTIPLE CONSTRUCTION	(X3) DAT COMPLE	E SURVEY
	9004			B. W	ING	12	/06/2017
NAME OF PRO	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BIRTH CONT	ROL CARE CENTER			872 E	E SAHARA AVE, LAS VEGAS, NEVADA ,8910	4	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REG	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL SULATORY FYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
0000	Deficiencies was g an Initial State Peri your facility on 12/0 Nevada Administra Chapter 449, Outp patient records we employee files wer to by the facility, fiv reviewed for compl findings and conclu- investigation by the Behavioral Health prohibiting any crin investigations, acti- relief that may be a under applicable fe	atient Facilities. Five re reviewed. Fifteen e reviewed and attested ve of these files were liance and accuracy. The usions of any e Division of Public and shall not be construed as	0	000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: SANDI NEIGH	Title: Administrator	Date: 12/15/2017
STATE FORM	Event ID: 6S8Y11	Facility ID:	Page 1 of 2

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING	(X3) DAT COMPLE	E SURVEY
		9004	B. W	/ING	12	/06/2017
AME OF PRO	OVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
RTH CONT	ROL CARE CENTER		872	E SAHARA AVE, LAS VEGAS, NEVADA	,89104	
(X4) ID PREFIX TAG	(EACH DEFICIENCY M REG	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL SULATORY FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
0142 SS= F	NAC 449.999448 ( standards of practi addition to the guic pursuant to NAC 4 a permit to operate shall establish guic policies for the out Require each perso outpatient facility to tuberculosis in acc 441A.375. Inspector Commer review and intervie ensure pre-employ testing was conduc 449.375 concernin of 5 employees (Er Findings include: A files on 12/06/17, r Employee #1 Empl 08/21/17. The file of test with a negative 08/23/17 and comp file lacked evidence prior to hire. Emplo hired on 04/11/17 and comp file lacked evidence prior to hire. Emplo hired on 04/11/17 and comp file lacked evidence prior to hire. Emplo hired on 04/11/17 and comp file lacked evidence prior to hire. Emplo hired on 04/11/17 and comp file lacked evidence prior to hire. Emplo hired on 10/30/1 11/08/17. The file I step TB test prior to Administrator ackn evidence of two step tests and reported two step TB proces	3) - Professional ce - NAC 449.999448 In delines established 49.999441, the holder of a noutpatient facility delines and maintain patient facility which: 3. on employed by the r under contract with the p have a skin test for ordance with NAC tes: Based on record w, the facility failed to ment tuberculosis (TB) cted according to NAC g TB requirements for 3 mployees #1, #2, and #5). The review of the employee evealed the following: loyee #1 was hired in contained a two step TB e result initiated on pleted on 09/15/17. The e of a two step TB test oyee #2 Employee #2 was The file contained a two negative result initiated ompleted on 04/20/17. dence of a two step TB mployee #5 Employee #5 0/17. The file contained a two negative result initiated ompleted on 04/20/17. dence of a two step TB mployee #5 Employee #5 0/17. The file contained a two on acked evidence of a two o hire. On 12/06/17, the owledged the files lacked ep pre-employment TB new hires have had the	0142	All new hire employees will und step TST upon offer of employr this will be completed by the fir- patient care. This may also be accomplished by completion of to first date of patient care. Thi has been added to our new em packets and our Administrator I made aware of this requirement importance of timely completion Medical Director will review new packets for comprehensive doc and timely completion of TST, e employee completes screening participation in direct patient ca Administrator is responsible to this plan is implemented and ca consistently. This was complet 17.	nent, and st day of BAMT prior s procedure ployee has been t and the h. Our w hire sumentation ensuring the prior to re. Our to ensure arried out	12/07/20



STATEMEN	of Health Care Quali T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION		(X3) DATE SU COMPLE	TED
	ROVIDER OR SUPPLIER	NVS6143OPF	STREET ADD		STATE, ZIP CODE		09/1	8/2012
	OMEN CARE		3599 S EA	STERN AVI		Addre	$\sim$	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORREC CTIVE ACTION SHO NCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
O 000	Initial Comments			O 000				× .
	the result of the sta was completed at y accordance with C	deficiencies was gene ate re-permitting insp your facility on 9/18/1 hapter 449 Nevada le for Outpatient Faci	ection that 2, in					
	An Infection risk as	ssessment was comp	pleted.					
	Ten patient medica	I records were review	wed.	•				
	by the Health Divis prohibiting any crin actions or other cla	onclusions of any inv ion shall not be cons ninal or civil investiga tims for relief that ma rty under applicable f	trued as ition, ay be					
	The following regul identified.	latory deficiencies we	ere					
O 070 SS=E	Infection Preventio	n Policies		O 070				
00-2	Section 29.							
	Policies for preven	tion of infection:						
	infections and com include policies and exposure to blood- infectious pathogen policies and procee	the prevention and co municable diseases d procedures to prev borne and other pote ns, including, without dures	must ent entially					
	the time and proce	ncluding provisions re dure for hand washir the use of an alcoho	ng with					
	(2) Use of gloves:						Am	erica
eficiencie	es are cited, an approved	plan of correction must b	e returned with	in 10 days af	ter receipt of this state		ies. Ut	<b>DELEC</b>
		DER/SUPPLIER REPRESE					fo	rli
ATE FOR	IM	RECEIVE	D	\$899	ZWD11		<u>ii continua</u>	ion sheet 1 of 11
		OCT 1 7 2012	t • .		$\sim$	1	10.10	
		BUREAU OF HEALTH QUALITY & COMPLIA LAS VEGAS, NV	CARE ANCE			0 10/15	2012	

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SUBVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS6143OPF 09/18/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3599 S EASTERN AVE A ALL WOMEN CARE** addrew Wrong LAS VEGAS, NV 89169 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID. (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) O 070 Continued From page 1 O 070 The proper use of medical gloves, including, without limitation, a requirement that each person who works at the outpatient facility must wear medical gloves when the person: (a) Anticipates coming in contact with blood or bodily fluids: (b) Handles contaminated instruments, items and equipment; (c) Handles biological waste or biologically contaminated waste that may cause harm to humans, animals or plants: (d) Handles linens potentially contaminated with biological waste or biologically contaminated waste that may cause harm to humans, animals or plants; and (e) Performs housekeeping activities or cleans contaminated surfaces. (3) Safe injection practices: Safe injection practices to prevent the contamination of equipment used for injections and medication, including, without limitation, a requirement that a new sterile needle and new sterile syringe be used for each patient and not used for more than one patient. (4) Handling of sharps: The proper handling of sharp instruments and the disposal of sharp instruments, which must be consistent with the standards developed by the Occupational Safety and Health Administration of the United States Department of Labor for the handling and disposal of such instruments. (5) Access of medications in vials: Techniques for accessing a vial of medication, which must comply with the requirements set forth in section 30 of this regulation. If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM 6899 VZWD11 Life

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FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES. (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS6143OPF 09/18/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3599 S EASTERN AVE **A ALL WOMEN CARE** Addren LAS VEGAS, NV 89169 Wrone SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) O 070 Continued From page 2 O 070 (6) Infusion Medications and tubing: The infusion of intravenous medications, which must provide, without limitation, that intravenous tubing and fluid bags or bottles are not to be used for more than one patient. (7) Sterilization and disinfection of medical equipment: The proper sterilization and disinfection of all medical equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility to: (a) Sterilize or ascertain the sterility of items that enter sterile tissue or the vascular system. including, without limitation, surgical instruments, endoscopes, endoscopic accessories, catheters, needles and probes used for ultrasounds: (b) Perform high-level disinfection of reusable items that come in contact with nonintact skin or mucous membranes, including, without limitation, respiratory therapy equipment, anesthesia equipment, bronchoscopes and gastrointestinal endoscopes; and (c) Perform low-level disinfection of reusable items that come in contact with only intact skin, including, without limitation, tourniquets, blood pressure cuffs, linens, stands that are used to hold medical instruments and other furnishings. (8) Handling of equipment: The proper handling of equipment, instruments and devices. Those policies and procedures must, at a minimum, require the outpatient facility to: (a) Sterilize and disinfect reusable items as described in subsection 7; (b) Properly dispose of single-use equipment, instruments and devices after use, if the outpatient facility has decided not to have the equipment, instruments or devices reprocessed; If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM VZWD11

PRINTED: 10/01/2012

AME OF PROVIDER OR SUPPLIER       STREET ADDRESS, OTV, STATE, ZP CODE         SALL WOMEN CARE       SUMMARY STATEMENT OF DEFICIENCIES       WMM       WMM         (X) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFX       PROVIDER'S FLAN OF CORRECTION         TAG       ISLANDARY STATEMENT OF DEFICIENCIES       ID       PREFX       ICAN 1000 CONSCRPTS FLAN OF CORRECTION       DO         0 070       Continued From page 3       ID       PREFX       PREFX       ICAN 1000 CONSCRPTS FLAN OF CON		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI NVS61430PF		(X2) MULTIPLE A. BUILDING B. WING			(X3) DATE SU COMPLE	
ALL WOMEN CARE       LAS VEGAS, NV 59169       WMM1       WMM1       WMM1         (24) 0 TAG       BUMMAPY STATEMENT OF DEFICIENCIES BEDUATIONY ON LSE DENTIFYING WFORMATION REDUATIONY ON LSE DENTIFYING WFORMATION TAG       IPD PRETX INC       PRETX PRETA       PRETA PRETA       PRETA PRETA       PRETA PRETA       PRETA PRETA       PRETA PRETA       PRETA PRETA       PRETA       PRE	IAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
Prefro       REACH DEFICIENCY MUST BE PRECEDED BY FULL REDULTORY OR LSC DENTIFYING INFORMATION)       PREFIX TAG       Construct action should be chose-repredended to to the APPROPRIATE DEFICIENCY)       Construct DEFICIENCY)         0 070       Continued From page 3 and (c) Ensure that: (1) All equipment, instruments and devices that may be reprocessed are reprocessed only by a third-party processor approved by the United States Food and Drug Administration; and (2) No equipment, instruments or devices that may be reprocessed are reprocessed at the outpatient facility.       0 070         (9) The proper handling and disposal of medical weake and specimens. (10) The proper cleaning and disinfection of all areas in which patient care is provided. (11) The proper cleaning on disinfections and communicable diseases, including, without limitation, the method by which the outpatient facility must: (a) Track and document the development and transmission of infections and communicable diseases which are related to the medical procedures performed at the outpatient facility. (b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and (c) Identify and address trends in such developments and transmissions of infections and communicable diseases.         (13) The care of patients with a communicable disease, including, without timitation, patients who are known to have a communicable diseases at the time of arrival at the outpatient facility and	A ALL W	OMEN CARE				WMM (	iddren		
and (c) Ensure that: (1) All equipment, instruments and devices that may be reprocessed are reprocessed only by a third-party processor approved by the United States Food and Drug Administration; and (2) No equipment, instruments or devices that may be reprocessed are reprocessed at the outpatient facility. (9) The proper handling and disposal of medical waste and specimens. (10) The proper cleaning and disinfection of all areas in which patient care is provided. (11) The proper maintenance of a clean and sanitary environment. (12) Infection identification and tracking: The identification and reporting of the development and transmission of infections and communicable diseases, including, without limitation, the method by which the outpatient facility must: (a) Track and document the development and transmission of infections and communicable diseases which are related to the medical procedures performed at the outpatient facility. (b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and (c) Identify and address trends in such developments and transmissions of infections and communicable diseases. (13) The care of patients with a communicable disease, including, without limitation, patients who are known to have a communicable diseases at the time of arrival at the outpatient facility and	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECT CROSS-REFERENC	FIVE ACTION SHO	DULD BE	COMPLETE
outpatient facility.         (9) The proper handling and disposal of medical waste and specimens;         (10) The proper cleaning and disinfection of all areas in which patient care is provided.         (11) The proper maintenance of a clean and sanitary environment.         (12) Infection identification and tracking:         The identification and reporting of the development and transmission of infections and communicable diseases, including, without limitation, the method by which the outpatient facility must:         (a) Track and document the development and transmission of infections and communicable diseases which are related to the medical procedures performed at the outpatient facility;         (b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and developments and transmissions of infections and communicable diseases.         (13) The care of patients with a communicable disease at the time of arrival at the outpatient facility and	O 070	and (c) Ensure that: (1) All equipment, i may be reprocessed third-party process States Food and D and (2) No equipment,	nstruments and device are reprocessed of or approved by the U rug Administration; instruments or device	nly by a Inited es that	O 070				
The identification and reporting of the development and transmission of infections and communicable diseases, including, without limitation, the method by which the outpatient facility must: (a) Track and document the development and transmission of infections and communicable diseases which are related to the medical procedures performed at the outpatient facility; (b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and (c) Identify and address trends in such developments and transmissions of infections and communicable diseases. (13) The care of patients with a communicable disease, including, without limitation, patients who are known to have a communicable disease at the time of arrival at the outpatient facility and		<ul><li>(9) The proper han waste and specime</li><li>(10) The proper cle areas in which pati</li><li>(11) The proper ma</li></ul>	ens. eaning and disinfectio ent care is provided. aintenance of a clean	on of all				•	
<ul> <li>(b) Report the development and transmission of infections and communicable diseases as required by federal, state and local laws; and</li> <li>(c) Identify and address trends in such developments and transmissions of infections and communicable diseases.</li> <li>(13) The care of patients with a communicable disease at the time of arrival at the outpatient facility and</li> </ul>		The identification a development and t communicable dise limitation, the meth facility must: (a) Track and docu transmission of infe communicable dise medical procedure	nd reporting of the ransmission of infecti eases, including, with od by which the outp ment the developme ections and eases which are relat	ions and out atient nt and ed to the					
disease, including, without limitation, patients who are known to have a communicable disease at the time of arrival at the outpatient facility and		<ul> <li>(b) Report the developments and com required by federal</li> <li>(c) Identify and add developments and</li> </ul>	municable diseases , state and local laws Iress trends in such transmissions of infe	as ; and		· · · · · · · · · · · · · · · · · · ·		ç	52
leficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.		disease, including, are known to have the time of arrival a	without limitation, pa a communicable dise at the outpatient facili	tients who ease at ty and				T	o) erica

FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING \_ NVS61430PF 09/18/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3599 S EASTERN AVE A ALL WOMEN CARE** Wona LAS VEGAS, NV 89169 a () SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) O 070 Continued From page 4 O 070 patients who are found to have a communicable disease during the course of treatment at the outpatient facility. (14) The screening for communicable diseases as described in NAC 441A.375 of all employees and of all persons under contract with the outpatient facility who work at the facility and have exposure to patients at the facility. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure post procedures were monitored by the facility for 10 of 10 patient records reviewed. Deepage 230four Planof 10/15/12 Conections Findings include: Ten patient medical records were reviewed. There was no documented evidence the patient's received a follow up telephone call to identify any signs and symptoms of infection. The infection control Registered Nurse (RN) was unable to provide documentation of tracking post procedural infections. On 9/18/12 at 4:10 PM, the infection control RN acknowledged there was no written documentation of tracking of post procedural infections. Severity: 2 Scope: 2 O 090 Surgical Equipment Sterilization O 090 SS=F Section 31. If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. STATE FORM 6899 VZWD11

PRINTED: 10/01/2012

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPL IDENTIFICATION N NVS61430PF	IUMBER:	(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE S COMPLI	
AME OF PROVIDER OR SUPP			DRESS, CITY, S	TATE, ZIP CODE	03/1	0/2012
A ALL WOMEN CARE			ASTERN AVE AS, NV 8916		ren	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCI CIENCY MUST BE PRECEDED B Y OR LSC IDENTIFYING INFORM	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
O 090 Continued Fro	m page 5		O 090			
Sterilization of	Surgical items and equi	ipment:				
in the care of an outpatient disinfected ac prevention an communicable	struments, items or equip patients at facility must be sterilized cording to the program for d control of infections an e diseases adopted by th lity pursuant to section 2	l or or the id ne				
sterilized or di agents at the (a) Before an contractor ma sterilizing or d equipment, the contractor mu instructions of sterilizer for:	truments, items and equi sinfected by equipment of outpatient facility: employee or independen y be assigned the respor isinfecting any instrumer e employee or independent st receive training conce the manufacturer of the and disinfecting the instru-	or cleaning nt nsibility for nt, item or ent erning the device or			· · · · ·	
item or equipn (2) The use ar disinfecting ec (3) The agents instrument, ite (b) An employ assigned the r	nent; nd maintenance of the st	terilizer or sinfect the actor ng or				
manufacturer paragraph (a); (2) Receive tra procedures if t equipment or disinfect an in	nual training concerning s instructions described and aining on any new equipr there is any change in th procedures used to steril strument, item or equipm ient facility shall ensure t	d in ment or le llize or nent.			Am	erica

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU NVS61430PF		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION		(X3) DATE SI COMPLE <b>09/1</b>	
AME OF F	PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE			
ALL W	OMEN CARE	· ·		STERN AVE S, NV 8916	, wong	Addren		
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O 090	documentation of a to this subsection is employee or indepe (3) Manufacturer 's The manufacturer ' any sterilizer or per procedure must be	Il training completed kept in the file of th	pursuant e ipment: erating tion ear the	O 090				
	<ul> <li>(4) The outpatient f employee or indepermanufacturer 's instantiation of the instruments be sterilized or disin (b) The procedures item or equipment l equipment is steriliz disinfection;</li> <li>(c) The procedures an instrument, item (d) The operation a</li> </ul>	acility shall ensure the endent contractor fol structions concerning s, items or equipment for cleaning an instru- before the instrument zed or undergoes hig for sterilizing or disi or equipment; nd maintenance of t	nat each lows the g: nt that may rument, nt, item or gh-level nfecting he			:	•	
	disinfection; (e) The frequency a testing of the sterili (f) The recommend disinfecting the inst and (g) The frequency of disinfecting to ensu minimum level of e	ipment used for high and type of biologic in zer; led agents for steriliz rument, item or equi of testing of any solu tre maintenance of the ffectiveness, but the less often than daily	ndicator zing and ipment; tion for ne solution					
•	(5) Use of biologic i The effectiveness of must be checked b indicator test:	indicator tests: of the sterilization pro y performing a biolog or more frequently i	ocedures gic f				Ame	erica

to 15/25/2012

TATEMEN ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE	R/CLIA MBER:	(X2) MULTIPL A. BUILDING			E SURVEY
		NVS61430PF		B. WING			9/18/2012
AME OF P	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, ST	FATE, ZIP CODE		10/2012
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O 090	Continued From pa	ige 7		O 090			
	1	all implantable devic	201				
	(6) Sterilization reco the biologic indicato the outpatient facilit test is performed to recommended testi equipment is perfor instructions regardin techniques are follo shall establish a me instruments, items of	ords and logs of the m or test must be maintant ty for at least 1 year a o ensure that the ing and maintenance rmed and the manufa- ng proper sterilization owed. Each outpatient othod to track and rec or equipment l or disinfected if there	results of ained by after the of the acturer ' s n t facility call		· ·		
	(7) Physical barriers To aid in environme facility shall provide		tween				
	Based on interview, document review, th documentation of sp medical assistant pri sterilization of instrui facility also failed to MetriCide OPA Plus	a not met as evidence , observation, record a pe facility failed to ass pecialized training to t rior to assuming the d ments. (Employee #2 assure the concentra Solution was verified Solution Test Strip pr ttion.	and sure the luties of 2). The ation of			· · · · · · · · · · · · · · · · · · ·	
	Findings include:	cumented evidence for	ound in	S	See Planof Cons Physe 3,4	ection	10/15/201
1	mployee #2's perso training regarding dir	onnel file of specialize sinfection and sterilize	ed ation of		0	An	ierica
	are cited, an approved pla			n 10 days after re	eceipt of this statement of de		ation sheet 8 of 1

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STATEMENT OF DE AND PLAN OF COF		(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING		(X3) DATE SU COMPLE	TED
NAME OF PROVID	FR OR SLIPPLIER	NVS6143OPF		BESS CITY S	TATE, ZIP CODE	09/1	8/2012
A ALL WOMEN			3599 S EA	STERN AVE	11000 address	3	
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
instru On 9 Regi spec rega instru II) M disin exan Daily Metr obse On 9 expla teste Solu there Vapo On 9 ackm OPA used	stered Nurse a calized training rding disinfection uments. etriCide OPA P fection solution nination room. documentation iCide OPA Plus erved by the GU 0/18/12 at 2:05 ained the Metric ed once a day w tion Test Strip. were four exa for Control System 0/18/12 at 3:50 nowledged she Plus Solution in prior to each in re was no docu	PM, the Infection Co icknowledged there v for Medical Assistan on and sterilization of Plus Solution (high lev n) was observed in ar n of testing the soluti s Solution Test Strip v JS Vapor Control Sys PM, the Registered N Cide OPA Plus Soluti vith the MetriCide OF The Registered Nursumination rooms with em. PM, the Registered f was not aware the M required the test strip use.	vas no t #1 f the on with a vas stem. Nurse ion was PA Plus se stated the GUS Nurse letriCide to be	O 090			
Prote was	ocol a MetriCid required prior t	ems Model G10VP C e OPA Plus Solution to each use of the so infection - MetriCide	Test Strip lution.				
Solu "Tl Solu Plus	tion sheet docu he concentratic tion must be ve	umented: on of your MetriCide ( erified by a MetriCide Strip prior to each use	OPA Plus OPA		See Planof (or Page 5	secting Ame	ricar
deficiencies are contract of the second s	ited, an approved	plan of correction must be		-	er receipt of this statement of deficie ZWD11	ncies.	ion sheet 9 of 11

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A ALL WOM (X4) ID PREFIX TAG O 090 Ca or its Se O 120 Pa SS=F Se Pa	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI ontinued From pa	de level of the solutio	3599 S EA LAS VEGA S FULL TION)	B. WING DRESS, CITY, S STERN AVE AS, NV 8916 PREFIX TAG O 090	TATE, ZIP CODE	RRECTION SHOULD BE	(X5) COMPLETE DATE
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O 120 Po SS=F Se	olicies For Patient						
SS=F Se Po				-			
Se	ection 34.	s & Employee 1B tes	sting	O 120			
	olicies for patients andards of practic	of the facility, profester:	sional				
to re ດເ m Er	section 27 of this gulation, the hold utpatient facility sh aintain policies fo	er of a permit to open nall establish guidelin r the outpatient facilit safety and well-being	rate an les and ty which:				
fo er ou ou	r services provide nsure that all pers utpatient facility or	essional standards of d by the outpatient fa ons employed by the under contract with omply with such profe	acility and the				
Re fa to	cility or under cor	on employed by the c itract with the outpati for tuberculosis in ac	ent facility				
Ba re	ased on interview view, the facility f	s not met as evidenc , record review and c ailed to ensure 3 of 4	locument		Phnof carecturs and exhibits er receipt of this statement of deficie	II	ic is las

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Bureau	of Health Care Quali	ty and Compliance			·		
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		NVS6143OPF		B. WING	·····	09/18	3/2012
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		e requirements of NA ng tuberculosis (TB). and #3)				· ·	
	Findings include:			,			
	received the first s There was no docu	hired 7/16/12. The er tep TB skin test on 6/ umented evidence the a second-step TB sl	/19/12. e	·			
	received the first s There was no doci	hired 8/27/12. The er tep TB skin test on 8/ umented evidence the a second-step TB s	/24/12. e				
	3/3/11 and 3/10/11	a two step TB skin te . There was no docu al TB test was admini	mented				
		) PM, the Infection Co ged the TB skin tests policy.					-
	Screening employ policy (no identifie	ees for communicabl d number) document	e disease ed:				
	step of a 2-step M twelve months, the Mantoux or other	has only completed antoux within the pre en the second step of single-step tuberculos be administered"	ceding f the 2-step			0	· ·
	Screening employ	umented evidence fo rees for communicab the annual TB skin te	le disease		See proge 5 of and dehibits	VOC E	1015/2012 SS
	Severity: 2	Scope: 3				Ame	ericans
If deficienci STATE FOF		d plan of correction must t	be returned wit		ter receipt of this statement of defic /ZWD11	li continuat	·Life
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTI A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE S COMPLE 11/0	
	ROVIDER OR SUPPLIER ONTROL CARE CENT		872 E SA	DRESS, CITY, S HARA AVE AS, NV 8910	STATE, ZIP CODE	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
O 000	This statement of d the result of an initia was conducted at y accordance with Ne (NAC), Chapter 449 for Services of Gen	eficiencies was gene al state permitting su our facility on 11/06/ wada Administrative O Outpatient Facilitie eral Anesthesia, Cor	rvey that 12 in Code s: Permit	O 000	PROVIDERS PLAN OF CORRECTION FOR DEFICIENCY O 201 NAC 449 SEE ATTACHED.	9.999445 (6):	÷
	10 patient medical	sessment was comp charts were reviewed	I.			· .	
×	by the Health Divisi prohibiting any crim actions or other cla	onclusions of any invo on shall not be consi inal or civil investiga ims for relief that ma ty under applicable f	tructed as tion, y be	9			
	identified.	atory deficiencies we					-
O 120 SS=C	NAC 449.999445 (6 instruments NAC 449.999445	5) Sterilization, disinf	ection of	O 120		3	
	6. Sterilization reco the biologic indicato the outpatient facilit test is performed to recommended testi equipment is perfor instructions regardi techniques are follo shall establish a me instruments, items	ing and maintenance med and the manufa ng proper sterilizatio owed. Each outpatier ethod to track and re or equipment previou cted if there is a failu	ained by after the of the acturer ' s n t facility call usly		RECEIVED DEC 11 2012 BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV	Aı	SS nerica
	Y DIRECTOR'S OR PROV		rPowe	hin 10 days aft USTAN INATURE	er receipt of this statement of deficience of the statement of the statement of deficience of the statement	·3·201	

PRINTED: 11/20/2013 FORM APPROVED

BTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY PLETED
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IAME OF PROVIDER OR SUPPLIER	TER 872 E SA	DRESS, CITY, HARA AVE AS, NV 891	STATE, ZIP CODE <b>04</b>		r.
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
a result of a state re conducted in your f accordance with Ne Chapter 449, Outpa	Deficiencies was generated as e-permitting inspection acility on 11/14/13, in evada Administrative Code, atient Facility. sesment was completed.	0000	е 2		
The findings and co by the Health Divisi prohibiting any crim actions or other cla available to any par state or local laws.	I charts were reviewed. onclusions of any investigation on shall not be construed as inal or civil investigations, ims for relief that may be ty under applicable federal, latory deficienceis were		RECEIVED DEC 02 2013 BUREAU OF HEALTHCARE QUALITY & COMPLIANCE LAS VEGAS, NV	а м	9 - 9 - 9
identified.	) Professional standards of	O 140	PROVIDERS PLAN OF CORRECT		
to NAC 449.999441 operate an outpatie guidelines and mair facility which:	idelines established pursuant , the holder of a permit to nt facility shall establish ntain policies for the outpatient n, safety and well-being of atient facility;		FOR DEFIENCY O 140 NAC 449 SEE ATTACHED.	.999448 (1)	
by: NAC 449.9999448 In addition to the gu to NAC 449.999441 operate an outpatie	NT is not met as evidenced idelines established pursuant , the holder of a permit to nt facility shall establish			Am	erica
ORATORY DIRECTOR'S OR PROVID	plan of correction must be returned with ER/SUPPLIER REPRESENTATIVE'S SIGN	hin 10 days af NATURE <i>Л</i>	ter receipt of this statement of deficiencienciencienciencienciencienciencie	es.	e e e e e e e e e e e e e e e e e e e

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ME OF PROVIDER OR SUPPLIER  RTH CONTROL CARE CENTER  TAG  SUMMARY STATEMENT OF DEROBINGES  TAG  SUMMARY STATEMENT OF DEROBINGES  TAG  SUMMARY STATEMENT OF DEROBINGES  TAG  CAROL DEROBING VIENT STATEMENT OF DEROBINGES  TAG  CAROL DEROBING VIENT SATER PRECEDED BY FULL  PRECTA TAG  PROVIDER STAN OF CORRECTION  CAROL DEROBING VIENT SATER PRECEDED TO THE APPROPRIATE  OF 120  Continued From page 1  O 120  O 120  O 120  O 120  During an interview and document review, the facility failed to establish a method to track and recall stanized instruments to the patient in the event of a failure.  During an interview on 11/06/12 with Physician #1, twas revealed that a method for tracking instruments to patients was not in place.  Severity: 1  Scope: 3  Stanuey 12-8-2012  STANUEY 12-8-2012  COMMENDER  COMPLETE  STANUEY 12-8-2012  COMMENDER  COMPLETE  CAROL DEROBING VIENCE  COMPLETE  CAROL DEROBING VIENCE  CAROL DEROBING	BIRTH CONTROL CARE CENTER 872 E SAI				IARA AVE		COMPL	(X3) DATE SURVEY COMPLETED 11/06/2012	
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This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish a method to track and recall sterilized instruments to the patient in the event of a failure. During an interview on 11/06/12 with Physician #1, it was revealed that a method for tracking sterilized instruments to a patient in the event of a failure was not in place. During a document review on 11/06/12 of sterilization logs for the biological indicator test, it was revealed that a method for tracking instruments to patients was not in place. Severity: 1 Scope: 3	(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD BE	(X5) COMPLETE DATE	
by: Based on interview and document review, the facility failed to establish a method to track and recall starilized instruments to the patient in the event of a failure. During an interview on 11/06/12 with Physician #1, it was revealed that a method for tracking sterilized instruments to a patient in the event of a failure was not in place. During a document review on 11/06/12 of sterilization logs for the biological indicator test, it was revealed that a method for tracking instruments to patients was not in place. Severity: 1 Scope: 3	O 120	Continued From pa	ge 1		O 120	· · · · · · · · · · · · · · · · · · ·	•	-	
<ul> <li>#1, it was revealed that a method for tracking sterilized instruments to a patient in the event of a failure was not in place.</li> <li>During a document review on 11/06/12 of sterilization logs for the biological indicator test, it was revealed that a method for tracking instruments to patients was not in place.</li> <li>Severity: 1 Scope: 3</li> </ul>	r.	by: Based on interview facility failed to esta recall sterilized inst	and document revie ablish a method to tr	ew, the ack and		n K		12/8/12	
sterilization logs for the biological indicator test, it was revealed that a method for tracking instruments to patients was not in place. Severity: 1 Scope: 3		#1, it was revealed that a method for tracking sterilized instruments to a patient in the event				• • •		н м	
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leficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.						: 1		SS	
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