		AND HUMAN SERVICES	·····	·		APPROVE 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		35D0946316	B. WING		01	/07/2019
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RED RIV	ER WOMEN'S CLINIC			512 1ST AVE N FARGO, ND 58102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
D 000	INITIAL COMMEN	rs	D 00	0		
	January 7, 2019 for laboratory in compl	on survey conducted on und Red River Women's Clinic iance with all applicable parts 3; The Clinical Laboratory ndments.				
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				I	Amer	icans
ABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	Uni	
ny deficien	cy statement ending with	an asterisk (*) denotes a deficiency wh	ich the insti	tution may be excused from correcting pro for nursing homes, the findings stated above	ding it is dete	rmined that

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provide. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DDINTED. 04/00/0040

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(<u>)MB NO</u>	<u>. 0938-0391</u>
						(X3) DATE SURVEY COMPLETED	
		35D0946316	B. WING	;		02	07/2017
NAME OF	PROVIDER OR SUPPLIER	· · · · · ·		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
RED RIV	ER WOMEN'S CLINIC	2			512 1ST AVE N FARGO, ND 58102		
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	February 7, 2017 fo Clinic laboratory in parts of 42 CFR, Pa	on survey conducted on bund Red River Women's compliance with all applicable art 493; The Clinical ement Amendments.					
						C	6
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LABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		KGIDATE
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PRINTED: 02/23/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35D0946316		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/19/2015	
ED RIV	ER WOMEN'S CLINIC	3		1ST AVE N RGO, ND 58102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
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	February 19, 2015 Clinic laboratory in parts of 42 CFR, P	ion survey conducted on found Red River Women's compliance with all applicable art 493; The Clinical ement Amendments.		FILE		
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		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35D0946316	A. BUILDING	APR 2 4 2013	E SURVEY PLETED 01/2013
AME OF P	ROVIDER OR SUPPLIER		STR	ETADORESS OF PREAFTER DODAITIES	
RED RIV	ER WOMEN'S CLIN	C		4RGO, ND 58102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
D6054	 493.1413(b)(9) TECHNICAL CONSULTANT RESPONSIBILITIES The technical consultant is responsible for evaluating and documenting the performance of individuals responsible for moderate complexity testing at least annually, after the first year. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, the laboratory failed to ensure a technical consultant evaluated and documented annual competency evaluations in 2011-2012 for 3 of 5 testing personnel sampled (Testing Personnel #2, #3, and #4). Failure to evaluate testing personnel annually limits the laboratory's ability to ensure testing personnel perform patient testing accurately. Findings include: Reviewed at approximately 3:55 p.m. on 04/01/13, the 2011-2013 patient testing logbook revealed the following testing personnel performed patient testing: 		D6054	1. The test processes found to be deficient will be corrected by annually evaluating all testing personnel, including personnel #2, #3 & #4 (physicians).	
				 2. Other test systems having the potential to be affected will be identified by including physicians as testing personnel in the future. Any new physicians will be deemed testing personnel & included in the annual competency evaluation. 3. The measures to be put into place will be to include physicians as testing personnel when conducting the Quarterly Quality Assurance Review. 4. No corrective actions need to be taken for patients. 5. The deficiency will be corrected by 5/7/1 	
BORATOR	 Testing Perso Testing Perso Testing Perso Reviewed at ap 04/01/13, the 2011 competency evalut Personnel #2, #3, Reviewed at ap 04/01/13, the poling 06/04/07, stated, moderate comple semi-annually in the poling of the personnel #2, #3 	g Personnel #2 in 2012 g Personnel #3 in 2011-2012 g Personnel #4 in 2011 ed at approximately 4:20 p.m. on he 2011-2012 testing personnel cy evaluations failed to include Testing #2, #3, and #4. ed at approximately 4:30 p.m. on he policy "Lab Personnel," dated stated, " All personnel performing complexity tests shall be evaluated ally in the first year, then annually		May 7 th , 2013. All testing personnel will have been present & evaluated by that date. 6. The facility will monitor the effectiveness of its corrective action by including physicians in testing personnel. The Quarterly Quality Assurance Review will include physicians as testing personnel – and the Quarterly Quality Assurance Review will be the tool used to ensure that the testing is done annually of ALL testing personnel.	2
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FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 1 of 2

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35D0946316		(X2) MULTIPLE CONSTRUCTION (X3) I A. BUILDING			DATE SURVEY	
		B. WING		04/01/2013		
NAME OF PROVIDER OR SUPPLIER RED RIVER WOMEN'S CLINIC			ST	7172013		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH DEFICIENCY		ON SHOULD BE COM HE APPROPRIATE	
D6054	04/01/13, Person did not perform a	bage 1 w at approximately 4:40 p.m. on nel #1 confirmed the laboratory nnual competency evaluations nel #2, #3, and #4.	D6054	7. The Technical Consultant an Director will monitor the corre quarterly and yearly.		
					S.	(C)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35D0946316		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		B. WING		04/2	6/2011			
RED RIVER WOMEN'S CLINIC 512 1S				ET ADDRESS, CITY, STATE, ZIP CO 1ST AVE N RGO, ND 58102	ADDRESS, CITY, STATE, ZIP CODE ST AVE N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
	April 26, 2011 four laboratory in comp	tion survey conducted on nd Red River Women's Clinic liance with all applicable parts 93; The Clinical Laboratory	D 000	FIL	E			
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					Amori	hone		

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