State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING FTAF-0016 07/19/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 S. WHITING ST, SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY T 000 12 VAC 5-412 Initial comments T 000 Plan of Correction An announced Initial Licensure Abortion Facility inspection was conducted at the above referenced T 030 facility July 18 and 19, 2012 by two (2) Medical Facility Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The Bylaws of the Governing Authority will be amended to The facility was found to not be in compliance with the State Board of Health 12 VAC 5-412, specify that the governing body Regulations for Abortion Facility's effective appoints the administrator and December 29, 2011. Deficiencies were identified delegates to the administrator and cited, and will follow in this report. the authority and responsibilities 5-30-12 T 030 T 030 12 VAC 5-412-140 E Organization and as defined in the job description management of the administrator. E. The bylaws shall include at a minimum the following: 1. A statement of purpose; 2. Description of the functions and duties of The Governing Body minutes will the governing body, or other legal authority; be amended to appoint the 3. A statement of authority and responsibility delegated to the administrator and to the clinical (name of person) as the staff: administrator. 4. Provision for selection and appointment of clinical staff and granting of clinical privileges; and 5. Provision of guidelines for relationships among the governing body, the administrator and The governing body minutes will the clinical staff. be amended to contain This RULE: is not met as evidenced by: guidelines on how clinical staff Based on document review and staff interview the are granted privileges. facility failed to ensure the governing body appointed the administrator. The facility governing body also failed to ensure the clinical staff were given privileges to practice in the facility. The findings include: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE HRESIDEN STATE FORM 3BIB11 If continuation sheet 1 of 29



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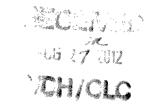
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State of Virginia STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 07/19/2012 FTAF-0016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **101 S. WHITING ST. SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC** ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) T 110 Continued From Page 8 T 110 T 110 This RULE: is not met as evidenced by: Based on a review of facility personnel files and an interview it was determined the facility falled to ensure physicians were licensed to practice medicine in Virginia and had the necessary The administrator will run a training and experience to perform abortions. NPDR (National Data Bank Request) on all physicians to The findings were: 8-30-12 verify through the NPDR that the A review of the personnel files for the physicians physicians meet the training and and certified registered nurse anesthetist (CRNA) revealed the facility staff failed to run a NPDR experience required to perform (National Data Bank Request) on practitioners as first trimester abortions and required by the regulations. The facility failed to verify through the NPDR the practitioners met the fulfill their job requirements. training and experience required to perform the job requirements. An interview was conducted with the administator on 7/18/2012 at approximately 3pm and the he/she stated the facility does not require the physicians to be board certified in Obstetrics and Gynecology. T 135 12 VAC 5-412-210 A Patients' rights T 135 A. Each abortion facility shall establish a protocol relating to the rights and responsibilities of patients consistent with the current edition of the Joint Commission Standards of Ambulatory Care. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities, in a language or manner they understand. Patients shall be given a copy of their rights and responsibilities upon admission. This RULE: is not met as evidenced by: Based on interviews and document review the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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ALEXANDRIA WOMEN'S HEALTH CLINIC 101 S. WH				HITING ST, SUITE #215 ORIA, VA 22304			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
T 155	E. The facility shall provide each patient or her designee with the name, mailing address, and telephone number of the: 1. Facility contact person; and 2. The OLC Complaint Unit, including the toll-free complaint hotline number. Patients may submit complaints anonymously to the OLC. The facility shall display a copy of this information in a conspicuous place. This RULE: is not met as evidenced by: Based on interviews and document review the facility staff failed to ensure each patient was given a copy of their rights and responsibilities upon admission. The findings include:		T 155	T 155 The facility shall provide each patient or her designee with the name, mailing address and telephone number of the facility contact person.		8-30-12	
			ew the t was		In addition, the rights and responsibilities form shall include the OLC Complaint Unit's address and toll-free complaint hotline number.	ddress	
	regarding what info on admission. Who given a copy of the show it to them and them one." The inf failed to include the Office of Licensure		ne patient hts are No, we we give he patients on for the		The facility shall display a contact information in the reception room.	ies of ve	
	administrator the rig	he facility on 7/18/12 ghts and responsibili osted anywhere in the	ties of				
T 170	B. Written infection procedures shall in 1. Procedures for s	B Infection prevention prevention policies clude, but not be limit screening incoming parties infectious illnesses	and ited to: patients	T 170			

PRINTED: 07/25/2012 **FORM APPROVED** State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 07/19/2012 FTAF-0016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 S. WHITING ST. SUITE #215 **ALEXANDRIA WOMEN'S HEALTH CLINIC** ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY T 170 T 170 Continued From Page 11 applying appropriate measures to prevent T 170 transmission of community acquired infection within the facility: 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including All staff will be reminded verbally 8-30-12 indications for use of soap and water and use of and through posted handalcohol-based hand rubs; hygiene posters that hand 4. Use of standard precautions: 5. Compliance with blood-bourne pathogen washing/hand rub hygiene is requirements of the U.S. Occupational Safety & mandatory before and after any Health Administration. 6. Use of personal protective equipment; contact with any patient, 7. Use of safe injection practices; including hand washing/hand rub 8. Plans for annual retraining of all personnel in Infection prevention methods; hygiene before and after donning 9. Procedures for monitoring staff adherence to gloves, for any type of procedure recommended infection prevention practices; including but not limited to: and 10. Procedures for documenting annual handling any specimens (blood, retraining of all staff in recommended infection urine, tissue), performing prevention practices. sonograms, performing surgical This RULE: is not met as evidenced by: procedures, handling of surgical Based on observations, document review and trays, initiating any bloodstaff interviews the facility failed to ensure all staff followed an infection prevention program. drawing procedures, and starting and removing any intravenous The findings include: fluids. On 7/19/12 the following observations were made: the attending physician was sitting at a desk reading the newspaper. He put the paper away when the patient arrived. The physician

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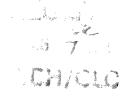
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interviewed the patient. The staff escorted the patient to the exam room. The physician went into the room (followed immediately by the surveyor who stood by the sink and continued the observation). The physician put on gloves and preceded to perform a vaginal ultrasound of the

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State of Virginia STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WNG FTAF-0016 07/19/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 S. WHITING ST, SUITE #215 **ALEXANDRIA WOMEN'S HEALTH CLINIC** ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG **DEFICIENCY** T 170 T 170 Continued From Page 12 Once the procedure had been completed the physician told the patient to get dressed and he would see her outside the exam room. The surveyor followed the physician out of the exam room. The physician picked up the patients medical record and began to make notations. He removed a prescription pad from a drawer. At no time was the physician observed washing his hands or performing hand hygiene. The observations were pointed out to the physician who stated, "I was not doing a procedure only an ultra sound. If I had been doing a procedure I certainly would have washed my hands." The above information was discussed with the administrator who stated. "He never washes his hands, he always uses gloves." When it was pointed out that sometimes the gloves may have holes in them the administrator stated, "Ohl That is gross!" 12 VAC 5-412-220 C Infection prevention T 175 T 175 C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following: 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; 3. Appropriate storage for cleaning agents (e.g., locked cabinets or rooms for chemicals used for cleaning) and product-specific instructions for use of cleaning agents (e.g., dilution, contact time, management of accidental exposures);

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A. BUILDING B. WNG FTAF-0016 07/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITING ST. SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) T 175 | Continued From Page 13 T 175 4. Procedures for handling, storing and T 175 transporting clean linens, clean/sterile supplies and equipment; 5. Procedures for handling/temporary 8-30-12 storage/transport of soiled linens; 6. Procedures for handling, storing, processing The facility will implement a and transporting regulated medical waste in policy and procedure for the use accordance with applicable regulations; of blankets for patient use. The 7. Procedures for the processing of each type of reusable medical equipment between uses on facility will employ a hospital different patients. The procedure shall address: linen service to provide blankets (I) the level of cleaning/disinfection/sterilization to be used for each type of equipment, for patient use. (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and All staff will wear impermeable. (iii) the method for verifying that the recommended level of disinfection/sterilization disposable surgical scrub gowns, has been achieved. The procedure shall disposable head covers and reference the manufacturer's recommendations disposable foot covers with each and any applicable state or national infection control quidelines: surgical procedure and with any 8. Procedures for appropriate disposal of procedure involving contact with non-reusable equipment; 9. Policies and procedures for and/or exposure to blood and maintenance/repair of equipment in accordance blood products. with manufacturer recommendations; 10. Procedures for cleaning of environmental Patients will be given disposable surfaces with appropriate cleaning products; 11. An effective pest control program, managed patient gowns. in accordance with local health and environmental regulations; and Individual surgical attire will be 12. Other infection prevention procedures laundered at home if the staff necessary to prevent/control transmission of an

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infectious agent in the facility as recommended

Based on observations and staff interviews the

This RULE: is not met as evidenced by:

facility staff failed to ensure a policy and procedure was in place to address how scrub attire and blankets for patient use were to be

or required by the department.

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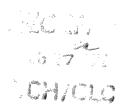
scrubs.

member will not be in contact

with contamination. Staff may

opt to wear hospital linen service

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State of Virginia STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING FTAF-0016 07/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITING ST, SUITE #215 **ALEXANDRIA WOMEN'S HEALTH CLINIC ALEXANDRIA, VA 22304** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) T 175 T 175 Continued From Page 14 laundered in a manner to prevent the spread of infections. The findings include: During the tour of the facility on 7/18/12 with the administrator scrub attire was observed hanging in an office area and blankets used by patients were in and on cabinets in the recovery area. The administrator stated, "The scurbs and blankets were laundered in the building laundromat." The administrator explained the first 3 floors of the building are zoned for commercial use and the remaining 12 or 13 floors are private apartments. She stated, "The laundromat is in the basement." The 2010 Perioperative Standards and Recommended Practices: Aseptic Practice of AORN (Association of Perioperative Registered Nurses) recommenced the following. Home laundering of surgical attire is not recommended. Without clear evidence about the safety for patients, health care workers, and their family members, AORN does not support the practice of home laundering of surgical attire. Reusable surgical attire, including cover jackets and cloth hats, should be laundered by a designated facility-approved and monitored commercial laundry after daily use. Commercial laundries are required to follow strict guidelines that incorporate: proper and controlled water temperatures: use of detergents; " use of oxidizing agents (e.g., chlorine bleach) in specified and monitored concentrations; repeated changes of water, and dryer or iron and press drying temperatures that typically are not found in home laundry equipment. Home laundering of surgical attire that is not visibly soiled is controversial, and there is no

concrete evidence to either support or refute the

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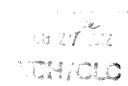
ALEXANDRIA, VA 22304							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
T 175	practice. Surgical attire becomes soiled or contaminated with microorganisms during wear. Taking worn, soiled, or contaminated surgical attire into the home can result in the spread of contamination to the home environment. AORN is aware that some provider facilities require personnel to launder scrub attire at home. Although AORN does not support this practice, steps should be taken to minimize contaminants to the home environment.	Т 230	T 230 The facility will implement a policy and procedure providing the necessary criteria for the discharge from anesthesia care. Such criteria shall include documentation of: stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain and minimal nausea and vomiting.	8-30-12			
T 230	12 VAC 5-412-250 C Anesthesia service C. The facility shall develop, implement and maintain policies and procedures outlining criteria for discharge from anesthesia care. Such criteria shall include stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain and minimal nausea and vomiting.						
	This RULE: is not met as evidenced by: Based on Interviews and document review the facility failed to have in place policies and procedures related to the criteria for discharge from anesthesia care. The findings include:						
	On 7/18/12 the administrator was asked to provide a copy of the policies outlining their criteria for discharge. The administrator provided a copy of a blank medical record indicating where vital sign were to be entered. The administrator stated, "I don't have a policy related to discharge."						
Т 285	12 VAC 5-412-260 E Administration, storage and dispensing of dru	T 285					
	E. Records of all drugs in Schedules I-V						

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

FTAF-0016

B. WING

07/19/2012

NAME OF PROVIDER OR SUPPLIER

ALEXANDRIA WOMEN'S HEALTH CLINIC

STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITING ST. SUITE #215

ALEXANDRIA, VA 22304

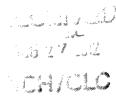
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T 285	Continued From Page 17	T 285		
	count."		Т 290	
T 290	12 VAC 5-412-270 Equipment and supplies	T 290	The exam table in the ultrasound	
	An abortion facility shall maintain medical		room has been replaced with	
	equipment and supplies appropriate and adequate to care for patients based on the level,	,	another table without any tears	
	scope and intensity of services provided, to include:		in the vinyl covering.	8-3212
	A bed or recliner suitable for recovery;		All items under the sink have	
	Oxygen with flow meters and masks or equivalent;		been removed.	
	Mechanical suction; Resuscitation or summent to include: as a		The wait area for medical	
	Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways;		abortions will be replaced with	
	5. Emergency medications, intravenous fluids,		chairs free of any tears.	
	and related supplies and equipment; 6. Sterile suturing equipment and supplies;		·	
	7. Adjustable examination light;		The pre-procedure room wait	
	Containers for soiled linen and waste materials with covers; and		area will have viny-covered chairs	
	9. Refrigerator.		The gurneys used for recovery	
	This RULE: is not met as evidenced by:		from IV sedation will be re-	
	Based on observations and interviews the facility staff failed to ensure equipment was maintained to		upholstered with vinyl covering	
	ensure proper infection control and failed to ensure expired supplies were not available for		There will be no supplies stored	
	use.		under the gurney.	
	The findings include:		There will be a monthly check for	
	On 7/18/12 during the tour of the facility with the		expiration date ofall curettes . All	
	administrator and assistant administrator, the		curettes will be placed in	
	following items were noted to have tears which would prevent the items from being cleaned		individual plastic bags indicating:	
	properly after each patient use:		size and type of curette and	
	The table in the ultrasound room had large tears in the vinyl covering and paper towels were found		expiration date.	
	under the sink in the ultrasound room.			
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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING FTAF-0016 07/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALEXANDRIA WOMEN'S HEALTH CLINIC 101 S. WHITING ST. SUITE #215 ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) T 290 Continued From Page 18 T 290 The areas described as the wait area for medication abortions and ultrasounds had 4 chairs with tears in the vinvL The area described as the pre-procedure room had 4 cloth chairs that could not be wiped clean after use by patients. The recovery area had 3 of 4 chairs with tears in them. The stretcher used for recovery from IV sedation was torn and items for multi patient use was stored under the stretcher. The administrator stated, "We will get the chairs and tables replaced and will move the supplies." On 7/18/12 during a tour of the procedure room with the administrator and assistant administrator the following expired items were observed: 19 - 12 mm (milliliter) disposable rigid curettes 7 - 12 mm flexible curettes 14 - 10 mm flexible curettes 2 - 9 mm flexible curettes 4 - 11 mm flexible curettes 23 - 5 mm flexible curettes 2 - 7 mm flexible curettes 6 - 4 mm flexible curettes The facility administrator stated, "We will get rid of those right now." T 315 12 VAC 5-412-300 A Quality assurance T 315 A. The abortion facility shall implement an ongoing, comprehensive, integrated, self-assessment program of the quality and appropriateness of care or services provided. including services provided under contract or agreement. The program shall include process, design, data collection/analysis, assessment and improvement, and evaluation. The findings shall be used to correct identified problems and revise

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 07/19/2012 FTAF-0016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **101 S. WHITING ST. SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC ALEXANDRIA, VA 22304** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DAT **DEFICIENCY**) T 315 Continued From Page 19 T 315 T 315 T320 policies and practices, as necessary. This RULE: is not met as evidenced by: The facility will implement a Based on interviews and document reviews the 830-12 quality assuranceprogram to facility staff failed to implement an ongoing comprehensive integrated, self assessment include: staffing patterns and program of the quality and appropriateness of performance; supervision care or service provided. appropriate to the level of The finding include: service; patient records; patient satisfaction; complaint On 7/18/12 the administrator was asked to provide documentation related to the services that provide resolution; recording and related to quality improvement. She stated. "I reporting of infections, don't collect data." When asked if the facility collects data on patient satisfaction she stated, complications and other adverse "We used to but we stopped because we were not events: staff concerns regarding getting anything back from the patient after they left." The administrator was asked how she and patient care. the staff knew what areas to improve or where improvement was needed she stated. "We just The program shall provide an know when we do something that needs to be ongoing, comprehensive. fixed." assessment of the quality and 12 VAC 5-412-300 B Quality assurance T 320 appropriateness of services, and T 320 evaluations to correct any B. The following shall be evaluated to assure identified problems and revise adequacy and appropriateness of services, and 8-30-12 to identify unacceptable or unexpected trends or any policy to better serve the occurrences: needs of our patients. 1. Staffing patterns and performance; 2. Supervision appropriate to the level of There will also be a survey given service; 3. Patient records: to each patient to address any 4. Patient satisfaction: concerns in the provision of her 5. Complaint resolution; 6. Infections, complications and other adverse care, including positive and events: and negative feedback. All surveys 7. Staff concerns regarding patient care.

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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WNG FTAF-0016 07/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITING ST, SUITE #215 **ALEXANDRIA WOMEN'S HEALTH CLINIC** ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) T 320 Continued From Page 20 T 320 This RULE: is not met as evidenced by: will not be signed or dated. Based on interviews and document reviews the unless the patient would like a facility staff failed to implement an ongoing response. All surveys will be comprehensive integrated, self assessment program of the quality and appropriateness of placed in a suggestion box which care or service provided. will be reviewed and any actions The finding include: will be made to improve our services. On 7/18/12 the administrator was asked to provide documentation related to the services that provide related to quality improvement. She stated, "I don't collect data." When asked if the facility collects data on patient satisfaction she stated, T 325 "We used to but we stopped because we were not getting anything back from the patient after they The quality improvement left." The administrator was asked how she and the staff knew what areas to improve or where committee responsible for the 8-30-12 improvement was needed she stated, "We just oversight and supervision of the know when we do something that needs to be program shall be established and fixed." shall consist of a physician, a T 325 12 VAC 5-412-300 C Quality assurance T 325 non-physician health care practitioner; a member of the C. A quality improvement committee responsible for the oversight and supervision of the program administrative staff and a staff shall be established and at a minimum shall member/patient representative consist of: 1. A physician 2. A non-physician health care practitioner; 3. A member of the administrative staff; and 4. An individual with demonstrated ability to represent the rights and concerns of patients. The individual may be a member of the facility's staff. In selecting members of this committee, consideration shall be given to the candidate's abilities and sensitivity to issues relating to quality of care and services provided to patients. This RULE: is not met as evidenced by:

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING FTAF-0016 07/19/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **ALEXANDRIA WOMEN'S HEALTH CLINIC 101 S. WHITING ST. SUITE #215 ALEXANDRIA, VA 22304** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) T 325 Continued From Page 21 T 325 Based on interviews and document reviews the facility staff failed to have a quality improvement committee and to identify who should be on the committee. The finding include: On 7/18/12 the administrator was asked to provide documentation related to the services/program provided related to quality improvement. She stated, "We don't have a program." T 335 T 335 2 VAC 5-412-300 E Quality assurance T 335 Results of the quality 8-30-12 E. Results of the quality improvement program improvement program shall be shall be reported to the licensee at least annually reported to the licensee at least and shall include the deficiencies identified and annually and shall include the recommendations for corrections and improvements. The report shall be acted upon problems identified and by the governing body and the facility. All recommendations for corrections corrective actions shall be documented. Identified deficiencies that jeopardize patient and improvement. All corrective safety shall be reported immediately in writing to actions shall be documented. the licensee by the quality improvement Any deficiencies that jeopardize committee. patient safety shall be reported immediately in writing to the This RULE: is not met as evidenced by: Based on interviews and document reviews the licensee by the quality facility staff failed to have a quality improvement improvement committee. committee and to identify who should be on the committee.

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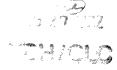
The finding include:

On 7/18/12 the administrator was asked to provide documentation related to the services that provide related to quality improvement. She stated, "I don't collect data." When asked if the facility collects data on patient satisfaction she stated,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG FTAF-0016 07/19/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 S. WHITING ST, SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC **ALEXANDRIA, VA 22304** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY** T 335 Continued From Page 22 T 335 "We used to but we stopped because we were not T 365 getting anything back from the patient after they left." The administrator was asked how she and the staff knew what areas to improve or where The facility shall maintain a policy improvement was needed she stated, "We just and procedure with specific steps know when we do something that needs to be to be taken to ensure all staff and fixed." patients are protected from the T 365 12 VAC 5-412-350 A Disaster preparedness T 365 hazards of fire and other disasters Each abortion facility shall develop, 8-30-12 implement and maintain policies and procedures The fire and disaster to ensure reasonable precautions are taken to protect all occupants from hazards of fire and preparedness plans shall be other disasters. The polices and procedures implemented and fire drills shall shall include provisions for evacuation of all be documented. There shall be occupants in the event of a fire or other disaster. mock fire drills and This RULE: is not met as evidenced by: documentation of same. Based on document review and staff interviews the facility falled to implement and maintain policies and procedures to ensure reasonable precautions were taken to protect staff and patients in the event of a fire or disaster. The findings include: On 7/18/12 the administrator was asked to provide the policies and procedures related to fire drills and disaster drills. She stated, "We don't have policies about fire and disaster drills. We just move all patients and staff to the hall way." T 370 12 VAC 5-412-350 B Disaster preparedness T 370 B. A facility that participates in a community disaster plan shall establish plans, based on its capabilities, to meet its responsibilities for providing emergency care.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING FTAF-0016 07/19/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 S. WHITING ST. SUITE #215 ALEXANDRIA WOMEN'S HEALTH CLINIC ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE DAT TAG DEFICIENCY) T 385 Continued From Page 24 T 385 policies about fire and disaster drills. I guess I T 390 would be the person in charge of making sure we dld fire and disaster drills. I don't think that is in my job description though." The facility shall ensure the fire 8-30-12 T 390 12 VAC 5-412-370 B Fire-fighting equipment and T 390 extinguishers are safely secured systems and the fire extinguishers will be B. All fire protection and alarm systems and inspected annually maintained in other fire fighting equipment shall be inspected and tested in accordance with current edition of serviceable condition, and the Virginia Statewide Fire Prevention Code appropriate labels of said (27-94 et seq. of the Code of Virginia) to maintain them in serviceable condition. inspection are in place. This RULE: is not met as evidenced by: Based on observations, document review and staff interviews the facility failed to ensure firefighting equipment (fire extinguishers) were inspected and safely secured. The findings include: On 7/18/12 during a tour of the facility with the administrator fire extinguishers without inspection stickers or tags were observed sitting on the floor on both the exam side of the suite and the procedure side of the suite. The administrator stated, "I guess we need to get those mounted to the wall or something." T 400 12 VAC 5-412-380 Local and state codes and T 400 standards Abortion faculties shall comply with state and local codes, zoning and building ordinances, and the Uniform Statewide Building Code. In addition, abortion facilities shall comply with Part 1 and sections 3.1-1 through 3.1-8 and section

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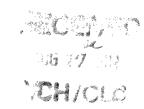
State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING FTAF-0016 07/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITING ST, SUITE #215 **ALEXANDRIA WOMEN'S HEALTH CLINIC** ALEXANDRIA, VA 22304 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) T 400 Continued From Page 25 T 400 3.7 of Part 3 of the 2010 Guidelines for Design T 400 and Construction of Health Care Facilities of the Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building The following findings of the OLC Code pursuant to Virginia Code 32.1-127.001. inspectors and the responses are: Entities operating as of the effective date of these regulations as identified by the department 1. The ultrasound room through submission of Reports of Induced Termination of Pregnancy pursuant to 12 VAC shall maintain full 830.17 5-550-120 or other means and that are now privacy by ensuring the subject to licensure may be licensed in their current buildings if such entities submit a plan sliding plastic window with the application for licensure that will bring remains closed. them into full compliance with this provision 2. A waiver is needed for within two years from the date of licensure. Refer to Abortion Regulation Facility the laboratory cannot Requirements Survey workbook for detailed accommodate a facility requirements. reclining chair nor a This RULE: is not met as evidenced by: ventilation hood. Based on observations, Interviews and a facility 3. The patient bathroom tour it was determined that the facility failed to ensure full compliance with state/local codes. door is deliberately left building ordinances as well as the Uniform unlocked and patients Statewide Building Code. Additionally, the facility failed to comply with having the following: an are informed that staff architect attestation that the facility meets all FGI personnel will be standards, proper ventilation, humidity. standing outside the 8-30-12 temperature controls, waste management program/services, HVAC duct system and door should the patient inspection reports, proper ventilation of the require any help or treatment rooms, proper air exchange for all treatment rooms, the heating/cooling and assistance. plumbing system to meet all codes, electrical 4. The staff bathroom system meets the National Electrical Code shall be kept locked at ordinance and all hand washing stations meet the 8-31-12 necessary width. length, depth & splash all times and a key will prevention. The findings include:

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PRINTED: 07/25/2012 State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING FTAF-0016 07/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 101 S. WHITING ST. SUITE #215 **ALEXANDRIA WOMEN'S HEALTH CLINIC** ALEXANDRIA, VA 22304 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY T 400 Continued From Page 27 T 400 presented a report from an Architect that surveyed replaced to meet the facility. The report is a summary and there is no indication of when the survey was done. In regulation codes. addition the report failed to contain the name of 8. A waiver is needed to the architect completing the report. The report list the necessary items needed to get allow time to move the the facility in compliance with the regulations and procedure room to contained the following to include but not limited Suite 215 (see #5) Use 1. Signage required to identify restricted, of current Procedure semi-restricted an unrestricted areas of the center room could be moved and proper attire for each area. 2. Ultrasound room does not meet requirements to the Ultrasound for acoustical and visual privacy and a hand Room where there is a washing sink. sink available for staff 3. 6' wide corridor required from surgery to public corridor for emergency ambulance transfer. Hand use. washing sinks brought into compliance. 9. A janitor's closet can 4. no janitor closet or eyewash station. 5. no air exchange. be maintained in the 6, no 100 square ft. clean storage room current storage area in 7. building elevators do not comply with required regulations or ADA requirements Suite 217 8. wall surfaces not washable 10. See T 175 regarding 9, pre and post op don't meet square footage use of Hospital Linen requirements per ARC report 437-17 10. no emergency communication system service. Use of the 11, pass through between soiled and clean building laundry room workroom must have self closing door 12. Overall building does not meet ADA standards will cease immediately. as to exterior access, elevators and toilet facilities. 11. Air ventilation system 13. HVAC system likely will not meet current is controlled by standards. 14. Fire and smoke alarm and control systems theBuilding will not meet current standard.

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15. Mechanical equipment rooms and exit corridors do not meet fire code requirements.

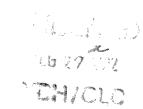
not meet current standards but should be evaluated by and engineer or contractor.

16. The 2 pipe perimeter HVAC system will likely

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management.



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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING FTAF-0016 07/19/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ALEXANDRIA WOMEN'S HEALTH CLINIC** 101 S. WHITING ST, SUITE #215 ALEXANDRIA, VA 22304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG DATE DEFICIENCY abortion services have not been adversely affected. We request a waiver for the 2010 Guidelines for design and construction to make changes to our facility that are allowable by the building management and if necessary to review the possibility of moving to another location.

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