Health Facility Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ABOR00001	A. BUILDING _____ B. WING _____	07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE ROCK FAMILY PLANNING SERVICES,	#4 OFFICE PARK DRIVE LITTLE ROCK, AR 72211

RECEIVED SEP - 2 2016 By

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
1 000	LICENSURE MEMO TAG An entrance conference was conducted on 07/25/16 with the Facility Representative. The Representative was informed the purpose of the visit was to conduct a state licensure survey. An exit conference was conducted on 07/27/16 with the Facility Representative. INFECTION CONTROL FOR ABORTION FACILITIES SECTION 10: A.1. The facility shall develop and use a coordinated process that effectively reduces the risk of endemic and epidemic nosocomial infections in patients, and health care workers. Based on observation and interview, the facility failed to ensure a clean and sanitary environment was maintained in that the furnishings of two (#1, #4) of five (#1-#5) recovery areas included cloth chairs; one (#5) recovery area had a chair with rips; disposable padding was observed on the floor between recovery rooms #1-#2 and #4-#5; the laundry room had a ceiling tile that was loose and hanging with a blue pad inserted above; three ceiling tiles had an area of brown discoloration in Procedure Room #1, and there was an accumulation of dust on equipment in the ultrasound room. The failed practice did not assure patients would be protected from likely sources of infection and affected all patients who received treatment at the facility. The findings were: A. Observation on 07/27/16 from 1500 - 1550 revealed the following: 1) Recovery areas #1 and #4 of 5 (#1-#5) had a cloth chair in the area which could not be sanitized between patients.	1 000	Infection Control: Section 10.A.1 (1&2) 1. Cloth chairs were available for guest seating in the recovery area, and one vinyl chair had a rip in the surface. These chairs were removed from the recovery area and replaced with vinyl chairs or hard surface chairs that are able to be sanitized. 2. This action took place on 7-29-2016. 3. The Clinic Director was responsible for replacing the chairs. 4. All cloth chairs in the facility are scheduled to be recovered with high quality vinyl that can be sanitized. This will ensure no cloth chairs can be moved to the recovery area for guest seating while waiting with patients. Torn chairs have been discarded. Infection Control: Section 10.A.1 (3) 1. Disposable padding will not be used on the floor in the recovery area. If disposable padding is used to contain a spill it will be immediately removed. All staff were made aware of this action. 2. The staff were informed of this desired action on 7-29-16. 3. All staff who work in the recovery area were informed of the desired action.	

LAB [redacted] TITLE Clinic Director (X6) DATE 8/30/16

STA [redacted] Z8T311

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1 000	Continued From page 1 2) Recovery area #5 had a chair with vinyl type covering with rips in the surface which could not be sanitized between patients. 3) Disposable blue padding was observed on the floor between recovery rooms #1-#2 and #4-#5. There were no patients in the recovery rooms at the time of observation. The Director of Nursing stated procedures were finished for the day and at the time of observation; the rooms had not been cleaned. 4) In the Laundry room, above the washer and dryer area, a ceiling tile was displaced and hanging down. A disposable blue pad was observed on top of the tile. At the time of observation, the Director of Nursing stated a prior water leak had occurred in the ceiling above the tile. 5) Three ceiling tiles in Procedure Room #1 were discolored and stained brown. At the time of observation, the Director of Nursing stated a prior water leak had occurred in the ceiling above the discolored tiles. 6) A Mindray Mobile Trolley for Ultrasound had an accumulation of dust on the surface. B. The Director of Nursing confirmed the findings in A. at the time of observation. INFECTION CONTROL FOR ABORTION FACILITIES SECTION 10.A.3.d There shall be policies and procedures establishing and defining the Infection Prevention and Control Program, including: ... (d) measures for prevention of infections; Based on observation, review of high level disinfectant (HLD) daily test strip logs, review of manufacturer's instructions and interview, it was determined the facility failed to assure patients	1 000	4. The nursing staff will be responsible for monitoring that the disposable padding is not left on the floor after patient discharge. Infection Control: Section 1..A.1 (4&5) 1. Discolored ceiling tiles observed in the laundry room and procedure rooms were replaced. 2. The tiles were replaced on 8-8-16. 3. The clinic director was responsible for ensuring the completion of these repairs. 4. A monthly clinic check will be added to the cleaning log to ensure the entire clinic is checked for any stains or areas needing extra attention. A member of the supervisory staff will be responsible for completing this action and will report to the Clinic Director or the medical director. Infection Control: Section 1..A.1 (6) 1. The mobile cart for the ultrasound was found to be dusty. Additional cleaning to the bottom of the cart was completed. 2. The cart was cleaned on 7-27-16. 3. The ultrasonographer completed the cleaning. 4. A weekly cleaning log will be created for the ultrasound room to ensure all areas have been cleaned.	

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1 000	Continued From page 2 were protected from likely sources of infection in that the Minimum Recommended concentration (MRC) of the HLD was not verified prior to each reprocessing cycle as required per manufacturer's instructions. Failure to test the MRC prior to each reprocessing cycle did not assure the concentration of the product was above the level needed to achieve HLD. The failed practice was likely to affect all patients treated at the facility. The findings were: A. Observation on 07/27/16 from 1500-1550, revealed six containers, identified by the Director of Nursing as used for HLD of non-critical equipment. The Director of Nursing stated at the time of observation the HLD used by the facility was MaxiCide OPA 28 day. B. Review on 07/29/16 from 1048 -1103 of "MaxiCide OPA 28 daily Test Strip Log" for Procedure Rooms #1 and #2 revealed the statement "MaxiCide OPA is to be tested daily with provided test strips. Pass/Fail of the strip should be recorded for each individual area of MaxiCide". Review of the test strip logs for Procedure Rooms #1 and #2 revealed from 01/06/16 - 07/29/16 Area 1 (hand piece soaking), Area 2 (hose soaking) and Area 3, (soaking done near Berkley) were not documented prior to each reprocessing cycle. C. Review of the manufacturer's instructions of use for MaxiCide OPA 28 day solution on 07/29/16 at 0930 revealed "Monitor the Minimum Recommended Concentration (MRC) of the solution prior to each reprocessing cycle to ensure the OPA concentration is above 0.35%". D. The Director of Nursing was interviewed on 07/29/16 at 1340 and confirmed the facility was	1 000	Infection Control: Section 10.A.3.d (1) 1. Maxicide OPA testing has been changed from daily testing to testing before each use. The policy and logs will be changed to reflect the need for additional testing prior to each cycle instead of daily. 2. Correction to the logs and training of the staff was completed on 8-30-16. 3. The OR supervisor will be responsible for ensuring the corrective action is taken. 4. The OR supervisor will monitor all employees testing of the maxicide and will observe that documentation is completed.	

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1 000	Continued From page 3 not checking the MRC of the MaxiCide OPA 28 prior to each reprocessing cycle. Based on observation, review of manufacturer's instructions, Center for Disease Control (CDC) Guidelines and interview, it was determined the facility failed to assure patients were protected from likely sources of infection from reusable nasal hoods. Failure to store nasal hoods to prevent recontamination did not assure patients would be protected from infection. The failed practice was likely to affect all patients treated at the facility. The findings were: A. Observation on 07/27/16 from 1500-1550 of Procedure Rooms #1 and #2 revealed a drawer in each room was lined with a paper product. The contents of each drawer included two nasal hoods. Each nasal hood had a paper product lining the inside. In an interview with the Director of Nursing at the time of observation she stated: the paper product in each of the nasal hoods was used to collect extra liquid after the items were high level disinfected and rinsed; nasal hoods were retrieved from the drawer prior to use by staff in the Procedure Room; and the facility adhered to CDC and manufacturer's guidelines. PHARMACEUTICAL SERVICES SECTION 11.A.2.d. Pharmaceutical services shall be under the direction of a licensed pharmacist if required by State law. In case the Abortion Facility does not require a licensed pharmacist, the Medical Director shall assume the responsibility of directing Pharmaceutical Services. A licensed pharmacist means any person licensed to practice pharmacy by the Arkansas State Board of Pharmacy who provides pharmaceutical services as defined in the Pharmacy Practice Act.	1 000	Infection Control: Section 10.A.3.d (2) 1. Nasal hoods will be allowed to dry completely before being placed in the drawer for use. This will eliminate the need for absorbable paper. All OR and nursing staff were informed of the required actions. 2. The correction and education of the staff was completed on 7-30-16 3. The Clinic Director was responsible for training OR and nursing staff. 4. Prior to each use the RN will observe that the nasal hoods have been stored appropriately.	

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1 000	Continued From page 4 The pharmacist or Medical Director shall make provisions that shall include, but not be limited to: (a) development and implementation of pharmacy policies and procedures; (b) annual review and revisions of pharmacy policies and procedures, with documentation of dates of review; (c) maintenance of medications in the Abortion Facility to meet the needs of the population served; (d) maintenance of medications in the Abortion Facility to ensure accountability; and (e) proper storage of medications. Based on observation, review of the medication log and interview, it was determined the facility failed to ensure an accurate count of two (Fentanyl, Midazolam) of three (Fentanyl, Midazolam and Diazepam) controlled drugs at the facility. Failure to have an accurate count of Fentanyl and Midazolam did not assure medication errors or unauthorized use of the drugs would be identified. The failed practice affected all patients treated at the facility. The findings were: A. Observation on 07/27/16 from 1500-1550 revealed Midazolam 1601 milligrams (mg) listed on the facility controlled drug log. The count was verified by the Director of Nursing at the time of observation and counted as 267 mg in excess of the 1601 mg documented on the controlled drug log. The Director of Nursing stated the excess was the result of an accumulation of medication vial overfills from the manufacturer. B. Observation on 07/29/16 at 1240 revealed Fentanyl 5072 milliliters (ml) listed on the facility controlled drug log. The count was verified by the Director of Nursing at the time of observation and counted as 13 ml in excess of the 5072 documented on the controlled drug log. The	1 000	Pharmaceutical Services: Section 11.A.2.d 1. Excess medication is accumulated from overfill by the manufacturer of the controlled drugs. When drawing up medications daily the nurse will document the amount of overage gained during drawing and administration of the controlled substances. At the end of the shift the count will be corrected by the RN who drew the medication. The excess accumulated will be added to the total amount of each controlled substance. This will ensure that the daily end of shift count will always reflect the actual amount of controlled substance available in the facility. 2. The change in documentation was explained to all RN staff responsible for drawing and administering the controlled substances. The change and education of the staff was completed on 8-30-16. 3. All RN staff will be responsible for ensuring this change is corrected. 4. The clinic director will monitor the count of the drugs weekly to be sure the corrected count is being maintained and that the actual amount of controlled substances is accurately reflected on the daily log.	

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1 000	Continued From page 5 Director of Nursing stated the excess was the result of an accumulation of medication vial overfills from the manufacturer. C. The Director of Nursing confirmed by interview on 07/29/16 at 1248 unauthorized use of the drugs as listed in A and B would be difficult to determine due to the undocumented controlled drug excess.	1 000		

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1 000	LICENSURE MEMO TAG On 11/20/17 at 10:15 AM, an entrance conference was conducted with the Facility Representative. The Representative was informed the purpose of the visit was to conduct a state licensure survey. On 11/21/17 at 12:25 PM, an exit conference was conducted with Facility Representatives. The findings of the survey were discussed.	1 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Arkansas Department of Health

5800 West Tenth Street, Suite 400 ● Little Rock, Arkansas 72204 ● Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

December 7, 2017

[redacted]
Little Rock Family Planning Services, PLLC
#4 Office Park Drive
Little Rock, AR 72211

Re: Facility Inspection 11/21/17

Dear Ms. [redacted]

On November 21, 2017, the Arkansas Department of Health conducted an inspection of your facility. The findings from this inspection revealed the Red Cross was not listed on the Emergency Phone Number list as required.

It is our understanding this has been corrected. Please fax a statement confirming our understanding to 501-661-2165.

Pursuant to Arkansas Ann Code §20-9-302 (3)(A)(ii) you have thirty (30) days from the mailing of this notice to respond with the confirmation or ask for a hearing. If you fail to do so, the license will be suspended. The suspension shall remain in effect until all violations have been corrected pursuant to §20-9-302 (3) (A)(iv).

Sincerely,

Becky Bennett

Becky Bennett, Section Chief
Health Facility Services
Phone: 501-661-2201