STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AB0026	A. BUILDING: _____ B. WING _____	09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY REPRODUCTIVE HEALTH, IN	700 HEBRON STREET CHARLOTTE, NC 28273

(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
E 131	.0302 Governing Authority 10A NCAC 14E .0302 (a) The governing authority, as defined in Rule .0101(6) of this Subchapter, shall appoint a chief executive officer or a designee of the clinic to represent the governing authority and shall define his or her authority and duties in writing. This person shall be responsible for the management of the clinic, implementation of the policies of the governing authority and authorized and empowered to carry out the provisions of these Rules. (b) The chief executive officer or designee shall designate, in writing, a person to act on his or her behalf during his or her absence. In the absence of the chief executive officer or designee, the person on the grounds of the clinic who is designated by the chief executive officer or designee to be in charge of the clinic shall have access to all areas in the clinic related to patient care and to the operation of the physical plant. (c) When there is a planned change in ownership or in the chief executive officer, the governing authority of the clinic shall notify the Division in writing of the change. (d) The clinic's governing authority shall adopt operating policies and procedures that shall: (1) specify the individual to whom responsibility for operation and maintenance of the clinic is delegated and methods established by the governing authority for holding such individuals responsible; (2) provide for at least annual meetings of the governing authority, for which minutes shall be maintained; and (3) maintain a policies and procedures manual designed to ensure professional and safe care for the patients which shall be reviewed, and revised when necessary, at least annually, and shall include provisions for administration and	E 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah J. Walsh — TITLE: Executive Director — (X6) DATE: 11-8-19

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E 131	Continued From page 1 use of the clinic, compliance, personnel quality assurance, procurement of outside services and consultations, patient care policies, and services offered. (e) When the clinic contracts with outside vendors to provide services such as laundry, or therapy services, the governing authority shall be responsible to assure the supplier meets the same local and state standards the clinic would have to meet if it were providing those services itself using its own staff. (f) The governing authority shall provide for the selection and appointment of the professional staff and the granting of clinical privileges and shall be responsible for the professional conduct of these persons. (g) The governing authority shall be responsible for ensuring the availability of supporting personnel to meet patient needs and to provide safe patient care. This Rule is not met as evidenced by: Based on review of facility policies and procedure, observation during tour, and staff interviews, the governing authority failed to ensure systems were in place to account for narcotic medications on hand for 2 of 2 narcotic medications. Findings include: Review on 09/12/2019 at 1652 of facility policies revealed there is no policy regarding narcotic count. Observation during tour on 09/12/2019 at 0910 revealed a locked medication cabinet. Review of the Narcotic Medication Count Log revealed documentation on 09/11/2019 of 72 Hydrocodone	E 131	The policy regarding counting narcotics (Norco and Valium) now includes the unopened bottles from the locked drug cabinet. Example: If there are 72 Norco (hydrocodone) tablets in the opened bottle, and there are two unopened bottles of Norco/Hydrocodone present in the locked cabinet, the count is 272 rather than 272. This count will be reflected on the daily medication log at the beginning and end of each day. Additionally, full bottles will be logged in at the top of the daily log sheet on the day they are received, lot #, expiration date, name of drug, and amount in bottle will be noted. Plan of correction implemented by Executive Director. Medical Director will sign Verification sheet as each new bottle information is entered.	9/13/19

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E 131	Continued From page 2 5/325 tablets on hand. Observation revealed there were two unopened bottles of Hydrocodone 5/325 containing 100 tablets in each bottle and one opened bottle of Hydrocodone 5/325 containing 72 tablets in the locked medication cabinet. Documentation indicated there should be 72 tablets on hand, while the actual observed on hand count was 272 tablets. Review of the Narcotic Medication Count Log revealed documentation on 09/11/2019 of 11 Valium 10 mg tablets on hand. Observation revealed there were two unopened bottles of Valium 10 mg containing 100 tablets in each bottle and one opened bottle of Valium 10 mg containing 11 tablets in the locked medication cabinet. Documentation indicated there should be 11 tablets on hand, while the actual observed on hand count was 211 tablets. Observation revealed the unopened bottles of Hydrocodone 5/325 and Valium 10 mg were not included in the narcotic medication count on 09/11/2019. Interview on 09/13/2019 at 0950 with RN (registered nurse) #1 revealed she was the scheduled RN in recovery for the day. Interview revealed she counts the narcotic medications with a second person. Interview revealed she did not include the unopened bottles of medication in her count. Interview revealed she was trained to perform the count in this way. Interview on 09/12/2019 at 1652 with the Executive Director #2 revealed "we don't have a policy in place as we have not had a problem with narcotic full bottles not included in the daily couts." Interview revealed "the only people who know where the key to the medication cabinet is kept is the RNs, CNA #3, and myself (Executive Director #2)." Interview revealed there was no system in place to identify if a full bottle of	E 131		

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E 131	Continued From page 3 medication was missing.	E 131	Orientation for PRN Registered Nurses will be documented the same as it is for permanent part time or full time RN's Executive Director will implement this correction. Monitoring will be upon June & January personnel file review.	
E 149	.0306(D) Personnel Records 10A-14E .0306 (d) The clinic shall provide an orientation program to familiarize each new employee or contractual employee with the clinic, its policies, and the employee's job responsibilities This Rule is not met as evidenced by: Based on facility procedure log, staff personnel files, and staff interview the governing authority failed to provide documentation of orientation for 3 RNs (registered nurses) working independently in the clinic. Findings include: A. Review on 09/12/2019 of the facililty procedure log revealed RN #1 worked 06/14/2019, 07/12/2019, and 09/13/2019 independently. Review on 09/12/2019 of the personnel file for RN #1 revealed her start date was 05/23/2019. Review revealed there was no documentation of orientation to the clinic. Interview on 09/13/2019 at 1300 with RN #1 revealed CNA #1 and Executive Director #2 oriented RN #1. Interview revealed the orientation consisted of reading the cell phone policy and procedure. RN #1 did not remember if the job description was reviewed during the orientation. Interview revealed RN #1 was not oriented to her role during a fire emergency. Interview on 09/13/2019 at 1130 with the	E 149		

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E 149	Continued From page 4 Executive Director #2 revealed she trained RN #1 in patient care and charting. Interview revealed "items on the checklist are reviewed along with fire exits." Interview revealed "I (Executive Director #2) don't know if the paperwork was done." 2. Review on 09/12/2019 of the facility procedure log revealed RN #2 worked 05/15/2019. Review on 09/12/2019 of the personnel file for RN #2 revealed her start date was 05/15/2019. Review revealed there was no documentation of orientation to the clinic. Interview on 09/13/2019 at 1130 with the Executive Director #2 revealed she trained RN #2 in patient care and charting. Interview revealed "items on the checklist are reviewed along with fire exits." Interview revealed "I (Executive Director #2) don't know if the paperwork was done." 3. Review on 09/12/2019 of the facility procedure log revealed RN #3 worked 09/06/2019. Review on 09/12/2019 of the personnel file for RN #3 revealed her start date was 09/06/2019. Review revealed there was no documentation of orientation to the clinic. Interview on 09/13/2019 at 1130 with the Executive Director #2 revealed she showed RN #3 the patient restroom, to check patient's pad for amount of bleeding, employee restroom, and how to evacuate a patient during a fire. Interview revealed Executive Director #2 reviewed with RN #3 patient charting, clinic flow, and medications logs. Interview revealed there was no policy and procedure review required and there was no	E 149		

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E 149	Continued From page 5 documentation of the clinic orientation in the personnel file of the agency RN.	E 149		
E 159	.0312(A) Medications and Anesthesia 10A-14E .0312 (a) Medication (1) No medication or treatment shall be given except on written order of a physician. (2) Medications must be administered in accordance with the Nurse Practice Act of the State of North Carolina, and must be recorded in the patient's permanent record. This Rule is not met as evidenced by: Based on review of the facility's policy and procedures, observations during facility tour, and staff interviews, the facility staff failed to assure medications were administered by a licensed nurse or medical doctor (MD). Findings include: Review on 09/13/2019 of the facility policies revealed there was no policy regarding Medication Administration. Observation during tour of the procedure room on 09/12/2019 at 0910 revealed a small pink glass medication cup with Cytotec (medication used in abortions) hand written on the cup with 19 white round tablets in the cup. The cup was inside a cabinet alongside opened containers of hibiclens (antiseptic skin cleaner), betadine (topical antiseptic), and a disinfectant spray.	E 159	The cytotec ordered by the physician post-operatively in the procedure room will be delayed until the patient is admitted to Recovery Room where the RN on duty will give the medication to the patient. Executive Director & Medical Director will implement this correction. RN's signature will be monitored at the time of existing daily patient chart review.	9-17-19

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E 159	Continued From page 6 Interview on 09/13/2019 at 1300 with the Executive Director #2 revealed the "surgical tech" is supposed to return the Cytotec to the nurse at the end of the day. Interview revealed the Cytotec should be administered, by the surgical tech, to the patients prior to them (the patients) going to the recovery area. Interview on 09/12/2019 at 0950 with CNA #1 revealed when the physician instructs to give the Cytotec, she (CNA #1) removes the medication from the cup with a gloved finger and places it under the patients tongue. Interview revealed a nurse is not the person giving the patient the Cytotec. Interview on 09/13/2019 at 0950 with RN #2 revealed she is not involved in giving the Cytotec in the procedure room.	E 159	(E 165) Executive Director will implement correction. Monitoring will be indicated by the term "log review" accompanied by employee's first name and date - this review will be done at the time of the 28-day Maxicide solution change (or any time sooner if solution needs replacing) and will be documented on Maxicide Test Strip log in surgery room.	
E 165	.0314 Cleaning of Materials and Equipment 10A-14E .0314 (a) All supplies and equipment used in patient care shall be properly cleaned or sterilized between use for different patients. (b) Methods of cleaning, handling, and storing all supplies and equipment shall be such as to prevent the transmission of infection through their use. This Rule is not met as evidenced by: Based on facility policy and procedure, manufacturer recommendations, observation during tour, high-level disinfectant log, and staff interview, the facility staff failed to perform	E 165	The open soak container of Maxicide that handles and connectors are placed in will be tested between the 28 day changes of the solution with Maxicide OPA 28 strips to ensure that the Maxicide (high level disinfectant) is still at effective strength. The 1.8% glutaraldehyde test indicator strips will be used and results recorded each day the solution is used.	9/13/19

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E 165	Continued From page 7 strength test of the Maxicide solution prior to each use. Review on 09/13/2019 of the facility policy titled "Maxiclide (sic) OPA 28 Test Strips" with a date of 12/01/2018 revealed "The open soak container of Maxicide that handles, and connectors are placed in will be tested, between the 28-day changes of the solution with Maxicide OPA 28 strips to ensure that the Maxicide (High-level disinfectant) is still at effective strength. This will be done once a week ..." Review on 09/13/2019 of the "MaxiCide Manufacturer's Recommendation" revealed "...Monitoring of Germicide to Ensure Specification are Met: ... the MaxiCide solution be tested with a 1.8% glutaraldehyde test indicator prior to each usage ..." Observation during tour on 09/12/2019 at 0910 revealed a small piece of paper on the wall in the procedure room with dates, pass, and some one's initials. The paper was identified as the MaxiCide test log. Observation on 09/12/2019 at 0948, of the MaxiCide spot strength test performed by CNA #1 resulted in a fail. Review of the "MaxiCide test log" indicated on 05/19/2019, 06/07/2019, 06/22/2019, 07/05/2019, 07/25/2019, 08/02/2019, 08/21/2019 the MaxiCide was tested and passed. There were no other "MaxiCide test logs" available for review. Interview on 09/12/2019 at 1600 with the Executive Director revealed the MaxiCide only had to be tested once every 28 days.	E 165		