State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-0019	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CHURCH HEALTHCARE CENTER	900 SOUTH WASHINGTON ST SUITE 300 FALLS CHURCH, VA 22046

(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 000	12 VAC 5- 412 Initial comments An announced Licensure Initial survey was conducted August 1, 2012 through August 2, 2012 by two Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 12/29/2011). Deficiencies cited follow in this report.	T 000		
T 010	12 VAC 5-412-140 A Organization and management A. Each abortion facility shall have a governing body responsible for the management and control of the operation of the facility. This RULE: is not met as evidenced by: Based on record review and interview the governing body failed to ensure the facility had: The required infection prevention policies, procedures and processes to prevent the spread of infections; and The required components for the quality improvement program The findings included: 1. Review of the facility's "Infection Control" manual and interview with Staff #1 on August 1, 2012 at 4:44 p.m. verified the findings below. The governing body failed to ensure the facility was in compliance with the following required infection prevention components: 12 VAC 5-412-220 (A) (2-13) for an infection prevention plan 12 VAC 5-412-220 B (2, 5-10) for an infection	T 010	**T010: 12 VAC 5-412-140 Organization /Management ;** BACKGROUND: *Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* **1.Infection Control overview by Governing Body** Corrective actions: Establish Infection Control overview by Governing Body through new By-Laws that include a Quality Improvement Program (QIP). The QIP consolidates existing CLIA and NAF manuals into a policy to comprehensively address process to prevent spread of infection. The QIP includes an infection prevention plan, policies and procedures, management of equipment and supplies, employee health program and related patient education, follow up	9/10/12 ongoing

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

Rosemary W Caddens | Director of Patient Services | September 10, 2012

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T 010	Continued From Page 1 prevention policies and procedures; 12 VAC 5-412-220 (C) (1-12) for the management of equipment and supplies to prevent the spread of infection; 12 VAC 5-412-220 (D) (2-5) an employee health program; and 12 VAC 5-412-220 (E) (2-3) related to patient education, follow-up and reporting infections to the appropriate health agency. 2. Review of the facility's quality documents did not provide evidence the committee evaluated the seven required components of staffing patterns and performance; supervision appropriate to the level of service; patient records; patient satisfaction; complaint resolution; infections, complications and other adverse events; plus staff concerns regarding patient care. The review of policies did not find evidence that all corrective action needed to be documented, that the governing body/board and the facility needed to act upon the quality report and identified deficiencies, which jeopardized patient safety needed to be reported immediately in writing. Staff #1 acknowledged during interview that no policy and procedure had been developed to address the Quality Improvement Program/Meeting. This interview occurred in the facility's office, on August 1, 2012, approximately at 2:10 p.m.	T 010	of and reporting of infections to appropriate health agency and review of annual summary of all quality indicators established. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. The implementation of Governing Body By-Laws , the policies and reviews will prevent recurrence. The Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency. **2. Staffing Pattern and Performance Evaluations** Corrective actions: Establish personnel performance Quality Assurance (QA) overview by Governing Body through new By-Laws that include a QA committee and documented annual personnel evaluation by Director of Patient Services. The QA consolidates existing CLIA and NAF processes into a policy to comprehensively address quality assurance. The Quality Assurance Committee (QAC) is to document its annual meeting and report its findings to the Governing Body. The QAC will review the annual summary report of all quality indicators including: staffing patterns and performance, supervision appropriate to level of service, patient chart surveys, patient compliment and complaint activity, adverse events reports detailing complications and infections, staff concerns regarding patient care and make recommendations for staffing changes and training. The Governing Body will document its reviews and will act upon the any quality identified deficiency that jeopardized patient safety and document action in writing. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. The implementation of Governing Body By-Laws , the QA policies and reviews will prevent recurrence. The Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 025	12 VAC 5-412-140 D Organization and management D. The governing body shall have a formal organizational plan with written bylaws. These shall clearly set forth organization, duties and responsibilities, accountability, and relationships of professional staff and other personnel. The	T 025		

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T 025	Continued From Page 2 bylaws shall identify the person or organizational body responsible for formulating policies. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to have written bylaws for the facility as required in Section 12 VAC 5-412-140. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to have bylaws that set forth organization, duties and responsibilities, accountability, and relationships of professional staff and other personnel. and identified the person or organizational body responsible for formulating policies. 2. Staff Member #1 acknowledged that bylaws were not available for the Surveyor to review. This interview occurred in the agency's office on August 1, 2012, at 1:31 p.m.	T 025	**T 025 VAC 5-412-140 D Organization / management:** BACKGROUND: *Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* Corrective actions: Formulated Governing Body bylaws detail in Article 1 - 4: organization, duties and responsibilities, accountability and relationships of professional staff and other personnel and identify who formulates policies. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff will complete an orientation to new structure and maintain a copy of the Governing Body Bylaws in their resource notebook. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	9/10/12 ongoing
T 040	12 VAC 5-412-150 Policy and procedures manual A copy of the approved policies and procedures and revisions thereto shall be made available to the OLC upon request. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to ensure that a copy of the approved policies and procedures and revisions thereto would be made available to the Office of Licensure (OLC) and Certification as required in	T 040	**T040 12 VAC 5-412-150 Policy and Procedures manual** BACKGROUND: *Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State*	9/10/12 ongoing

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T 040	Continued From Page 3 Section 12 VAC 5-412-150. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to address that the policies and procedures would be sent to OLC upon request. 2. Staff Member #1 acknowledged that all policies and procedures were not available for the Surveyor to review. This interview occurred in the agency's office on August 1, 2012, at 1:29 p.m.	T 040	*Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* **1.Availability of PPM to OLC in Richmond** Corrective actions: Formulated Governing Body bylaws detail in Article 5 that the policies and procedures would be sent to OLC upon request . Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff will complete an orientation to new structure. Director of Patient Services, Assistant Administrator or delegated staff will be advised to respond to OLC requests. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency. **2.Availability of PPM to OLC on-site** Corrective actions: All our best Practices, guidelines, CLIA, OSHA and NAF Best Practices were available for review however not well organized in a policy and procedure format. Our 7 best practices manuals and 9 logs, guidelines and training notebooks have now been reorganized into the OLC preferred and requested format Sections: Administrative; Emergency Preparedness; Patient Care; Personnel; Quality Assurance and Infection Control with supportive at-site-of-use logs, notebooks or guideline postings. Measures to maintain compliance: Staff will complete an orientation to new structure that includes knowing where the PPM notebooks are stored and how to reference the support logs, guidelines and training notebooks. Staff will maintain a copy of the PPM Table of Contents in their resource notebook.	
T 045	12 VAC 5-412-160 A Administrator A. The governing body shall select an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to ensure that it select an administrator whose qualifications, authority and duties would be defined in a written statement adopted by the governing body as required in Section 12 VAC 5-412-160. A. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to place in writing the appointment of the Administrator.	T 045		

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T 055	Continued From Page 5 interview, it was determined that the Governing Body failed to ensure that a qualified individual would be appointed in writing to act in the absence of the administrator were not available for the Surveyor to review as required in Section 12 VAC 5-412-160. C. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to address the appointment of the alternate to the Administrator. 2. Staff Member #1 acknowledged that no written policy addressed in writing the designation of the Alternate to the Administrator. This interview occurred in the agency's office on August 1, 2012, at 1:40 p.m.	T 055	BACKGROUND: *Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* Corrective actions: Formulated Governing Body bylaws detail in Article 2 reporting any change of the administrator whose title is Director of Patient Services. The Governing Body will document in writing that changes have been reported. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Governing Body will review annually making all written documentation required and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 060	12 VAC 5-412-170 A Personnel A. Each abortion facility shall have a staff that is adequately trained and capable of providing appropriate service and supervision to patients. The facility shall develop, implement and maintain policies and procedures to ensure and document appropriate staffing by licensed clinicians based on the level, intensity, and scope of services provided. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to have written policies and procedures that addressed the obtaining criminal records checks, reporting violations to the appropriate Boards of the Health Professions, job descriptions that describe authority and minimal	T 060	**T055 12 VAC 5-412-160 C Appointment of assistant administrator** BACKGROUND: *Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices*	

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T 045	Continued From Page 4 2. Staff Member #1 acknowledged that no written policy addressed the appointment of the Administrator. This interview occurred in the agency's office on August 1, 2012, at 1:35 p.m.	T 045	Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency. **T045 12 VAC 5-412-160 A Administrator Appointment** BACKGROUND: *Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* Corrective actions: Formulated Governing Body bylaws detail in Article 3 the appointment of the administrator whose title is Director of Patient Services. The Governing Body will document in writing the appointment of the Director of Patient Services which will be part of the annual review. A written designation will be filed in the Administrative section of the PPM. The Governing Body will document annually all designations. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Governing Body will review annually making all written documentation required and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency. **T045 12 VAC 5-412-160 B Change of Administrator**	9/10/12
T 050	12 VAC 5-412-160 B Administrator B. Any change in the position of the administrator shall be reported immediately by the licensee to the department in writing. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to ensure that any change in the position of the administrator would be reported immediately by the licensee to the Office of Licensure and Certification (OLC) as required in Section 12 VAC 5-412-160. B. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to address the notification immediately, in writing, of any changes in Administrator to the OLC. 2. Staff Member #1 acknowledged that no written policy addressed the changes in Administrator. This interview occurred in the agency's office on August 1, 2012, at 1:35 p.m.	T 050		ongoing
T 055	12 VAC 5-412-160 C Administrator C. A qualified individual shall be appointed in writing to act in the absence of the administrator. This RULE: is not met as evidenced by: Based on review of policies and procedures and	T 055		

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T 060	Continued From Page 6 qualifications and annual reviews of performances were not available for the Surveyor to review as required in Section 12 VAC 5-412-170. A. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to have bylaws, address how to obtain criminal records checks, reporting violations to the appropriate Boards of the Health Professions, job descriptions that describe authority and minimal qualifications, annual reviews of performances and had policies and procedures by the Governing Body. 2. Staff Member #1 acknowledged that all policies and procedures were not available for the Surveyor to review. This interview occurred in the agency's office on August 1, 2012, at 1:29 p.m.	T 060	*memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* Corrective actions: Formulated Governing Body bylaws detail in Article 3 authority of Director of Patient Services to designate an assistant administrator to act in her absence. A written designation will be filed in the Administrative section of the PPM. The Governing Body will document annually all designations. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Governing Body will review annually making all written documentation required and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 070	12 VAC 5-412-170 C Personnel C. Each abortion facility shall obtain a criminal history record check pursuant to 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy, whose job duties provide access to controlled substances within the abortion facility. This RULE: is not met as evidenced by: Based on review of personnel files and interview, it was determined that two (#3 and #12) of six (#1-#4, #9 and #11) staff members who have access to narcotics failed to provide results of the criminal record checks from the Department of Virginia State Police were not available for the Surveyor to review as required in Section 12 VAC 5-412-170.	T 070	**T060 12 VAC 5-412-170 A Personnel** 9/10/12 BACKGROUND: *FCHC existing outline of customary and position specific duties and responsibilities and staff procedures detailed requirements for each staff position but were not in the OLC preferred format. Additionally, Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance*	

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T 070	Continued From Page 7 The findings included: 1. The Surveyor reviewed personnel files on August 2, 2012, at 1:30 p.m., in the agency's office. Two (#3 and #12) staff members who had access to narcotics failed to have results of criminal records checks from the State Police in the personnel file for the Surveyor to review. 2. Staff Member #1 acknowledged that the results of the criminal records checks were not available for the Surveyor to review from the State Police. This interview occurred in the agency's office on August 2, 2012, at 1:31 p.m.	T 070	*practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* Corrective actions: All staffing patterns for our center have been clarified and job descriptions in the new format re-written specifying authority and minimal qualifications. The Governing Body Bylaws specify annual review of staffing patterns and job descriptions. The Quality Assurance Committee reviews performance quality indicators of staff and report to the Governing Body. FCHC policies for criminal record checks have been expanded to include reporting violations to the appropriate Boards of Health Professions, verifying current professional licensing or certification and VDH look-up. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure for their annual employee conference which now includes specific quality indicators that will be further reviewed by the new QAC. Director of Patient Services will report any violations of professional ethics to the appropriate Boards of Health Professions. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 095	12 VAC 5-412-170 H Personnel H. Personnel policies and procedures shall include, but not be limited to: 1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification; 2. Process for verifying current professional licensing or certification and training of employees or independent contractors; 3. Process for annually evaluating employee performance and competency; 4. Process for verifying that contractors and their employees meet the personnel qualifications of the facility; and 5. Process for reporting licensed and certified health care practitioners for violations of their licensing or certification standards to the appropriate board within the Department of Health Professions. This RULE: is not met as evidenced by: Based on employee record review and staff interview, the facility staff failed to ensure job	T 095	**T070 12 VAC 5-412-170 C Personnel Criminal Record Checks** Corrective actions: The Criminal records Checks for staff member #3 and #12 have been completed and placed in their employee file. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: New employees will be informed of the Criminal Record Check requirement. Assistant Administrator will monitor employee file and review annually for completeness. Governing Body will review annually and address any	9/10/12

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CHURCH HEALTHCARE CENTER	900 SOUTH WASHINGTON ST SUITE 300 FALLS CHURCH, VA 22046

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T 095	Continued From Page 8 descriptions for employees were reviewed at least annually for six (#1, #5-6, #8 and #10-#11) of twelve (#1-#12) employee records reviewed and no policies and procedures for written job descriptions, the process for verifying licensing, process for annual evaluations and competencies, process for verifying that contractors meets the qualifications for the facility and for reporting licensed and certified staff to the Board of Health Professions were not available for the Surveyor to review as required in Section 12 VAC 5-412-170. H. 1-5. The findings included: 1. On August 2, 2012, at 1:00 p.m., employee records were reviewed, in the facility's office. Of the twelve records reviewed, six employees did not have evidence that the job descriptions were reviewed at least annually in their personnel record. The employees were as follows: Employee #1 - date of hire (DOH) September 02, 2002, #5 - DOH September 02, 2002, #6 - DOH September 12, 2002, #8 - DOH May 25, 2005, #10 - DOH August 19, 2002, #11 - DOH August 8, 2010. Review of the Policy and Procedure manual had no process for reporting to the Deportment of Health Professions any violations by licensed and certified employees, Written job descriptions that specify authority and qualifications for each job classification, process for verifying current professional licensing or certification and training of employees or independent contractors, process for annually evaluating employee performance and competency and the process for verifying that contractors and their employees meet the personnel qualifications of the facility were not available for the Surveyor to review. 2. On August 1, 2012, at 4:00 p.m., Staff #1 acknowledged during interview, that the annual evaluations were not completed on all staff.	T 095	emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency. **T095 12 VAC 5-412-170 H Personnel** BACKGROUND: *FCHC existing outline of customary and position specific duties and responsibilities and staff procedures detailed requirements for each staff position but were not in the OLC preferred format. Additionally, Falls Church Medical Center, LLC (t/a Falls Church Healthcare Center – FCHC) has been operating, since opening as an OB/GYN office practice in 2002, under Articles of Organization and an Operating Agreement as specified by State Corporation Commission; this did not require an additional Governing Body or by-laws. Since opening in 2002 our medical services have been guided by our Mission Statements and Organizational Plan which specified staffing and utilizing best practices memorialized in a Procedure Manual approved by the Medical Director. FCHC has reorganized our existing operating structures to now include Governing Body and By-laws for the Governing Body to address our administrative, organizational and quality assurance practices and the deficiencies identified by OLC inspection. This reorganization resulted in format change of our existing best practices manual into a policy and a process with written documentation of reviews for quality assurance as recommended by the inspectors maintaining a balance between the reality of our resources and our processes.* Corrective actions - GENERAL: All staffing patterns for our center have been clarified and job descriptions in a consolidated format re-written for each position: Director of Patient Services, Medical Director, Assistant Administrator, Surgical Coordinator /Gynecology Coordinator, RN/LPN, Health Educators, Medical Assistants, Receptionist/Medical Records Clerk. The Consulting Agreements for our clinicians Identified as Employee #2, 3, 9, and 11 are being duplicated in the Job Description format. The Consultants (independent contractors) will now also have a review to be scheduled in November as part of our Annual Clinician Meeting. Policies detailing the process will be developed and approved by the Governing Body as detailed in the Governing Body Bylaws. Corrective actions - GENERAL: The employee files have been reviewed by the Assistant Administrator; any incomplete/missing documentation of Job descriptions, their 2011 employee review as applicable	9/10/12

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T 095	Continued From Page 9 Further acknowledgement of no policies and procedures for personnel were incomplete. This interview occurred in the facility's office.	T 095	and/or SHHP for Identified employees #5,#6,#8, #10, #11 is corrected. The Governing Body Bylaws specify annual review of staffing patterns and job descriptions. The Quality Assurance Committee reviews performance quality indicators of staff and report to the Governing Body. Corrective action - VERIFYING LICENSING: As detailed in T060 - FCHC policies for criminal record checks have been expanded to include reporting violations to the appropriate Boards of Health Professions, verifying current professional licensing or certification and VDH look-up. SPECIFIC: Employee Reviews: *BACKGROUND: FCHC's existing system for employment review includes self-evaluation and a conference with the Director of Patient Services to address career goals, weaknesses, training, advancement and compensation. This review was traditionally conducted every 18 months of employment or during September – October. ALL employees except #1 had an employee review June 2011. The emergency regulations signed by the Governor and in effect January 1, 2012 specified regulations to be implemented.* Corrective actions: The first employee review under the Emergency Regulations at FCHC is scheduling in September; the employee will be asked to document reviewing their job description during their conference. Additionally these reviews will now include Quality Indicators that can be reported to the QAC for their annual meeting. The documentation of their conference will be retained in their employee file. Corrective action: Employee #1. Employee #1 is the Director of Patient Services (who conducts the employee conferences), is the Governing Body (which reviews the employees' Job Descriptions and review) and represents the LLC owner as its organizing member. A policy for this review memorializing that different quality indicators are used to evaluate this position (person) is based on the overall success of FCHC and on National Abortion Federation's inspections and reporting, CLIA inspections and reporting, Insurance Company inspection and reporting, patient feedback, census numbers, average longevity of staff and adverse events. A summary chart suitable for QAC review will be utilized. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing.	
T 100	12 VAC 5-412-170 I Personnel I. A personnel file shall be maintained for each staff member. Personnel record information shall be safeguarded against loss and unauthorized use. Employee health-related information shall be maintained separately within the employee's personnel file. This RULE: is not met as evidenced by: Based on review of personnel files, review of policy and procedures and staff interview, it was determined that five (#2-#3,#9 and #11-12) of twelve (#1-#12) personnel files reviewed failed to have results of consent or declination for obtaining the Hepatitis B vaccine were not available for the Surveyor to review as required in Section 12 VAC-5-412-170. 1. The findings included: 1. The Surveyor reviewed personnel files on August 2, 2012, at 1:30 p.m., in the agency's office. Five (#2-#3,#9 and #11-12) of twelve (#1-#12) personnel files reviewed failed to have results of consent or declination for obtaining the Hepatitis B vaccine. 2. The policies and procedures were reviewed at various times in the facility's room, on August 1-2, 2012. The policy under Staff Health Protection Program stated that the agency would implement consent or declination for vaccination of Hepatitis B as recommend by the Center for Disease Control. This vaccination was recommended for Healthcare workers and Public Safety workers	T 100		

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T 100	Continued From Page 10 who are exposed to blood. 3. Staff Member #1 acknowledged that all results of the Hepatitis B vaccinations were not available for the Surveyor to review. This interview occurred in the agency's office on August 2, 2012, at 1:32 p.m.	T 100	Measures to maintain compliance: Staff trained to new process/procedure for their annual employee conference which now includes specific quality indicators that will be further reviewed by the new QAC. Employee reviews for Staff, consultants, and the Director of Patient Services are conducted. Director of Patient Services will report any violations of professional ethics to the appropriate Boards of Health Professions. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 140	12 VAC 5-412-210 B Patients' rights B. The facility shall establish and maintain complaint handling procedures which specify the: 1. System for logging receipt, investigation and resolution of complaints; and 2. Format of the written record of the findings of each complaint investigated. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to ensure that policies and procedures for handling complaints were available for the staff to utilize were not available for the Surveyor to review as required in Section 12 VAC 5-412-210.1-2. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to address the process for logging complaints and having a log for all complaints to be reviewed. 2. Staff Member #1 acknowledged that no written policy addressed complaints and no Complaint Log were available for the Surveyor to review. This interview occurred in the agency's office on August 1, 2012, at 1:41 p.m.	T 140	**T100 12 VAC 5-412-170 I Personnel SSHP Documentation of Hepatitis B Vaccination.** Corrective actions: The SSHP documentation of Hepatitis B vaccination consent or declination for Staff # 2,3,9,11, 12 has been completed and placed in their employee file. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: New employees will be informed of SSHP program by the SSHP Coordinator. Assistant Administrator will monitor employee file and review annually for completeness. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency. **T140 12 VAC 5-412-210 B Patient Rights Logging Complaints and Review** Corrective actions: Our Patients' Rights program was amended to include a log for all compliments and complaints, an additional informational contact on-site to voice issue and method for documenting resolution and action. The Governing Body Bylaws will approve the expanded policy which designates Director of Patient Care responsible for complaint resolution and includes intake, acknowledgement and proposed resolution within 30 days, investigation, and review by QAC and retention of records for 3 years. The on-line form for compliment or complaints will be downloaded and available for patients on-site. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to	9/10/12 9/10/12

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T 145	Continued From Page 11	T 145	Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. The Compliment and Complaint log will be included in staff review and report to QAC. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 145	12 VAC 5-412-210 C Patients' rights C. The facility shall designate staff responsible for complaint resolution, including: 1. Complaint intake, including acknowledgement of complaints; 2. Investigation of the complaint; 3. Review of the investigation findings and resolution for the complaint; and 4. Notification to the complainant of the proposed resolution within 30 days from the date of receipt of the complaint. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to ensure that policies and procedures for input to take the complaint, investigate and resolve the complaint with a written response of complaints were not available for the Surveyor to review as required in Section 12 VAC 5-412-210.C.1-4. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to address the process for complaint intake, including acknowledgement of complaints, investigation of the complaint, review of the investigation findings and resolution for the complain and notification to the complainant of the proposed resolution within 30 days from the date of receipt of the complaint . 2. Staff Member #1 acknowledged that no written policy addressing complaints were available for the Surveyor to review. This interview occurred in the agency's office on August 1, 2012, at 1:42 p.m.	T 145	**T145 12 VAC 5-412-210 C Patient Rights** **Governing Body comprehensive policy and review** Corrective actions: Our Patients' Rights program was amended to include a log for all compliments and complaints, an additional informational contact on-site to voice issue and method for documenting resolution and action. The Governing Body ByLaws will approve the expanded policy which designates Director of Patient Care responsible for complaint resolution and includes intake, acknowledgement and proposed resolution within 30 days, investigation, and review by QAC and retention of records for 3 years. The on-line form for compliment or complaints will be downloaded and available for patients on-site. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. The Compliment and Complaint log will be included in staff review and report to QAC. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	9/10/12

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T 165	Continued From Page 13 Disease Control and Prevention. An individual with training and expertise in infection prevention shall participate in the development of infection prevention policies and procedures and shall review them to assure they comply with applicable regulations and standards. 1. The process for development, implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented. 2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing. 3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review. This RULE: is not met as evidenced by: Based on record review and interview the facility failed to have an infection prevention plan: with processes for the development, implementation and maintenance of infection prevention policies and procedures based on guidance and regulations; and with the provision that infection prevention policies and procedures will be reviewed annually with documented recommendations changes and updates. The findings included: Review of the facility's infection prevention plan revealed policies dated 2002. The infection prevention plan did not include the process for the development, implementation and maintenance of infection prevention policies and procedures based on current guidance and regulations. The	T 165	The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Surgery and Gynecology Coordinators continue to train staff to new process/procedure and review their processes. Mini trainings /in-services have been held weekly since August inspection. Staff will continue On-line reviews through BLR Webinars, ProTraings.com, ACN and NAF webinars. OSHA Training annually or as required. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	

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T 160	12 VAC 5-412-210 F Patients' rights The facility shall maintain documentation of all complaints received and the status of each complaint from the date of receipt through its final resolution. Records shall be maintained for no less than three years. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to ensure that policies and procedures for the length of time that complaints would be maintained were not available for the Surveyor to review as required in Section 12 VAC 5-412-210.1-2. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to address the process for complaints to be kept from the date of receipt until three years had passed. 2. Staff Member #1 acknowledged that no written policy addressed how long complaints would be maintained for the Surveyor to review. This interview occurred in the agency's office on August 1, 2012, at 1:42 p.m.	T 160	**T160 12 VAC 5-412-210 F Patient Rights Retention of Compliments and Complaints Records** Corrective actions: Our Patients' Rights program was amended to include a log for all compliments and complaints, an additional informational contact on-site to voice issue and method for documenting resolution and action. The Governing Body Bylaws will approve the expanded policy which designates Director of Patient Care responsible for complaint resolution and includes intake, acknowledgement and proposed resolution within 30 days, investigation, and review by QAC and retention of records for 3 years. The on-line form for compliment or complaints will be downloaded and available for patients on-site. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. The Compliment and Complaint log will be included in staff review and report to QAC. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	9/10/12
T 165	!2 VAC 5-412-220 A Infection prevention A. The abortion facility shall have an infection prevention plan that encompasses the entire facility and all services provided, and which is consistent with the provisions of the current edition of "Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care", published by the U.S. Centers for	T 165	**T165 12VAC 5-412-220 A Infection prevention – Plan Process** Corrective actions: Expanded FCHC infection prevention plan to include the process of development, implementation and reviews. The QAC will review in annual meeting, Governing Body Bylaws established policy approvals and review. Surgery and Gynecology Coordinators trained/experienced in development of infection prevention policies and procedures in accordance with CDC Guidelines and OSHA trainings. Prevent recurrence of Deficiency:	9/10/12

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T 165	Continued From Page 14 infection prevention plan did not reveal evidence of annual review. The plan did not have a provision for annual review with documentation of recommendations, changes and updates. An interview was conducted on August 1, 2012 at 3:18 p.m., with Staff #1. Staff #1 reviewed the regulation and the facilities "Infection Control" policies. Staff #1 reported he/she did not have documentation the "Infection Control" policies and procedures were annually reviewed. Staff #1 reported the facility did not have the regulation requirements as part of their infection prevention plan.	T 165		
T 170	12 VAC 5-412-220 B Infection prevention B. Written infection prevention policies and procedures shall include, but not be limited to: 1. Procedures for screening incoming patients and visitors for acute infectious illnesses and applying appropriate measures to prevent transmission of community acquired infection within the facility; 2. Training of all personnel in proper infection prevention techniques; 3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs; 4. Use of standard precautions; 5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration. 6. Use of personal protective equipment; 7. Use of safe injection practices; 8. Plans for annual retraining of all personnel in infection prevention methods; 9. Procedures for monitoring staff adherence to recommended infection prevention practices; and	T 170	**T170 12VAC 5-412-220 B Infection prevention Training and documentation** Corrective actions: 1. 8/2/12 Staff #8 cleaned the Vacutainer and disinfected. 8/7 and 8/14 trained phlebotomists to procedure to clean and inspect Vacutainer between use and at end of each day. Instructions added to CLIA Manual with reuse guideline of log start and discontinue based on census. 8/2/12 Lidocaine Vial and Methotrexate vial with no open date were discarded. Staff #8 retrained with labeling procedure. 8/14 Mini in-service retrain staff with labeling, sanitization and storage. 2-4. 5/11/12 FCHC staff had our annual OSHA Blood Borne Pathogen training conducted by ICC, training was documented. Infection Control best practices expanded to include a policy that training will be reviewed as a QI by the QAC. The Surgery and Gynecology Coordinators will document their monitoring of staff and report to QAC. Prevent recurrence of Deficiency: A master list of changes in procedures was made from the inspectors exit interview with staff. A training schedule was prepared by Surgery and Gynecology Coordinators and re-training and corrective actions taken. The corrective actions taken will prevent recurrence of deficiency.	9/10/12 and ongoing

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T 170	Continued From Page 15 10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices. This RULE: is not met as evidenced by: Based on observations, record review and interview the facility failed to: 1. Ensure implementation of safe injection practices related to dating /discarding open vials of medications and disinfection of reused vacutainer holders. 2. Develop required infection prevention policies and procedures regarding training staff and U.S. Occupational Safety & Health Administration (OSHA) blood-borne pathogen requirements. 3. Procedures for monitoring staff adherence to recommended infection prevention practices. 4. Develop a plan for annual retraining of staff and the policies and procedures for documenting staff's annual infection prevention training. The findings included: 1. Observation and interview during the initial tour August 1, 2012 from 8:50 a.m. to 9:32 a.m., with Staff #1 and Staff #8 revealed the facility reused vacutainer holders. Observation revealed the two vacutainers, designated as clean and ready for use, by Staff #8, had a dark reddish substance on the inner surface of the hub where the vacutainer tube for blood collection attached. Staff #8 reported the cleaning process as: "We run water through the vacutainers and then soak them in alcohol at the end of the day." Staff #8 did not provide an answer to whether the vacutainer holders were disinfected between each patient's blood draw. Staff #8 was asked to observe the	T 170	Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. Training and In-services will continue to be kept in Staff Training manual but also documented within employee file. Documentation shared with QAC as part of their annual review. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	

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T 170	Continued From Page 16 inner surface of each vacutainer he/she had designated as clean. Staff #8 stated "That looks like blood. They aren't clean." Staff #8 placed the vacutainers in a stream of running water and after observation reported the substance identified as "blood" was gone. Staff #8 verified the two-vacutainer holders had not been disinfected after their last use. The surveyor requested the manufacturer's cleaning process and documentation of multiple use capability. Staff #8 presented the manufacturer's directions for use with documentation with "Recommended Use: 100 needle uses per holder." The facility did not provide direction for cleaning the vacutainer holders between drawing blood on different patients prior to the surveyors' exit. The facility did not have a policy and procedure for disinfecting the vacutainers between different patient's blood draws. Observation and interview conducted on August 1, 2012 at 2:15 p.m., with Staff 1 and Staff #8 revealed the following medications vials had been accessed, placed back in the medication cart without an access date: Lidocaine HCL 1% a 30 ml (milliliter) vial- Staff #8 verified that approximately one-third of the medication remained in the vial. Methotraxate 250 mg (milligrams) per ml a 10 ml vial- Staff #8 verified that approximately one half of the medication remained in the vial. Staff #1 reported staff knew to date the medication vials when opened. Staff # reported opened vials were kept for 28 days and without a date, the 28 days could not be determined. [Lidocaine HCL is use as a local and topical anesthetic agent and anti-dys-rhythmic, agent. Methotraxate is an antimetabolite and antifolate drug. It is used in treatment of cancer, autoimmune disease, ectopic pregnancy, and for	T 170		

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T 170	Continued From Page 17 the induction of medical abortions.] 2. Review of the facility's "Infection Control" policies and procedures did not include a policy, procedure, or process for training and re-training of staff in infection prevention. The facility's "Infection Control" manual did not include policies, procedures or processes related to OSHA requirements for training related to blood-borne pathogens. An interview was conducted on August 1, 2012 at 3:18 p.m. with Staff #1. Staff #1 reported the facility provided training but did not have policies and procedures, which documented the process. An interview was conducted on August 1, 2012 at 3:23 p.m. with Staff #8. Staff #8 reported responsibility for maintaining the sign-in sheet for infection prevention in-services. Staff #8 reported although he/she kept the OSHA forms, the facility did not have a documented process for OSHA required training and re-training related to blood-borne pathogens. 3. An interview and review of the facility's "Infection Control" manual conducted on August 1, 2012 at 3:18 p.m., with Staff #1 did not reveal procedures for monitoring staff adherence to recommended infection prevention practices. Staff #1 reported the facility conducted monitoring but did not document the activity. Staff #1 reported the facility did not have a written policy and procedure related to monitoring staff's adherence to infection prevention practices. 4. An interview and review of the facility's "Infection Control " manual conducted on August 1, 2012 at 3:18 p.m., with Staff #1 did not have evidence that a plan had been develop for annual retraining of staff. The facility's "Infection Control"	T 170		

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T 170	Continued From Page 18 manual did not have policies and procedures for documenting staff's annual infection prevention training. Staff #1 verified the findings.	T 170		
T 175	12 VAC 5-412-220 C Infection prevention 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); 4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies and equipment; 5. Procedures for handling/temporary storage/transport of soiled linens; 6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations; 7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address: (i) the level of cleaning/disinfection/sterilization to be used for each type of equipment, (ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and (iii) the method for verifying that the recommended level of disinfection/sterilization has been achieved. The procedure shall reference the manufacturer's recommendations and any applicable state or national infection	T 175	T175 12VAC 5-412-220 C Infection prevention Cleaning Corrective actions: 8/2/12 Staff #8 was orientated to new requirements Staff #8 & and # 7 cleaned all environmental surfaces identified during the inspection making immediate corrections. 1. - 2 8/10/12 Containers were purchased and put in use for cloth items. Sedation provider advised to cover her supplies. Physician instructed to change gloves after POC examination before accessing pathology container. Any sponges used will soaked between same day use in turgicide antibacterial and be discarded at end of day or alternatively Microwaved according to the ARS 2/2008 guideline. Any reused supplies from Wet Prep will be soaked overnight in turgicide. 8/ 21/12 and 9/7/12 mini in-service of staff on establishing and maintain clean surfaces in wet prep 8/28/12 mini in-service training of staff on preventing contamination from environmental sources, covering equipment , patient linens, sanitization of surfaces sanitation of legs covers between patients. 9/7 MA mini in-service to review how to further store and process pathology containers. 8/28/12 vinyl stirrup covers ordered to replace/supplement cloth covers. Infection control guidelines expanded to reflect changes in processes. 3. 8/4/12 Items were removed from under the sink and placed on a wire cart for ready access to spill cleanup. 4. Consolidation of processes into a policy for the 12 components of regulation 12 VAC 5-412-220 C formulated and will be approved by Governing Body and QAC at annual meeting. Prevent recurrence of Deficiency: The corrective actions taken and training will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Landlord agreed to improve their nightly services. The Weekly Cleaning service was notified of deficiencies in their cleaning, monitored; after evaluating no significant improvement	9/10/12

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T 175	Continued From Page 19 control guidelines; 8. Procedures for appropriate disposal of non-reusable equipment; 9. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations; 10. Procedures for cleaning of environmental surfaces with appropriate cleaning products; 11. An effective pest control program, managed in accordance with local health and environmental regulations; and 12. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department. This RULE: is not met as evidenced by: Based on observations, record review and interview failed to: 1. Ensure linens and other items were handled in a manner to prevent contamination and were washed at the correct temperature to prevent the spread of infections; 2. Perform appropriate cleaning of environmental surfaces {As evidenced by dried blood on two of two procedure tables and four of five recovery recliner had an unidentified substance spilled on the lower inner rails. A non-packaged endotracheal tube with metal guide was available for use next to an (oral) suction apparatus and one of three (oral) suction apparatus had dust on its surface and dust on the attached yankauer catheter. Dried blood splatters were found on the wall, door and door frame between the "Wet Lab" and procedure room.}; 3. Ensure chemicals and paper products were not stored under sinks	T 175	in environmental surface maintenance changed to a new vendor 9/1/12 who is maintaining the environment surfaces. Staff closing a room is to survey all wall surfaces and clean as needed, will report need for repainting or repairs to Director of Patient Services or Surgery Coordinator. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	

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T 175	Continued From Page 20 4. Develop policies and procedures that encompassed the twelve requires listed in the regulations. The findings included: 1. Observations and interviews were conducted on August 1, 2012 from 9:02 a.m. to 11:45 a.m., with Staff #1 and Staff #8. The observations revealed the following linens were stored on an open cart or shelf un-protected from environmental contamination: Six (6) cloth patient gowns in Procedure room #2 ("Local room") and eight (8) cloth gowns in Procedure room #1; Twenty (20) pair of socks utilized by patients in Procedure room #2; ten (10) pairs of socks utilized by patients in Procedure room #1 and eight (8) pairs of socks in Recovery room #1; Ten (10) pillowcases in Procedure room #1: Staff #8 reported a pillowcase was placed under the patient during the procedure to assist staff with transferring the patient post procedure from the procedure table to a stretcher. An interview conducted on August 1, 2012 at 9:50 a.m., with Staff #8 revealed he/she was not aware the linens should be covered to prevent contamination from environmental sources. Other linens observed during tour included: Thirteen (13) cloth sheets and nineteen (19) blankets used for patient care and at least twenty (20) towels used for cleaning plus establishing a "clean surface" in the "Wet"(Dirty) Lab" and the "Dry (Clean) Lab." Staff #8 reported the six cloth leg covers observed on the procedure and sonogram tables were not changed between patient/procedures. Staff #8 reported the cloth leg covers were washed at the end of the day. Staff #8 acknowledged the cloth leg covers could not be disinfected between patients.	T 175		

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Review of the facility's "Infection Control" manual did not reveal a policy related to procedures for handling Linens and storage of linens. Staff #1 verified a policy did not exist.

An observation and interview conducted on August 1, 2012 at 2:30 p.m., with Staff #1 revealed the laundry area was located within a closet marked janitor. Staff #1 reported that all linens and staff's scrubs were washed on site. The observation revealed a standard washer/dryer combination unit. Staff #1 reported the blankets were washed in cold water and the rest of the linens on the appropriate setting for the material. Staff #1 reported the washer was connected to the general hot water supply for the building and had the same hot water temperature as in the sinks. Staff #1 was informed of the required hot water temperature (160 degrees Fahrenheit). Staff #1 reported the washer did not currently have a heat booster to reach the required water temperature.

2. Observations and interviews were conducted on August 1, 2012 from 9:02 a.m. to 11:45 a.m., with Staff #1 and Staff #8. An observation at 9:50 a.m., with Staff #8 in the "Local" procedure room (#2) revealed dried blood of various coloration located on the padded foot/leg support of the procedure table and the metal support under the padded area. Staff #8 stated, "They couldn't have cleaned this last night." The observation revealed dried blood on the metal base of the procedure table. Staff #8 verified the findings.

Observations in the "Local" procedure room revealed the (oral) suction apparatus was uncovered. Staff #8 acknowledged the suction apparatus had film of dust on its surface and on the uncovered attached yankauer catheter. The

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T 175	Continued From Page 22 observation revealed an uncovered plastic endotracheal tube with a metal guide inserted. Staff #8 verified the opening near the tip of the endotracheal tube had dust and other particulate matter on the inner surface. Staff #8 reported the cart was utilized by the anesthesiologist. An observation was conducted in Procedure room #1 at 11:16 a.m., with Staff #8. Staff #8 reported the room was ready for the procedures scheduled for the day. The observation revealed the procedure table had visible dried blood on the metal joints (Bilaterally) that connected the metal leg stirrup/supports. Staff #8 verified the blood observed on the base of the procedure table and on the front of the drawers between the two leg stirrup/supports. Observations in the "Second Recovery" area revealed four of the five recovery recliners had an un-identifiable substance spilled on the lower inner rail. Staff #1 verified the findings. An observation on August 2, 2012 at 9:48 a.m. revealed the facility's designated Dirty scrub room the "Wet Lab" had been set up with towels on the counter and on the ledge between the "Wet Lab" and designate Clean scrub room the "Dry Lab." During an interview on August 2, 2012 at 9:30 a.m., Staff #1 informed the surveyor the staff designated to perform the "Wet Lab" task of cleaning and disinfecting the equipment were assigned to assist in the procedure room related to the number of cases. Staff #1 reported equipment would not be clean/disinfected until the three scheduled cases were completed. Observations conducted in the "Wet Lab"/ Dirty scrub room on August 2, 2012 from 9:58 a.m. to	T 175		

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T 175	Continued From Page 23 12:30 p.m. revealed dried blood splatter on: the middle to lower portion of the swing door to Procedure Room 2; the door jamb to Procedure Room 2; and the wall above the freezer near Procedure Room 2. An interview was conducted on August 2, 2012 at 11:01 a.m., with Staff #1. Staff #1 was informed of the findings. Observations prior to the staff assigned to perform "Wet Lab" task entered the area; revealed the physician inspected the products of conception in the "Wet Lab" and placed the tissues in containers for pathology. The physician utilized the same gloves to examine the products of conception and to handle each pathology container. The outer surfaces of two pathology containers were contaminated with blood from the physician's gloves. The contaminated pathology containers were placed in the pass through window between the "Wet Lab/Dirty scrub room and the "Dry Lab"/Clean scrub room. At approximately 12:15 p.m. when Staff #7 and Staff #8 entered the "Wet Lab" to perform cleaning and disinfection of equipment they were unaware, the pathology containers had contaminated the ledge between the dirty and clean areas. The surveyor stopped the process of placing cleaned instruments on the contaminated ledge. [A "Dirty" scrub room is a room designated to receive, clean and disinfect used instruments and or equipment following a procedure. After instruments are cleaned and disinfected in the "Dirty" scrub room, they are taken to the "Clean" scrub room where instruments are packaged and sterilized as appropriate for use again.] The observation revealed a scrub sponge on the	T 175		

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T 175	Continued From Page 24 utility sink. An interview was conducted on August 2, 2012 at 12:20 p.m., with Staff #8. Staff #8 reported the sponge was used to clean blood splatter on the walls, counters and sink. Staff #8 reported the sponge was kept on the sink for that purpose. Staff #8 reported the method of cleaning the sponge as rinsing it under water. According to the USDA Agriculture Research Service (ARS) newsletter dated February 2008 "...Sponges were soaked in 10% bleach solution for 3 minutes, lemon juice for 1 minute, or pure water for 1 minute, placed in a microwave oven for 1 minute at full power, or placed in a dishwasher for a full wash-dry cycle, or left untreated (control). Microwaving and dishwashing treatments significantly lowered bacterial counts compared to any of the immersion chemical treatments or the control. Counts of yeasts and molds recovered from sponges receiving microwave or dishwashing treatments were significantly lower than those recovered from sponges immersed in chemical treatments." According to ARS website Best Ways to Clean Kitchen Sponges - April 23, 2007 - News from the USDA Agricultural Research Service.mht read: "...treated each sponge in one of five ways: soaked for three minutes in a 10 percent chlorine bleach solution, soaked in lemon juice or deionized water for one minute, heated in a microwave for one minute, placed in a dishwasher operating with a drying cycle-or left untreated...They found that between 37 and 87 percent of bacteria were killed on sponges soaked in the 10 percent bleach solution, lemon juice or deionized water-and those left untreated. That still left enough bacteria to potentially cause disease. Microwaving sponges killed 99.99999 percent of bacteria present on them, while dishwashing killed 99.9998 percent of bacteria..."	T 175		

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T 175	Continued From Page 25 3. Observations were conducted on August 1, 2012 from 9:02 a.m. to 11:45 a.m., with Staff #1 and Staff #8. An observation at 9:02 a.m. revealed the following items stored under the sink in the Laboratory: hydrogen peroxide, blood spill kit and dish detergent. Staff #8 reported he/she had not been aware that item could not be stored under the sink. An observation at 11:30 a.m. in the "Wet (Dirty) Lab" revealed two quart bottles of hydrogen peroxide, dish detergent and two rolls of paper towels stored under sink. 4. Review of the facility's "Infection Control" manual did not reveal policies and processes for the twelve required components in regulation 12 VAC 5-412-220 (C). An interview was conducted on August 1, 2012 at 4:44 p.m., with Staff #1. Staff #1 reported the facility had failed to have a system in place to develop, maintain and implement infection prevention policies, procedures and processes. Staff #1 acknowledged the facility did not have policies, procedures, or processes to comply with 12 VAC 5-412-220 (C) (1-12). Staff #1 acknowledged certain areas had procedures on how to perform task, but not every task under 12 VAC 5-412-220 (C) was included.	T 175		
T 180	12 VAC 5-412-220 D Infection prevention D. The facility shall have an employee health program that includes: 1. Access to recommended vaccines; 2. Procedures for assuring that employees with communicable diseases are identified and prevented from work activities that could result in transmission to other personnel or patients;	T 180	**T180 12VAC 5-412-220 D Infection prevention Communicable Disease with SHPP** Corrective actions: Expanded FCHC's Staff Health Protection Program – SHPP (Employee Health Program) to ensure OSHA compliance and address work activities/ processes for staff with communicable illness, patient screening for documentation of TB screening and Hepatitis B vaccine. Implement Screening processes for patient and staff. Please also reference T095 12 VAC 5-412-170 H Personnel response.	9/10/12

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T 180	Continued From Page 26 3. An exposure control plan for blood-bourne pathogens; 4. Documentation of screening and immunizations offered/received by employees in accordance with statute, regulation or recommendations of public health authorities, including documentation of screening for tuberculosis and access to hepatitis B vaccine; 5. Compliance with requirements of the U.S. Occupational Safety & Health Administration for reporting of workplace-associated injuries or exposure to infection. This RULE: is not met as evidenced by: Based on record review and interview the facility failed to have four of the five requirements for their employee health program. The findings included: Review of the facility's "Infection Control" manual on August 1, 2012 did not include the required components: A procedures for assuring that employees with communicable diseases are identified and prevented from work activities that could result in transmission to other personnel or patients; An exposure control plan for blood-bourne pathogens; Documentation of screening and immunizations offered/received by employees in accordance with statute, regulation or recommendations of public health authorities, including documentation of screening for tuberculosis and access to hepatitis B vaccine; and Policies and procedures to ensure compliance with requirements of the U.S. Occupational Safety & Health Administration for reporting of workplace-associated injuries or exposure to infection	T 180	Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	

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T 180	Continued From Page 27 An interview was conducted on August 1, 2012 at 4:44 p.m., with Staff #1. Staff #1 reported the facility had failed to have a system in place to develop, maintain and implement infection prevention policies, procedures and processes. Staff #1 acknowledged the facility did not have policies, procedures, or processes to comply with 12 VAC 5-412-220 (D) (2-5).	T 180		
T 185	12 VAC 5-412-220 E Infection prevention E. The facility shall develop, implement and maintain policies and procedures for the following patient education, follow-up, and reporting activities: 1. Discharge instructions for patients, to include instructions to call or return if signs of infection develop; 2. A procedure for surveillance, documentation and tracking of reported infections; and 3. Policies and procedures for reporting conditions to the local health department in accordance with the Regulations for Disease Reporting and Control (12 VAC 5-90), including outbreaks of disease. This RULE: is not met as evidenced by: Based on record review and interview the facility failed to have a procedure for surveillance, documentation and tracking of reported infections; and policies and procedures for reporting conditions to the local health department in accordance with the Regulations for Disease Reporting and Control (12 VAC 5-90), including outbreaks of disease. The findings included: Review of the facility's "Infection Control" manual	T 185 T 195	**T185 and T195** **12VAC 5-412-220 C and 12 VAC5-412-240 A** **Infection prevention Reporting Infections** Corrective actions: Develop a policy memorializing our best practices for monitoring patients post procedure for overall wellness and infections that expands our NAF Adverse Event report and summary log currently in use. Patients who miss their follow up are called 2 times to access status as well as offer reschedule. Unfortunately Staff #8's response was incomplete she may not have the log but FCHC as an OB/GYN center does indeed maintain a log and record of Morbidity Reports that is overseen by the Gynecology Coordinator who reports to VDH. Include the system by reference in this policy. Have policy reviewed and approved by the Governing Body. All infections resultant from surgery or IUD insertion are reported to clinician, monitored and documented in patient chart and Adverse Events log. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Governing Body established policy for screening of sexually transmitted infections.	9/10/12

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T 185	Continued From Page 28 on August 1, 2012 did not include the required components for following patients post procedures. The facility did not have a process for surveillance, documentation and tracking of reported infections. The facility's "Infection Control" manual did not include policies and procedures for reporting conditions to the local health department in accordance with the Regulations for Disease Reporting and Control (12 VAC 5-90), including outbreaks of disease. An interview was conducted on August 1, 2012 at 4:44 p.m., with Staff #1 and Staff #8 . Staff #8 reported the facility had failed to have a process in place to obtain infection data on patient that did not return to the facility for follow-up care. Staff #8 reported the facility did not have an infection log or other data to document surveillance and tracking of reported infections whether by the patient or physician. Staff #8 reported the facility had a list of the reportable diseases. Staff #8 stated, "I do not have a policy formulated on what or how to report to the local health department." Staff #1 acknowledged the facility did not have policies, procedures, or processes to comply with 12 VAC 5-412-220 (E) (2-3).	T 185		
T 195	12 VAC 5-412-240 A Medical testing, patient counseling and labor A. Prior to the initiation of any abortion, a medical history and physical examination, to include confirmation of pregnancy, shall be completed for each patient. 1. Use of any additional medical testing, including but not limited to ultrasonography shall be based on an assessment of patient risk. The clinical criteria for such additional testing and the actions to be taken if abnormal results are found shall be documented.	T 195	12 VAC5-412-240 A See Page 28	

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FALLS CHURCH HEALTHCARE CENTER	900 SOUTH WASHINGTON ST SUITE 300 FALLS CHURCH, VA 22046

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T 290	Continued From Page 30	T 290		
T 290	12 VAC 5-412-270 Equipment and supplies An abortion facility shall maintain medical equipment and supplies appropriate and adequate to care for patients based on the level, scope and intensity of services provided, to include: 1. A bed or recliner suitable for recovery; 2. Oxygen with flow meters and masks or equivalent; 3. Mechanical suction; 4. Resuscitation equipment to include; as a minimum, resuscitation bags and oral airways; 5. Emergency medications, intravenous fluids, and related supplies and equipment; 6. Sterile suturing equipment and supplies; 7. Adjustable examination light; 8. Containers for soiled linen and waste materials with covers; and 9. Refrigerator. This RULE: is not met as evidenced by: Based on observation and interview the facility failed to maintain an emergency "Incident tray" in one of two procedure rooms. The facility failed to ensure that outdated supplies were not available for patient procedures/treatments in one of two procedure rooms. The findings included: 1. Observations and interviews conducted on August 1, 2012 from 9:02 a.m. to 11:45 a.m., with Staff #8 revealed the emergency "Incident tray" in Procedure room #1 had expired intravenous (IV) fluids and supplies. The observation revealed the 5% Dextrose 1000 ml (milliliter) bag had expired September 2011 and the IV line expired September 2003. Staff #8 reported staff checked the "Incident Tray" monthly. The form for documenting the "Incident tray" had been checked	T 290	**T 290 12-VAC 5-412-270 Equipment and supplies** Corrective actions: 8/2 – 8/4/2012 All supply shelves and rooms were surveyed by Staff # 8, #7, 4, and resurveyed by Staff #1 and 10. All outdated or expired supplies were removed and restocked as needed. 8/7/12 Mini in-service for staff to retrain on stock rotation, survey for outdated supplies and documentation of surveys. Staff # 8, Surgical Coordinator retrained on how to monitor her MA staff and how to document her supervision and review of their processes. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency and ensure that outdated supplies will not be available for patient care. Director of Patient Services and Assistant Administrator will monitor Staff #8 supervision skills and document her performance for 4 months and report to QAC improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually and address any emergent issues and take corrective actions.	9/12/10

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T 290	Continued From Page 31 noted it should be checked on "Mondays Biweekly". The last entry documented on the "Incident tray" form was "March 26, 12 @ (at) 11:45 a (a.m.)." Staff #8 verified the findings. 2. Observations and interviews were conducted on August 1, 2012 from 9:02 a.m. to 11:45 a.m., with Staff #8. An observation at approximately 10:22 a.m. revealed a vertical storage container labeled with various sized curettes. The observation revealed the following disposable flexible curettes were outdated: Size 6 mm (millimeters)- Seventeen (17) had expired October, 2010 and twenty-five (25) expired November, 2011; Size 8 mm- Fifteen (15) had expired May, 2012; Size 9 mm- One (1) expired December, 1996; two (2) expired February, 2010, ten (10) expired October, 2010; eleven (11) expired April, 2011; eleven (11) expired August 2011; and four (4) November, 2011; Size 10 mm- One (1) had expired in February, 1999; three (3) expired February, 2002 and thirty-one (31) expired in October, 2010. Staff #8 reported the staff assigned to re-stock the procedure rooms with curettes was responsible for checking the expiration dates. Staff #8 stated, "Obviously, they are not checking." Staff #8 reported the facility did not have policies and procedures for ensuring outdated supplies were not available for patient treatments/procedures.	T 290		
T 315	12 VAC 5-412-300 A Quality assurance 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,	T 315 T320 T325 T330 T335	**T315; T320; T 325; T-330; T 335; 12VAC 5-412-300 A, B, C, D, E Quality Assurance Develop Policy, Appoint Committee, Implement Plan, Correct deficiencies identified.** Corrective actions: BACKGROUND: *FCHC began work on correcting this deficiency when identified by our inspectors that our existing QA and quality control programs didn't satisfy 12VAC 5-412-300* . 8/2 Staff asked to assist and support their co-workers in this effort to standardize and review our center's patient care and the center's operation.	8/15/12

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T 315	Continued From Page 32 design, data collection/analysis, assessment and improvement, and evaluation. The findings shall be used to correct identified problems and revise policies and practices, as necessary. This RULE: is not met as evidenced by: Based on review of the Policy and Procedure Manual and interview, it was determined that no comprehensive plan had been implemented to develop a Quality Improvement Committee to access and evaluate the services of the facility as required in Section 12 VAC 5-412-300. A. The findings included: 1. On August 1-2, 2012, the Surveyor reviewed the Policy and Procedure Manual at various times in the facility's office. No policies and procedures to form a Quality Improvement Committee, to asses and improve services provided, to become a means of educating the staff and update polices and procedures were available for the Surveyor to review. 2. Staff #1 acknowledged during interview that no policy and procedure had been developed to address the Quality Improvement Meeting. This interview occurred in the facility's office, on August 1, 2012, approximately at 2:10 p.m.	T 315	8/6/12 The Governing Body Bylaws established the authority and directed establishment of a comprehensive Quality Assurance Plan (QAP). 8/15/12 A Quality Assurance Committee (QAC) was established including members as delineated by VAC 5-412-300. The Composition of the committee responsible for the oversight and supervision of the plan consist of: A physician ,A non-physician healthcare practitioner, A member of the administrative staff who will serve as chairman, and an individual with demonstrated ability to represent the rights and concerns of patients (who may be a member of the our staff or a non-staff person). The members were selected considering their knowledge, sensitivity to issues relating to quality of care breadth of services provided at FCHC, their organizational skills and recommendation of the QAC chair. Actions are ongoing to establish the plan and process for a comprehensive QAP with QI and QAC. The committee is mid-process developing a comprehensive plan, developing Quality indicators to facilitate evaluation as detailed VAC 5-412-300 utilizing the existing Quality Assurance program established for CLIA and NAF compliance. The QAC will meet not later than October 15 to develop the plan to provide comprehensive self-assessment program of the quality and appropriateness of the care provided to our patients. FCHC's activities shall be evaluated to assure adequacy and appropriateness of services and to identify unacceptable or unexpected trends or occurrences within: Staffing patterns and performance, Supervision appropriate to the level of service, Patient records, Patient satisfaction, Complaint resolution, Infections, complications and other adverse events, Staff concerns regarding patient care. The QAC implements FCHC quality improvement program by reporting to the Governing body annually the deficiencies identified and their recommendations for corrections and improvements. The report is acted upon by the governing body and implemented. Corrective actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing and corrections made and documented. The committee is undertaking preparations for their first meeting to be held early October in which they will develop a comprehensive plan for the quality assurance for the center. The target for their annual meeting is mid-November.	
T 320	12 VAC 5-412-300 B Quality assurance B. The following shall be evaluated to assure adequacy and appropriateness of services, and to identify unacceptable or unexpected trends or occurrences: 1. Staffing patterns and performance; 2. Supervision appropriate to the level of service; 3. Patient records;	T 320		

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T 320	Continued From Page 33 4. Patient satisfaction; 5. Complaint resolution; 6. Infections, complications and other adverse events; and 7. Staff concerns regarding patient care. This RULE: is not met as evidenced by: Based on review of the Policy and Procedure Manual and interview, it was determined that no policy and procedure were developed to ensure all the subjects of the Quality Improvement Committee would be addressed as required in Section 12 VAC 5-412-300. B.#1-#7. The findings included: 1. On August 1-2, 2012, the Surveyor reviewed the Policy and Procedure Manual at various times in the facility's office. No policy and procedure to list the subjects that would be discussed in the Quality Improvement Committee meeting as Staffing patterns and performance, supervision appropriate to the level of service, patient records, patient satisfaction, complaint resolution, infections, complications and other adverse events and staff concerns regarding patient care. 2. Staff #1 acknowledged during interview that no policies and procedures were developed that would address the subjects that would be discussed in the Quality Improvement Committee Meeting. This interview occurred in the facility's office, on August 1, 2012, approximately at 4:16 p.m.	T 320	In the first year the committee will meet 3 times or as needed to fully implement the QA program, then annually to review all quality indicators specified in their plan. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency and fully establish a meaningful Quality Assurance evaluation. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing. Measures to maintain compliance: Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 325	12 VAC 5-412-300 C Quality assurance C. A quality improvement committee responsible for the oversight and supervision of the program shall be established and at a minimum shall	T 325	12 VAC5-412-300 C See Page 32	

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T 325	Continued From Page 34 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: Based on review of the Policy and Procedure Manual and interview with Staff #1, it was determined that no policy and procedure were developed to address membership for the Quality Assurance Committee as required in Section 12 VAC 5-412-300.C.1-4. The findings included: 1. On August 1-2, 2012, the Surveyor reviewed the Policy and Procedure Manual at various times in the facility's office. No polity and procedure to address that membership would include a non-physician health care practitioner , a physician, a member of the administrative staff and 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. 2. Staff #1 acknowledged during interview that no policy and procedure were developed that addressed the Quality Assurance Committee membership. This interview occurred in the facility's office, on August 1, 2012, approximately	T 325		

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T 195	Continued From Page 29 2. Medical testing shall include a recognized pregnancy test and determination on Rh factor. 3. The facility shall develop, implement and maintain policies and procedures for screening of sexually transmitted diseases consistent with current guidelines issued by the U.S. Centers for Disease Control and Prevention. The policies and procedures shall address appropriate responses to a positive screening test. 4. A written report of each laboratory test and examination shall be a part of the patient's record. This RULE: is not met as evidenced by: Based on review of policies and procedures and interview, it was determined that the Governing Body failed to ensure that policies and procedures for reporting sexually transmitted infections were not available for the Surveyor to review as required in Section 12 VAC 5-412-240.A.3. The findings included: 1. The Surveyor reviewed policies and procedures at various times on August 1-2, 2012, in the facility's office. The facility's policies failed to address the process for screening of sexually transmitted infections consistent with current guidelines issued by the U.S. Centers for Disease Control and Prevention; and would address appropriate responses to a positive screening test. 2. Staff Member #1 acknowledged that no written policy the process for reporting, trending and analyzing sexually transmitted infection were not available for the Surveyor to review. This interview occurred in the agency's office on August 1, 2012, at 1:43 p.m.	T 195	12 VAC5-412-240 A See Page 28	

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T 325	Continued From Page 35 at 4:20 p.m.	T 325	12 VAC5-412-300 D See Page 32	
T 330	12 VAC 5-412-300 D Quality assurance D. Measures shall be implemented to resolve problems or concerns that have been identified. This RULE: is not met as evidenced by: Based on review of the Policy and Procedure Manual and interview with Staff #1, it was determined that no policy and procedure were developed to address how the problems would be resolved by the Quality Improvement Committee as required in Section 12 VAC 5-412-300. D. The findings included: 1. On August 1-2, 2012, the Surveyor reviewed the Policy and Procedure Manual at various times in the facility's office. No polity and procedure to address how problems and concerns identified would be resolved by the Quality Improvement Committee. 2. Staff #1 acknowledged during interview that no policy and procedure were developed that addressed problem solving by the Quality Improvement Committee. This interview occurred in the facility's office, on August 1, 2012, approximately at 4:21 p.m.	T 330		
T 335	2 VAC 5-412-300 E Quality assurance E. Results of the quality improvement program shall be reported to the licensee at least annually and shall include the deficiencies identified and recommendations for corrections and improvements. The report shall be acted upon by the governing body and the facility. All corrective actions shall be documented.	T 335	12 VAC5-412-300 E See Page 32	

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T 335	Continued From Page 36 Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee. This RULE: is not met as evidenced by: Based on review and interview, it was determined that no policy and procedure were developed to address how and when the results of the for the Quality Improvement Committee Meeting and the action taken upon recommendations from the Governing Body as required in Section 12 VAC 5-412-300. E The findings included: 1. On August 1, 2012, the Surveyor reviewed the Policy and Procedure Manual at various times in the facility's office. No polity and procedure to address the results of the quality improvement program would be reported to the licensee at least annually and would include the deficiencies identified and recommendations for corrections and improvements with the report being acted upon by the governing body and the facility. In addition, the policy and procedure failed to identify deficiencies that jeopardize patient safety and would be be reported immediately in writing to the licensee by the quality improvement committee. 2. Staff #1 acknowledged during interview that no policy and procedure were developed that addressed reporting of the meeting minutes and corrective actions that needed to be identified by the Quality Improvement Committee. This interview occurred in the facility's office, on August 1, 2012, approximately at 4:21 p.m.	T 335		

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T 355	Continued From Page 37	T 355		
T 355	12 VAC 5-412-330 B Reports B. Abortion facilities shall report all patient, staff or visitor deaths to the OLC within 24 hours of occurrence. This RULE: is not met as evidenced by: Based on review and interview, it was determined that the facility failed to present a policy and procedure that addressed how patient, staff or visitor deaths would be reported as required in Section 12 VAC-5-412.330. B. The finding included : 1. The Surveyor reviewed policy and procedure manual at various times in the facility's office on August 1-2, 2012. The facility failed to address the mandatory reporting to the Office of Licensure and Certification deaths within 24 hours. 2. Staff #1 acknowledged during interview that no policy and procedure for deaths were available for the Surveyor to see. This interview occurred in the facility's office on August 1, at 4:30 p.m.	T 355	**T 355 – 12 VAC 5-412-330 B Reports** Corrective actions: 9/8/12 Policy addressing deaths was developed with mandatory reporting to the OLC within 24 hours. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Measures to maintain compliance: Staff trained to new process/procedure. Governing Body will review annually all policies and address any emergent issues and take corrective actions.	9/10/12
T 380	12 VAC 5-412-360 B Maintenance B. When patient monitoring equipment is utilized, a written preventative maintenance program shall be developed and implemented. This equipment shall be checked and/or tested in accordance with manufacturer's specifications at periodic intervals, no less than annually, to ensure proper operation and a state of good repair. After repairs and/or alterations are made to any equipment, the equipment shall be thoroughly tested for proper operation before it is returned to service. Records shall be maintained on each piece of equipment to	T 380	**T 380 12 VAC 5-412-360 B Maintenance** Corrective actions: Annually PM are done on all patient monitoring equipment. 9/4/12 The comprehensive Preventative Maintenance program in place since 2002 and documented in the CLIA Manual was moved to the new Policy and Procedure Manual Administration; reviewed and updated as needed. 8/15/12 A policy for the PM program was added to the Policy Manual, 9/4/12 Mini in-service training on how to identify equipment that is damaged, out of service or needs repairs to be reported to Director of Patient Services within 24 hours. If patient health or safety is jeopardized the equipment is immediately taken out of service. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Director of Patient Services will monitor and report to Governing Body improvements or adverse issues in writing.	9/10/12

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T 380	Continued From Page 38 indicate its history of testing and maintenance. This RULE: is not met as evidenced by: Based on observation, record review and interview the facility failed to have a preventative maintenance program and a method to identify equipment, which was out of service.	T 380	Measures to maintain compliance: PM servicing for all equipment and support items will continue to be scheduled annually in September or as needed. Governing Body and the QAC will review annually and address any emergent issues and take corrective actions or make recommendations for new equipment purchases. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	
T 400	12 VAC 5-412-380 Local and state codes and 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 3.7 of Part 3 of the 2010 Guidelines for Design and Construction of Health Care Facilities of the Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building Code pursuant to Virginia Code 32.1-127.001. Entities operating as of the effective date of these regulations as identified by the department through submission of Reports of Induced Termination of Pregnancy pursuant to 12 VAC 5-550-120 or other means and that are now subject to licensure may be licensed in their current buildings if such entities submit a plan with the application for licensure that will bring them into full compliance with this provision within two years from the date of licensure. Refer to Abortion Regulation Facility Requirements Survey workbook for detailed facility requirements. This RULE: is not met as evidenced by: Based on observations and interviews the facility failed to provide evidence of compliance with state and local codes, zoning and building ordinances, and the Uniform Statewide Building Code. In	T 400	**T 400 12 VAC 5-412-380 Local and state codes and standards** *BACKGROUND:* FCHC is a tenant in an office building built in the early 1950's which is maintained by the owner/landlord. The building houses 5 other medical service providers as well as 20 other small businesses. Corrective actions: **Landlord related:** 8/02/12 landlord contacted and 8/6 provided letter addressing Handicap access will be adjusted. 8/30/12 landlord contacted and provided documentation that the facility had outside air exchanges and used filters of at least MERV 7 with 30% efficiency as well as a MERV rating chart. 9/6/12 Discussed temperature setting of water and installation of heat booster to our suite. 9/7/12 retained Plumber to research, purchase and install heater booster washer with temperature gauge. **Suite related:** 9/4/12 Light Sedation 11'X 15' room was reconfigured to allow 3'6" clearance on all sides of the 2' x 5' exam table simply by moving or relocating patient monitoring equipment that is used during a surgery . Designated Clean supply storage is in cabinets or covered rolling bins or shelves or carts within each exam room. Ventilation is provide passively and actively by the radiators with direct access through louvers to filtered outside air. Temperature controls are within each radiator. 9/5/12 Room thermometer added to each exam room to monitor and document temperature. 8/3/12 all uncovered carts used for stored items were covered. Items stored on shelves were put in closed containers on the shelves. All environmental surfaces will be monitored and dusted each morning. 8/4/12 Replacement process for Dry Prep counter begun. Contractor retained. 8/10 Counter top ordered. 9/10 Counter top shipped. 9/ 13 counter top received. Installation scheduled for 9/19	as Spaced with Text

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FALLS CHURCH HEALTHCARE CENTER	900 SOUTH WASHINGTON ST SUITE 300 FALLS CHURCH, VA 22046

(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 400	Continued From Page 39 addition, abortion facilities shall comply with Part 1 and sections 3.1-1 through 3.1-8 and section 3.7 of Part 3 of the 2010 Guidelines for Design and Construction of Health Care Facilities of the Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building Code pursuant to Virginia Code 32.1-127.001. The findings included: Observations conducted on August 1, 2012 from 8:55 a.m. to 5:00 p.m., with Staff #1, Staff #7, Staff #12, and Staff #8. An interview conducted with Staff #1 at 8:55 a.m., revealed the facility had not obtained an attestation from an architect related to the building's compliance with FGI guidelines. The observations revealed the following: The building's vehicular drop-off and pedestrian entrance was not graded. An individual confined to a wheelchair would need to maneuver over a curb greater than seven (7) inches. There was no documentation that the treatment rooms had the minimum of two outside air exchanges. The treatment/procedure room utilized for conscious sedation did not have the required three feet six inches of clearance at each side, the head and at the foot. The facility did not have designated "Clean" supply storage area. Sterile supplies were stored on open carts in the procedure rooms. The areas utilized for storage did not have evidence of ventilation, humidity, and temperature control. The open carts used to store the sterile supplies had dust and other particulate matter on the shelves. The counter near the steam autoclave in the "Dry (Clean) Lab" the surface was not intact and the	T 400	9/4/12 Chairs in hallway removed to increase accessibility to the 5'5" hallway/corridors. All corridors within our suite are 5' or greater. 8/4/12 The blood borne spill clean-up supplies were removed from under the sinks and maintained on rolling cart for ready access. Prevent recurrence of Deficiency: The corrective actions taken will prevent recurrence of deficiency. Surgery Coordinator will monitor and report to Director of Patient Services improvements or adverse issues in writing. Measures to maintain compliance: Staff trained to new process/procedure. QAC and Governing Body will review annually and address any emergent issues and take corrective actions. No patients were affected evidenced by no increase in adverse events during the period of deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-0019	A. BUILDING _____ B. WING _____	08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS CHURCH HEALTHCARE CENTER	900 SOUTH WASHINGTON ST SUITE 300 FALLS CHURCH, VA 22046

(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 400	Continued From Page 40 under-surface wood was exposed. The laboratory area used to draw patient's blood had two chairs in the hallway, which reduced the accessibility of the hallway. The plumbing used to perform the on-site laundry did not meet the required temperature (160 degrees Fahrenheit) The public corridors were measured and found to be less than the required five (5) feet in width. The facility could not provide evidence of the airflow requirements of two air changes (AC) per hour outside air in the examination, treatment and procedure rooms. The facility could not provide evidence the building air handlers were equipped with filters of at least 30 percent efficiency rating and equipped with at least MERV 7 filters. The facility staff had stored chemicals and paper products under the sink in two work areas (The blood draw Lab and the "Wet Lab".) Staff #1 verified the above findings during interviews conducted from 8:55 a.m. to 5:00 p.m., on August 1, 2012.	T 400		

BYLAWS The Governing Body of

Falls Church Medical Center, LLC

As required to satisfy 12VAC5-412 140 Organization, Management, Administration

Article 1

PURPOSE AND ORGANIZATION

1.1 The purpose of these Bylaws is to establish a Governing Body; to assure our existing Articles of Organization, Operating Agreement, Mission as detailed in our Cornerstones and Principles, Organizational Statement, the Organizational Chart and Functional Program of Falls Church Medical Center, *a Woman's Center Serving the Women and Families of our Community*, t/a Falls Church Healthcare Center (FCHC, Center) is implemented. This to assure FCHC's continuing quality and compassionate healthcare to women for their comprehensive reproductive health services and to assure National Abortion Federation and Insurance Payers Guidelines and Best Practices and the appropriate governmental guidelines are met including those expressly targeted against abortioncare providers. The Governing Body is Falls Church Medical Center, LLC and the Organizing member(s)/Agent as registered with the Virginia State Corporation Commission.

Article 2

DUTIES AND RESPONSIBILITIES

2.1 The Governing Body is responsible for Management and Control of our medical practice. The Duties and Functions of the Governing Body are to assure quality patient care for our patients by outlining professional guidelines for all staff members; ensure compliance with State and Federal Regulations governing Gynecological and Abortion practices; overview staffing patterns and job descriptions, encourage and develop policies for ongoing training and performance reviews for all staff members; develop policies for and evaluate Quality Assurance program and coordinate and review the center's Quality Assurance Program (QAP) through the Quality Assurance Committee; conduct annual reviews including the best practices manual (Policy and Procedure Manual - PPM) and document corrective actions of identified deficiencies that jeopardize patient safety; to appoint the Director of Patient Services (administrator/registered agent) and to report any change in the position to OLC as required; to appoint the Medical Director of the Center and to always maintain the dignity and confidentiality of patients.

Article 3

DIRECTOR OF PATIENT SERVICES AUTHORITY AND RESPONSIBILITIES

3.1 The Governing Body designates a Director of Patient Services for the Center who represents the Governing Body and is responsible for the daily management of the facility and implementation of its mission, policies, best practices, guidelines. The Director of Patient Services is authorized and empowered to carry out the rules and regulations of the practice as promulgated by the Virginia Department of Health. The authority and responsibility includes but is not limited to:

1. To ensure compliance with all State licensing requirements and regulations.
2. To meet with all state regulatory representatives and act as a representative of the Governing Body to the State Department of Health.
3. To report any regulatory issue(s) to the Governing Body , the QAC or Medical Director as appropriate and document. She shall directly report to the Governing Body as required and requested and will report any major breaches in protocol or problematic developments or occurrences as they arise
4. Coordinate and report all the necessary reviews and reports to the Governing Body annually.
5. Report Violations of Professional Conduct to the appropriate Boards of Health Professions, review all Criminal Record Checks and conduct annual License Look-up of clinical staff and consultants.
6. Carry out the duties and responsibilities specified in the Director of Patient Services Job Description

3.2 The Director of Patient Services shall designate an Assistant Administrator to act on her behalf during her absence. The Assistant Administrator has the authority to appoint one of the coordinators or staff members to act on her behalf during her absence.

Article 4

RELATIONSHIP OF PROFESSIONAL STAFF AND OTHER PERSONNEL

4.1 The relationship of staff to the operation of the Center is memorialized in the Organizational Chart and the Basic Outline of Duties and Activities. All staff responsibilities shall be listed in an appropriate job description for the staffing patterns of the Center.

4.2 The Medical Director shall be recommended by the Director of Patient Services then appointed with clinical privileges and oversight of medical protocols by the Governing Body.

4.3 The Consulting Clinicians shall be recommended by the Medical Director then shall be appointed and granted clinical privileges by the Governing Body under the supervision of the Medical Director.

4.4 The Governing Body directs the Director of Patient Services to select all mid-level clinical staff and support staff and grant privileges based on qualifications laid out in the appropriate job description using her best judgment and understanding of the staffing patterns.

4.5 The relationship between the Governing Body, Director of Patient Services, Medical Director and administrative and clinical Staff exists to assure FCHC will continue providing quality and compassionate healthcare to women for their comprehensive reproductive health services.

4.6 The Director of Patient Services, Assistant Administrator, Coordinator of Gynecological Services and Coordinator of Surgical Services shall serve as the direct and on-site supervisors.

4.7 The clinical Staff shall be under the direct authority and supervision of the Director of Patient Services and Medical Director and is responsible for reporting to them any breaches in protocol or concerns about the safety of employee or patient care.

4.8 The office Staff shall be under the direct authority and supervision of the Assistant Administrator and is responsible for maintaining patient records as required.

Article 5

RESPONSIBILITY FOR FORMULATING POLICIES

5.1 The Governing Body will annually review the Policy, Procedures and Best Practices for the Center and note review on the Governing Body Annual Review Log.

5.2 The Governing Body will assign formulation of Policies and Procedures to the Director of Patient Services, Medical Director and other personnel, advisors or consultants who will formulate or revise policies, procedures, best practices and guidelines as needed.

5.3 The Governing Body will make PPM (Policy and Procedure) available to the Office of Licensure and Certification upon request.

FALLS CHURCH HEALTHCARE CENTER

Admin Policies and Procedures Manual

To ensure compliance with the *Emergency and Temporary Regulations for Licensure of Abortion Facilities* (12 VAC 5-412) that expire 12/31/2012

Department: Administrative	**Policy Description: Policy for Quality Improvement**
Page: 1 of	**Replaces Policy Dated**:
Effective Date:	**Reference Number:** VAC 5-412
Approved:	

Scope:	Quality Improvement Committee shall consist of: Director of Patient Services, Medical Director, Gynecology Coordinator and Assistant Administrator or their designees
Purpose:	Responsible for the oversight and supervision of the quality improvement programs in FCHC
Policy:	Falls Church Healthcare Center, LLC's mission is to provide quality patient care to women seeking abortions and gynecological services. This facility shall operate in a professional manner and comply with all State of Virginia regulations pertaining to Abortion Facilities. In an effort to provide the best quality patient care possible the Quality Improvement Committee shall review any and all reports of concerns or deficiencies identified during the year or as needed and shall make recommendations for corrections and improvements. All corrective actions shall be acted on by the Governing Body and shall be documented. Any identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the Governing Body by the Quality Improvement Committee
Procedure:	Shall meet annually or as need arises and submit its report to Governing Body in writing.
Reference:	

	I. Policies and Procedures/ Facility References The following Infection Control policies and procedures will be maintained and made part of the facility's infection control plan: 1. Exposure Control Plan 2. Procedure for follow up on reported infections 3. Infection Control Best Practices 4. Procedures for cleaning before, during and after patient care 5. Hand hygiene and PPE's 6. Biohazardous waste management 7. Mandatory reporting of communicable disease conditions 8. Asepsis technique 9. Staff Health Protection Program (SHPP) 10. Monitoring the environment of care 11. Disaster preparedness 12. Orientation and training program/documentation
Reference:	**12VAC5-412-220** www.cdc.gov Occupational Safety and Health Administration http://www.osha.gov

FALLS CHURCH MEDICAL CENTER, LLC

Annual Review Documentation

BY Quality Assurance Committee (QAC)

BY Governing Body (GB)

Quality Assurance items or Action Item	QAC only	GB only	Current Year ____	Previous Year_____	Reviewed / approved or reapproved	Reviewed/recommendations	Referred to
PPM							
Policies		x					
Certification of Administrator		x					
Appointment of Clinical Staff		x					
Approval of Medical Director		x					
Infection Control program							
Staff Training • OSHA • Emergency • PPE • SHPP							
Staff Employment Review	x						
Adverse Events: • Complication • Infections • Hospital • Deaths							
Compliments and recognitions • Patients • On-line form • VDH • NAF • Yelp, etc							

Complaints • Patients • On-line form • VDH • NAF • Yelp etc							
Deficiencies • CLIA • API • OLC • NAF • Spore Testing							
Quality Indicators Staff performance Staff supervision Staff concerns							
Additional Issues							
QAC REPORT to GB		x					

Submitted by: DATE:

Falls Church Healthcare Center

Clinical Policies and Procedures Manual

Department: Quality of Care	**Policy Description:** Annual Staff Assessment
Page: 1 of 1	**Replaces Policy Dated**: 9/2002,
Effective Date: 8/10/12	**Reference Number:**
Approved:	

Scope:	All facility personnel.
Purpose:	To provide for continued quality of patient care at FCHC and provide staff opportunity for self-assessment of their performance.
Policy:	To provide for continued quality of patient care at this facility, Staff Assessment for both clinical and non-clinical employees is conducted on an annual basis. The type and extent of competency assessment is based on the individual employee's role and job responsibilities. Staff will be assessed on quality indicators for skill and over all contribution to the center by their supervisors, the Director of Patient Services and through a self assessment. Documentation of Staff Assessment is maintained within the facility and is available for evaluations, regulatory compliance, and accreditation surveys. On an annual basis, or more often if needed, the Governing Body and the QAC of the facility is provided with a report of the review, its results and recommendations, if any.
Procedure:	The Self Assessment questions included in the Annual Review evaluation include: • Concerns regarding Pataient Care • Supervision appropriate to level of patient services employee provides • what else is needed to improve your performance and career growth.
Reference:	

FALLS CHURCH HEALTHCARE CENTER

Admin Policies and Procedures Manual

To ensure compliance with the *Emergency and Temporary Regulations for Licensure of Abortion Facilities* (12 VAC 5-412) that expire 12/31/2012

Department: Patient Rights	**Policy Description: Rights and Complaint Process**
Page: 1 of	**Replaces Policy Dated**: 5-2005
Effective Date: 8-15-12	**Reference Number:** VAC 5-412
Approved:	

Scope:	All Staff, Director of Patient Services
Purpose:	To define FCHC commitment to upholding Patient rights and Privacy
Policy:	FCHC will offer each patient comprehensive information about her rights, responsibility and privacy in accordance with HIPPA guidelines and VDH regulations
Procedure:	Each patient shall be given a copy of their rights and responsibilities upon registration in a summary form with ready access to take-home brochure of Rights and Responsibilities, the Privacy Policy Notebook and complaint and compliment options. Staff will make every effort to assist the patient understand the pamphlets. Documentation of the patients review is maintained in the patient's chart. Patient Compliments and Complaints will be registered with options to speak with Director of Patient Services, use FCHC on-line form or submit the VDH complaint form. All Compliments or Complaints will be acknowledged promptly and documented.
Processes	1. A patient complaint log shall be created and kept in the assistant administrator's office. The complaints log is be maintained for 3 years. 2. The Director of Patient Services is responsible for complaint resolution and will delegate to appropriate staff. 3. Steps for receiving patient complaint: Patient states to staff member the desire to file a complaint. Patient will be offered opportunity to discuss issue with coordinator of the day who is to meet with the patient to address and if possible resolve the issue Patient is given a Patient Rights and Responsibilities pamphlet which includes information on submitting a complaint to the clinic or outside agencies. If a patient prefers to make a formal complaint, a complaint form is provided. The Administrator investigates the complaint, reviews the findings, and issues a resolution. That patient is notified within 30 days from the date of receipt of the resolution. All actions are documented on the Compliment and Complaint Log and noted in the patient's chart. All complaints are reported to the QAC.

Falls Church Healthcare Center, LLC.

Patient Compliment/Complaint Grievance Log (C/CG)

NOTE: More details if needed posted in Pt or Staff Folder

Pt Last Name, First D.O.B & D.O.S	Reported by/ Date C/CG	Summary of C/CG	FCHC RCVD By/Date	Affected Staff Notified	Summary of Actions/By	Date Completed	GA Signoff

FALLS CHURCH HEALTHCARE CENTER

Admin Policies and Procedures Manual

To ensure compliance with the *Emergency and Temporary Regulations for Licensure of Abortion Facilities* (12 VAC 5-412) that expire 12/31/2012

Department: Infection Control	**Policy Description: Infection disease - STI**
Page: 1 of 1	**Replaces Policy Dated**:
Effective Date: 8-5-12	**Reference Number:** VAC 5-412
Approved:	

Scope:	Health Educators and clinical staff and administrators
Purpose:	To assist patient understanding her wellness and implement care for sexually transmitted infections
Policy:	FCHC is to assist prevention and treatment of STIs by emphasizing education and counseling of persons at risk, and assist patients in access resources for appropriate testing in accordance with the current CDC Sexually Transmitted Diseases Treatment Guidelines.
Procedure:	Counseling and Testing is an active part of our Gynecology services and included for patients at risk with IUD insertions and basic Well Woman Services. As part of the patient's clinical medical history review, health care providers routinely assess whether the patient is at higher risk for STIs and consequently address management of possible infections. STI testing is not a service included in Aspiration D & C care at FCHC so patients deemed at high risk will be given information about our Gynecology services and encouraged to consider testing at their follow-up or referred back to their primary care clinician where testing can be conducted. Within our Practice the Gynecology Coordinator maintains a log of patients testing positive for STI and reports as required on the Morbidly Report to VDH. Trends are to be reported to the Medical Director.
Reference:	CDC Sexually transmitted infections guideline. VDH Morbidity Reports

FALLS CHURCH HEALTHCARE CENTER

Clinical Policies and Procedures Manual

Department: Infection Control	**Policy Description:** Environmental Surfaces Cleaning
Page: 1 of 2	**Replaces Policy Dated:**
Effective Date: 9/1/12	**Reference Number:** 12VAC5-412-220C
Approved:	

Scope:	
Purpose:	To maintain a clean environment for patients and minimize the risk of patient and healthcare personnel exposure to potentially infectious microorganisms.
Policy:	The patient care environment throughout the facility will be maintained in a state of cleanliness that meets best practices guidelines in order to protect patients and healthcare personnel from potentially infectious microorganisms. Environmental cleaning is a team effort. Personnel responsible for cleaning the exam rooms and equipment will receive education and training on proper environmental cleaning and disinfection methods, agent use and selection, and safety precautions.
Procedure:	Personal protective equipment (PPE) must be worn according to the Occupational Safety and Health Administration (OSHA) Blood borne Pathogen Standard when disposing of waste that could result in exposure to blood borne or other potentially infectious microorganisms and hazardous material. 1. At the beginning of each day or prior to the first procedure, horizontal surfaces, exam lights, exam room furniture will be dusted and wiped using a clean disinfecting wipe or turgicide spray. Damp wipe waste receptacles, dry thoroughly and re-line as needed. 2. Cleaning of exam room between patients using turgicide or other approved agent o Clean hands and put on gloves o Collect and remove or compact waste o Collect and remove all soiled linen o Remove gloves and clean hands o Use a cloth dampened in disinfectant solution to clean and disinfect horizontal surfaces that have come in contact with a patient or body fluids, including blood pressure cuffs, tourniquets and leads, stirrup covers o Clean all medical equipment including sono probe, light pole . o Clean and disinfect bed o When cleaning is complete, remove gloves and clean hands 3. At end of each day exam rooms will be surveyed, cleaned and prepared for the following day. Any damaged equipment is to be reported to Surgery Coordinator or Director of Patient Services. o Clean hands and put on gloves o Collect and remove waste o Collect and remove all soiled linen o Clean hands and change gloves o Clean and disinfect all door handles, push plates, light switches and controls o Spot wash all walls o Clean and disinfect all exterior surfaces of machines and equipment including Berkley, sedation monitors, lights,; inspect furniture including wheels/casters o Clean and disinfect all environmental surfaces including exterior of

	cabinets and doors, especially around handles o Clean and disinfect bed o Replace all furniture and equipment to its proper location o Remove gloves and clean hands o Clean and store cleaning equipment 4. Policy and procedure apply to unused rooms because personnel entering unused rooms and moving equipment and supplies in and out of the room can increase the risk of environmental contamination. 5. Mechanical friction and a facility approved agent will be used to ensure an adequate supply of clean cloths is available Clean hands and put on gloves Remove dirty linen, then remove gloves and clean hands Apply clean gloves and clean room, working from clean to dirty and high to low areas of the room using fresh cloth(s) or disposable Change the cleaning cloth when it is no longer saturated with disinfectant and after cleaning heavily soiled areas Start by cleaning doors, door handles, push plate and touched areas of frame Check walls for visible soiling and clean if required Clean light switches Clean inside and outside of sink, sink faucets and mirror; wipe plumbing under the sink; apply disinfect toilet seat and sinks; ensure sufficient contact time with disinfectant Clean wall mounted alcohol-based hand rub dispenser Clean all furnishings and horizontal surfaces in the room including chairs, telephone, tables or desks. Pay particular attention to high-touch surfaces Survey floors clean as needed Remove gloves and clean hands, wash with soap and water Replenish supplies as required 6. Disposal Check sharps container and change when ¾ full (do not dust the top of a sharps container) Remove waste 7. Personnel responsible for cleaning must perform hand hygiene: • Before initial patient environment contact (e.g., before coming into the procedure room or recovery); • After potential body fluid exposure (e.g., after cleaning bathroom, handling soiled linen, equipment or waste); and • After patient environment contact (e.g., after cleaning recovery or procedure room; after cleaning equipment such as stretchers; after changing mop heads). • Gloves must be removed on leaving each procedure room or recovery space. Personnel must **clean hands after removing gloves** as gloves do not provide complete protection against hand contamination.
	12VAC5-412-220C CDC's Guideline fhttp://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf

Falls Church Healthcare Center
Policy and Procedure Manual

Department: Infection Prevention	**Policy Description:** Injection Safety
Page: 1 of 1	**Replaces Policy Dated**:
Effective Date: 1/1/12	**Reference Number:**
Approved:	

Scope:	Clinical Staff
Purpose:	Injection safety includes practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and healthcare provider during preparation and administration of parenteral medications. DEFINITIONS: • Aseptic technique- the manner of handling medications and injection equipment to prevent microbial contamination.
Policy:	All healthcare workers will adhere to the safe injection practices by following aseptic technique and infection prevention when handling or preparing parenteral medications, administering injections and procurement and sampling of blood.
Procedure:	Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof. **ASEPTIC TECHNIQUE** All injectables should be accessed in an aseptic manner. Proper hand hygiene should be performed before handling medications, and if a medication vial has already been opened, the rubber septum should be disinfected with alcohol prior to piercing it. The use of a new sterile syringe and needle should be used to draw up medications while preventing contact between the injection materials and the non-sterile environment. Syringes and needles should be used for a single patient only and for a single procedure. The storage and preparation of medications and supplies should be performed in a designated "clean" area that is not adjacent to areas where potentially contaminated items are placed. Never store needles and syringes unwrapped as sterility cannot be assured. **IV SOLUTIONS** A single use parenteral medication should be administered to one patient only. Single-use IV solutions should be administered to one patient only, during one treatment. Never use intravenous solution containers (i.e. bags or bottles) to obtain flush solutions for more than one patient. **FLUSHING** Use single dose containers for flush solutions whenever possible. Ideally the safest practice is to restrict each medication vial to a single patient, even if it's a multi-dose vial. However, if a multi-dose medication vial must be used for more than one patient, the vial should only be accessed with a new unused sterile syringe and needle even if the vial is dedicated to a single patient.
Reference:	**12VAC5-412-220-B7** (http://www.cdc.gov/injectionsafety/)

Falls Church Healthcare Center

ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL, GOVERNING BODY BYLAWS
COPY TO EMPLOYMENT FILE

Personnel – Job description

Job Title	**Surgical Coordinator or Gynecology Coordinator**
Primary Assignment Area	Supervisory Clinical and Administration
Location	ON SITE
Reports to	Director of Patient Services
Supervisor	Director of Patient Services

OVERVIEW OF POSITION

Each staff member is responsible for understanding the full range of FCHC activities in order to be able to offer suggestions for improvements and activities that insure professional development; support community outreach and advocacy and initiate programs to perpetuate the Center's pro-choice mission expanding patient access to comprehensive reproductive healthcare of women of all financial ability. FCHC relies on each staff team member to use initiative, complete assigned duties and to ask questions and seek guidance when needed. You are to apply and practice medical and health education skills, support medical skills and administrative skills, to provide lab services, phlebotomy and other clinical services for patients within the scope of your training and duties. Assisting in evaluations and supervision of your staff team will contribute to the smooth operation of the center. Each staff member is responsible for the daily implementation of FCHC best practices and guidelines.

SPECIFIC TO THE POSITION OF Surgical Coordinator or Gynecology Coordinator: Supervises Medical assistants and or nursing staff in their daily duties. Manages record keeping and state reporting for the gynecology and abortion services. Ensures all equipment and supplies are properly maintained. Cross trains staff as needed. Contribute to the smooth operation of patient care with compassion, friendliness and meaningful patient support.

GENERAL MINIMUM QUALIFICATIONS:

- Must share and embrace the vision, mission and Cornerstone Principles of Falls Church Healthcare Center.
- High energy, positive attitude, self-starter. Ability to manage stress and tensions inherent with interference and protests by persons attempting to prevent legal abortion services.
- Have the training or experience, and licensure if required, to carry out the duties of the position to which you aspire.
- Demonstrated ability to work with groups and individuals
- Computer literate
- Direct experience in Pro-choice advocacy, community outreach and bi-lingual is a plus
- Demonstrate a readiness to learn and ability to implement and follow procedures
- To contribute to the smooth operation of the center

SPECIFIC MINIMUM QUALIFICATIONS FOR:

High School or GED or WES
Nursing or Medical Assistant background, education and 3 years experience
Laboratory testing training or 5 years experience a plus
Sterile Technique, Autoclave and Instrument care and preparation training or 3 years experience
Proficiency in maintaining logs and records
Prompt attention to detail, orderly habits

PRIMARY DUTIES OF THE POST

Additional activities will be detailed in Outline of Duties and Activities of your Orientation Packet.

1 Coordinate the services to prepare for patient care. Interface with Clinicians to verify their guidelines, best practices, preferences and equipment and supplies needed. Interface with Medical Director to update protocols and inform staff.

2 Train and supervise all staff who will assist clinician with patient care. Train with Security, transfer and emergency procedures.

3 Assign staff according to patient census needs and prepare Daily assignment schedules and plan for adequate staffing in advance by reviewing daily patient schedules.

4 Reviews assigned staff's performance monthly, identify deficiencies and train to correct. Provide annual evaluation of staff she supervises. Report to Director of Patient Services monthly

5 Monitor and develop in-service opportunities to facilitate improvement of Center and assist staff in professional development. Lead staff in-services as needed.

6 Serve as a member of the Center's nursing or MA staff for patient care assuming those duties and responsibilities including health education, and patient recovery are provided to insure smooth flow.

7 Perform other assignments as directed which may include Laboratory and Autoclave monitoring and reporting.

8 Maintain all Logs relative to patient care which may include adverse events, OSHA reportable incidents, abnormal results notifications and treatments, state reporting, NAF reporting.

9 Stay current with all CDC guidelines, ACOG and NAF guidelines to maintain the current best practices. Recommend changes to Director of Patient Services. Participate in the Quality Assurance Committee.

10 Participate in development of infection prevention policies and procedures in accordance with CDC Guidelines and OSHA trainings. Train staff with proper use of PPEs and Follow universal precautions per OSHA and CDC guidelines. Serve as the contact for OSHA trainer.

11 Attend Staff in-services and trainings. Participate in annual review of performance evaluation. Recommend subsequent development of new services, procedures and resources appropriate to the Center.

12 Review standing orders, best practices and protocols , guidelines to insure that applicable NAF Standards and Guidelines, and procedures are implemented. Maintain all logs and reports as required for the position.

13 Follow all personnel guidelines including arriving on time, maintaining a professional demeanor and appearance and maintaining a personal resource notebook/file for daily reference and use.

KEY COMPETENCIES REQUIRED

Phlebotomy preferred

Autoclave operation

4 year Experience with infection prevention practice or equivalent trainng

Training in Blood Borne Pathogens preferred

BLS and Basic First Aid training preferred

PERSONAL SPECIFICATION

Personable, ability to observe and comfortable with giving direction to staff

Organized and ability to multi-task and work toward deadlines

FALLS CHURCH HEALTHCARE CENTER

Admin Policies and Procedures Manual

To ensure compliance with the *Emergency and Temporary Regulations for Licensure of Abortion Facilities* (12 VAC 5-412) that expire 12/31/2012

Department: Administrative	**Policy Description: Serious incidents/injuries/death at FCHC**
Page: 1 of	**Replaces Policy Dated**:
Effective Date:	**Reference Number:** VAC 5-412
Approved:	

Scope:	Attending Physician, Director of Patient Services and all staff.
Purpose:	To provide guidance for handling and documenting major incident, injury of death of person at the center.
Policy:	In the case of an employee, contractor, student, volunteer and visitor is found unconscious without pulse or breathing on site the staff will immediately start BLS procedures and instruct other person to contact 911 and the Director of Patient Services. A staff person will obtain basic information and medical history about the person as if possible, write information to have available for first responders. BLS will continue until Ambulance response arrives and provides services. FCHC reports all serious incidents/injuries/death that may occur in the center. In the event of a serious incident/injury/death a "Serious Incidents/Injury/Death Report Form" will be submitted to VDH/OLC within 24 hours. Documentation will be kept on file for three years. The Quality Assurance Committee will evaluate incidents/injuries/deaths at least annually or as needed. Recommendations for improvements shall be documented and presented to the Governing Body and after approval implemented.
Procedure:	Immediately Start CPR and call 911. File Serious Incidents/Injury/Death Report Form with Licensing within 24 hours
Reference:	

FALLS CHURCH HEALTHCARE CENTER

Providers Plan Of Corrections Packet

- Plan of Correction
- Governing Body ByLaws
- Policy of Quality Improvement
- Quality Assurance Plan
- Infection Control Plan
- Annual Review Documentation QAC and Governing Body
- Annual Staff Assessment
- Patient Rights and Complaint Process
- Compliment and Complaint Documentation
- Infectious Disease – STI Policy
- Environmental Surfaces Cleaning
- Injection Safety Policy
- Example of reformatted Job Description
- Serious Incident/Injuries/Death Policy

FALLS CHURCH HEALTHCARE CENTER

Clinical Policies and Procedures Manual

Department: Quality Assurance	**Policy Description:** Quality Assurance Plan
Page: 1 of 2	**Replaces Policy Dated:** 8/2010
Effective Date: 9/14/2012	**Reference Number:** 12 VAC5-300-A, B, C, D, E
Approved:	

Scope:	All facility personnel
Purpose:	To establish a QAP to achieve optimal care for the consumer as well as provide for patient and employee safety.
Policy:	QAP establishes a Quality Assurance Committee , provides ways for both administrative personnel and staff to identify real or potential problems, document findings, and use methodology to improve processes to improve outcomes in various areas as noted below.
Procedure:	A. QAP for the facility serves as 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 plan includes process design, data collection/analysis, assessment and improvement and evaluation. The findings are used to correct identified problems and revise policies and practices. B. To ensure adequacy and appropriateness of services, to acknowledge excellent service and to identify unacceptable or unexpected trends or occurrences the following shall be evaluated: 1. Staffing patterns and performance, done annually and as needed. 2. Supervision appropriate to the level of service, done annually and with position vacancies. 3. Patient records; with one record checked weekly Director of Patient Services; and full audit of each patient record within 3 days of service; if recurrent errors determined by chart audits the Director of Patient Services is to be notified and notification and actions documented. 4. Patient satisfaction; through patient satisfaction queries in a format ensuring privacy of responses including review of YELP and on-line surveys. 5. Complaint resolution; monitor Compliment and Complaint log for trends. 6. Infections, complications and other adverse events 7. Staff concerns regarding patient care. 8. Periodic safety checks on all equipment and review of Preventive Maintenance Program C. The Quality Assurance Committee is responsible for the oversight and supervision of the program and shall consist of: 1. A physician 2. A non-physician health care practitioner 3. A member of the administrative staff 4. An individual with demonstrated ability to represent the rights and concerns of patients. This may be a member of the facility's staff. 5. There may be coordination between the Regional Director's multiple sites of responsibility to provide a range of insight helpful to the improvement process. D. When problems are identified measures shall be implemented to resolve the problems and concerns that have been identified. E. Results of the quality improvement program will be reported at least annually to the Governing Body and shall include the deficiencies identified and recommendations for corrections and improvements. The report shall be acted upon by the governing body and the facility. All corrections actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee.
Reference:	12 VAC5-300-A, B, C, D, E ; CLIA MANUAL

Falls Church Healthcare Center

Clinical Policies and Procedures Manual

Department: Infection Control	**Policy Description:** Infection Control Plan
Page: 1 of 2	**Replaces Policy Dated**: 9/2002
Effective Date: 9-1-12	**Reference Number: 12VAC5-412-220**
Approved:	

Scope:	All stakeholders
Purpose:	The center will maintain an ongoing Infection Control program designed to prevent, control and investigate infections and communicable diseases among patients, healthcare workers, and visitors.
Policy:	Authority Gynecology Coordinator and Surgery Coordinator
Procedure:	COMPONENTS: Components of the Infection Control program are: A. Defined Responsibility The Governing Body is the ultimate authority for the Infection Control program. The ongoing responsibility for the program is assigned by the Administrator to an individuals trained regarding Infection Control and the responsibilities of the position. The designated individuals will report to the Quality Assurance Committee and provide reports regarding the program activities, findings, and improvement strategies. The plan is developed in accordance with CDC, OSHA an NAF evidence based practices while responsive to the VDH guidelines and regulations. Professional best practices to be utilized in the implementation of the Infection Control Program as well.: B. Monitoring and Survey is an active process to identify and analyze outcomes related to infection control, and includes: 1. Environmental surveillance to identify and correct practices found in the workplace 2. Preventive surveillance such as immunization of staff 3. Observation and documentation of sterilization and disinfection practices 4. Verification of education and training for staff 5. Conformity with safe sharps handling 6. Public Health reporting and monitoring of community trends 7. Maintenance of a log of reported infections C. Patient Assessment and Triage All patients will receive a pre-operative or pre-procedure assessment of current and past health history, including a symptom-based evaluation for current communicable disease. The in office care setting does not provide for isolation rooms and therefore contact with patients who are potentially contagious must be limited. D. Hand Hygiene Protocols for proper hand hygiene and surgical hand antisepsis are an essential element of the program. E. Laundry Services Facility policies and procedures will outline the handling, processing, and storage of clean and dirty linen, as well as the use of disposable supplies. F. Environment of Care Environmental factors reviewed as part of the Infection Control plan include work flow to prevent cross contamination, sterilization and reprocessing procedures and documentation, ventilation, temperature and humidity of rooms, appropriate ventilation, housekeeping responsibilities, disinfection of surfaces between patients, cleaning schedules, and pest management. G. Education Orientation and training regarding infection prevention and control will include the topics of hand hygiene, high level disinfection/sterilization, waste management procedures, and infection prevention practices. Information related to employee health and the centers SHPP and mandatory training annually for OSHA required Blood Borne Pathogens.. H. Improvement Strategies Monitoring of infection control measures will be conducted and variances will be reported to the QAC and to Director of Patient Services for specific occurrences. Corrective and preventive measures for improvement will be undertaken as needed.