State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FTAF-0017 | A. BUILDING _____ B. WING _____ | 07/26/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NOVA WOMEN'S HEALTHCARE | 10400 EATON PLACE, SUITE 515 FAIRFAX, VA 22030 |

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| T 000 | 12 VAC 5- 412 Initial comments<br><br>An unannounced Licensure Initial survey was conducted July 24, 2012 through July 26, 2012 by three Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. Two complaints were investigated in conjunction with the initial survey.<br>The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 12/29/2011). Deficient practice was cited and follow in this report. | T 000 | | |
| T 010 | 12 VAC 5-412-140 A Organization and management<br><br>A. Each abortion facility shall have a governing body responsible for the management and control of the operation of the facility.<br><br>This RULE: is not met as evidenced by:<br>Based on observation, record review and interview the governing body failed to monitor and ensure policies/procedures and processes were implemented related to :<br><br>1. Delineation of privileges for two of four physicians. (Staff # 3 and Staff #9)<br><br>2. Physicians signing with date and time orders for medications and discharge orders.<br><br>3. The completion of a history and physician's physical prior to the termination procedure.<br><br>4. Staff training and competency for identifying anatomy associated with the products of conception.<br><br>The findings included: | T 010 | After VDH survey, our Medical Executive Committee (MEC) that reports to the governing board, held a meeting that addressed issues found in the survey. New policies and procedures have been implemented to avoid future occurrence. | 07/31/12 |

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

ADMINISTRATOR 9/13/12

State of Virginia

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| T 010 | Continued From Page 1<br><br>1. Two of four physician files reviewed did not have completed or governing board approved delineation of privileges. Staff #3's credentialing file did not include delineation of privileges. The delineation of privileges within Staff #9's credentialing file did not include a governing board approval signature.<br><br>An interview was conducted on July 25, 2012 at approximately 11:44 a.m., with Staff #6. Staff #6 acknowledged the information for Staff #3 and Staff 9 was incomplete and did not document approved delineation of privileges.<br><br>Review of the facility's policy titled "Governance and Administration" read "5.1 Governing Board: The President of {facility's name} has appointed a Governing Board ... The Board assumes full legal responsibility for implementing and monitoring policies, governing the Facility's total procedures and for ensuring that these policies are administered so as to provide quality healthcare in a safe environment ..."<br><br>Review of the facility's policy titled "Governance and Administration" read "5.2 Medical Executive Committee (MEC) Board related to self governance of the facility's medical staff and for performance improvement of the professional services provided by all practitioners privileged through the credentialing process ... Procedure: ... Making recommendations to Governing Board aimed at assuring that facilities and personnel are adequate and appropriate to carry out the mission ..."<br><br>Review of the facility's policy titled "Credentialing" read, "Policy: Credentials shall be provided by those physicians seeking practice privileges. | T 010 | Copies of delineation of privileges for staff #3 and staff #9 have been completed and are available for review. Credentialing for staff #3 and staff #9 as well as all the others were reviewed for completion. In the future, we will check physician files every 6 months to make sure that their credentialing files are up to date. | 08/06/12 |

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| T 010 | Continued From Page 2<br><br>These credentials shall be reviewed by the credentialing Committee [sic] and specific practice privileges identified and recorded before presentation to the Board of Managers ... The application and Committee's recommendation are given to the Governing Board. Final approval rest with the Governing Board ...7.2 Privileging Procedure: The practitioner must complete the appropriate Delineation of Privileges Form and supply the requested documentation to allow the Medical Director to accurately assess the practitioner's qualifications. The completely verified credentialing documentation, along with the practitioner-completed requested Delineation of Privileges, will be presented to the Governing Board for recommendation and approval for privileges ..."<br><br>2. Review of Patients #1 - #20's medical records did not provide evidence of consistent physicians signing with date and time orders for medications. Patient #1 - #20's medical records did not have a physician's order for discharge or transfer to a higher level of care (Patients #5 and #8).<br><br>An interview conducted on July 25, 2012 at 11:47 a.m., with Staff #4 revealed that verbal orders were given when a patient needed transfer to a higher level of care. Staff #4 acknowledged the verbal orders need to written plus signed, dated and timed by the physician.<br><br>Review of the facility's policy titled "Verbal Orders" read "Orders for drugs and biologicals that are transmitted by the physician verbally should be followed by a written order that is signed by the prescribing physician ... The prescribing physician must sign, date, and time written orders in the patient's medical record confirming the verbal order. This shall be done as soon as possible ..." | T 010 | Review of patient #1-#20's medical records did not provide evidence of consistent physicians signing with date and time orders for medications. New forms have been created and have been used for physicians to provide signature, date and time when the order is given. The same form also contains instructions that prompt nurse to obtain physician order for specific actions such as to obtain discharge order or to transfer patient to a higher level of care. The nurse is responsible to review chart for completion prior to patient discharge. | 08/20/12 |

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| T 010 | Continued From Page 3<br><br>3. The physician failed to complete a history and physical prior to the abortion procedure.<br><br>Review of medical records on July 24 and 25, 2012 revealed the following patient that underwent first trimester pregnancy terminations did not have a history and physical performed by a physician:<br>Patient #5: date of procedure March 29, 2012;<br>Patient #8: date of procedure March 3, 2012;<br>Patient #15: date of procedure March 3, 2012;<br>Patient #18: date of procedure March 3, 2012;<br>Patient #19: date of procedure March 3, 2012; and<br>Patient #20: date of procedure March 3, 2012.<br><br>An interview and record review was conducted on July 25, 2012 at 3:38 p.m., with Staff #2. Staff #2 acknowledged the physician had failed to complete the history and physical portion of the form. Staff #2 acknowledged the six patient did not received a history and physical prior to the termination of their pregnancy.<br><br>4. Staff training and competency for identifying anatomy associated with the products of conception.<br><br>Observations were conducted July 24 and 25, 2012 as Staff #8 processed the products of conception (poc) after the procedures. Staff #8 identified whether the tissue removed during the abortion process contained the villi or fetal parts. On two observations, Staff #8 verbally informed the physician the results were "Okay". The physician documented in the patient's medical record that the gross pathology had been completed and verified per his/her signature.<br><br>Review of Staff #8's employee record did not reveal documented training or competencies related to identifying components of the products of conception. | T 010 | New procedure was implemented to ensure physician's compliance in documenting all services rendered including a history and physical assessment prior to procedure. Forms for physician to complete were edited and simplified to remind physician to document their finding before proceeding to the next step. The nurse is responsible to review chart completion, especially for history and physical before letting patient to proceed with the next step. This addition to the manual is approved by and shall be reviewed annually by the Governing Board.<br><br>On 07/31/12 physician held staff training for identifying anatomy associated with products of conception. Staff #8 received formal documented training on that day. This training will be held every 6 months by the physician in the future to ensure competency. The Governing Board has approved it and the Director of Nursing will be responsible to review and check medical staff's ongoing training and competency. Documentation copy of staff training is available for review. | 07/31/12<br><br>08/20/12<br><br>07/31/12 |

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| T 010 | Continued From Page 4<br><br>An interview conducted on July 25, 2012 at 12:45 p.m., with Staff #5 verified the technician within the "Soiled/Dirty Utility" identified the products of conception post the procedure. Staff #5 reported he/she did not identify the components of the poc for every case. Staff #5 stated, "The tech finds it then I ask if everything is seen." Staff #5 reported that he/she had not participated in determining the technician's competency or training, but felt "They become the expert" from viewing the poc.<br><br>[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.] | T 010 | During the MEC meeting on July 31, 2012 it was decided to implement policy for physician to observe the products of conception after every procedure. We edited our Policy and Procedure Manual under section 7.1 Specimen Collection and Tissue Pathology. D: All tissues removed resulting from the procedure shall be examined by physician to verify that villi or fetal parts are present; if villi or fetal parts cannot be identified with certainty, the tissue specimen shall be sent out for further pathologic examination and the patient alerted to the possibility of ectopic pregnancy, and referred appropriately. Physicians are aware that they have to observe products of conception after every procedure. This is approved by and shall be reviewed annually by the Governing Board. | 07/31/12 |
| T 095 | 12 VAC 5-412-170 H Personnel<br><br>H. Personnel policies and procedures shall include, but not be limited to:<br>1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification;<br>2. Process for verifying current professional licensing or certification and training of employees or independent contractors;<br>3. Process for annually evaluating employee performance and competency;<br>4. Process for verifying that contractors and their employees meet the personnel qualifications of the facility; and<br>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. | T 095 | | |

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| T 095 | Continued From Page 5<br><br>This RULE: is not met as evidenced by:<br>Based on observations, review of personnel files and interviews, it was determined that:<br>One (#7) of nine (#1-#9) Medical Staff Technician failed to have documented training of competency to ensure that review of the products of conception were reviewed accurately and<br>Five (#4-#8) of nine (#1-#9) annual performance evaluations as required in Section 12 VAC 5-412-170.H.3.<br><br>The findings included:<br><br>1. During observations in the "Dirty" Utility Room, Staff #7 was observed determining if the products of conception had all the parts for the physician to review. [A "Dirty" scrub/utility 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/utility room, they are taken to the "Clean" scrub/utility room where instruments are packaged and sterilized as appropriate for use again.] On 7/24-25/12, the Surveyor observed Staff #7 examine the products of conception and state to the physician that the determination was "okay", on 7/24/12, at 01:30 p.m. and on 7/25/12., at 10:45 a.m.<br><br>Review of the personnel file for Staff #7 contained no documentation of training or competency to determine/verify if all parts of the products of conception were obtained/identified.<br><br>Staff #1 verified during interview that no documentation of training and competency for Staff #7 was available for the Surveyor to review. The physician verified during interview that Staff #7 was an "expert" at reviewing the products of conception. The physician acknowledged he/she | T 095 | On 07/31/12, a physician held training for identifying anatomy associated with products of conception. The training will be conducted every 6 months. Documentation of staff training especially for staff #7 is available for review. | 07/31/12 |

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| T 095 | Continued From Page 6<br><br>had not participated in Staff #7's training or competencies related to identifying the parts of the products of conception. The physician reported he/she based their opinion of Staff #7's expertise solely on the staff's experience. This interview occurred in the facility's office, on 7/25/12, at 3:45 p.m.<br><br>2. Review of five (#4-#8) of nine (#1-#9) staff member that had been hired failed to have annual evaluations. Staff #4 was hired on 05/25/10, Staff #5 was hired on 12/13/10, Staff #6 was hired on 06/01/04, Staff #7 was hired on 11/08/05 and Staff #8 was hired on 11/27/08.<br><br>Staff #1 verified during interview that all staff failed to have competency and annual reviews. This interview occurred on 7/25/12, at 4:30 p.m. | T 095 | Annual evaluations were performed on or before 09/04/12 for all employees. In the future Administrator and or Director of Nursing will maintain annual evaluations on all employees as stated in our policy and procedure manual. Documentation of evaluations is available for review. | 09/04/12 |
| T 105 | 12 VAC 5-412-180 A Clinical staff<br><br>A. Physicians and non-physician health care practitioners shall constitute the clinical staff. Clinical privileges of physicians and non-physician health care practitioners shall be clearly defined.<br><br>This RULE: is not met as evidenced by:<br>Based on record review and interview the facility failed to determine and document the clinical privileges for two of four physicians.<br><br>The findings included:<br><br>Review on July 25, 2012 of the facility's credentialing of four physicians revealed two of the physicians (Staff #3 and Staff #9) did not have approved delineation of privileges. Staff #3 did not have documentation of privileges. Staff #9's privileges had not been signed as approved by the | T 105 | Delineation of privileges for staff #3 and staff #9 were approved and completed. Documentation copies are available for review. | 08/06/12 |

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| T 105 | Continued From Page 7<br><br>facility's medical executive committee or governing body.<br><br>Review of the facility's policy titled "Credentialing" read, "Policy: Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentialing Committee [sic] and specific practice privileges identified and recorded before presentation to the Board of Managers ... The application and Committee's recommendation are given to the Governing Board. Final approval rest with the Governing Board ...7.2 Privileging Procedure: The practitioner must complete the appropriate Delineation of Privileges Form and supply the requested documentation to allow the Medical Director to accurately assess the practitioner's qualifications. The completely verified credentialing documentation, along with the practitioner-completed requested Delineation of Privileges, will be presented to the Governing Board for recommendation and approval for privileges ..."<br><br>An interview was conducted on July 25, 2012 at approximately 11:44 a.m., with Staff #6. Staff #6 acknowledged the information for Staff #3 and Staff 9 was incomplete and did not document approved delineation of privileges. | T 105 | | |
| T 115 | 12 VAC 5-412-180 C Clinical staff<br><br>C. A physician shall remain on the premises until all patients are medically stable, sign the discharge order and be readily available and accessible until the last patient is discharged. Licensed health care practitioners trained in post-procedure assessment shall remain on the premises until the last patient has been discharged. The physician shall give a discharge | T 115 | | |

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| T 115 | Continued From Page 8<br><br>order after assessing a patient or receiving a report from such trained health care practitioner indicating that a patient is safe for discharge. The facility shall develop, implement and maintain policies and procedures that ensure there is an appropriate evaluation of medical stability prior to discharge of the patient and that adequate trained health care practitioners remain with the patient until she is discharged from the facility.<br><br>This RULE: is not met as evidenced by:<br>Based on record review and interviews the facility's physicians failed to write discharge orders for twenty of twenty patients in the sample who had first trimester pregnancy terminations. (Patients #1 - #20)<br><br>The findings included:<br><br>Three surveyors conducted the review of twenty medical record on July 24 and 25, 2012. The review of Patients #1- #20's medical records did not reveal a documented physician's order for discharge. The medical records had nursing documentation "D/chg (Discharge) per MD's (Medical Doctor) d/c." The medical records for Patients #1 - #20 did not have documentation the physician assessed or received information from trained staff related to the patient's stability and readiness for discharge.<br><br>An interview conducted on July 24, 2012 at 3:14 p.m., with Staff #1 and Staff #2 revealed the physician did not write discharge orders. Staff #2 reported the staff had criteria for discharge and utilized the criteria, when discharging patients. Staff #2 acknowledged each patient admitted to the facility was admitted under the care of a physician and the physician was responsible for discharging the patient. | T 115 | We have edited our Policy and Procedure Manual Volume 2. Under section 4.11 Discharge from Facility: Patients shall be discharged only on the written signed order of a physician. A physician is present until the medical discharge of the patient following clinical recovery from the procedure and or anesthesia. Prior to medical discharge a physician must evaluate the patient or a delegated qualified individual supervised by a physician approved by the Governing Board. In the past, physicians were present within the facility until the last surgical patient was ready for discharge, but we failed to document it. We edited the forms to create space for physicians to document discharge orders and assessment prior to discharge. The nurse is responsible to review patient's chart for completion. This addition to the manual is approved by and shall be reviewed annually by the Governing Board. | 08/02/12 |

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| T 135 | 12 VAC 5-412-210 A Patients' rights<br><br>A. Each abortion facility shall establish a protocol relating to the rights and responsibilities of patients consistent with the current edition of the Joint Commission Standards of Ambulatory Care. The protocol shall include a process reasonably designed to inform patients of their rights and responsibilities, in a language or manner they understand. Patients shall be given a copy of their rights and responsibilities upon admission.<br><br>This RULE: is not met as evidenced by:<br>Based on interview and record review the facility failed to establish a procedure or process for documentation that patient received their rights and responsibilities at the time of admission.<br><br>The findings included:<br><br>Review of the facility's policy and procedure manuals did not reveal a process for documenting patients were provided with a copy of their rights and responsibilities at the time of admission.<br><br>An interview was conducted on July 24, 2012 at 4:11 p.m., with Staff #1. Staff #1 reported patients were given information at the time of admission. Staff #1 stated, "I'm not sure if that information is documented in the patient's chart."<br><br>An interview was conducted on July 25, 2012 at 9:31 a.m., with Staff #2. Staff #2 reported the facility had been aware of the requirement to document the patient's receipt of their rights/responsibilities. Staff #2 reported the facility initiated a new form in June 2012 to document the patient's receipt of their rights/responsibilities.<br><br>A review of twenty medical records was conducted on July 24 and 25, 2012; the review | T 135 | Our Policy and Procedure Manual has been updated to show process for documenting that patients were provided with a copy of their rights and responsibilities at the time of admission.<br>2.7. Patient Rights Policy under Procedures: Patient shall receive as their own copy the Patient Advance Notices that includes the Patient Bill of Rights, Patient Responsibility Statement and Grievances at least at the time of admission. Patient shall sign the Notice of Privacy Practices & Patient Advance Notices form that states they have received a copy of the Patient Advance Notices and the form shall be kept in the patient's chart. This addition to the manual is approved by and shall be reviewed annually by the Governing Board. | 08/02/12 |

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| T 135 | Continued From Page 10<br><br>included five patients from the months of June and July 2012. The review of Patients #1- #20's medical records did not reveal documentation the patients had received their rights and responsibilities at the time of admission.<br><br>An interview was conducted on July 25, 2012 at 3:32 p.m., with Staff #1 and Staff #2. Staff #2 reported review of the medical records. Staff #2 confirmed the patient records (Patient #1 - #20) did not have documentation the patients had received their rights/responsibilities at the time of admission. Staff #2 reported the staff had failed to implement the new form. | T 135 | | |
| T 145 | 12 VAC 5-412-210 C Patients' rights<br><br>C. The facility shall designate staff responsible for complaint resolution, including:<br>1. Complaint intake, including acknowledgement of complaints;<br>2. Investigation of the complaint;<br>3. Review of the investigation findings and resolution for the complaint; and<br>4. Notification to the complainant of the proposed resolution within 30 days from the date of receipt of the complaint.<br><br>This RULE: is not met as evidenced by:<br>Based on record review and interview the facility failed to include notification of the complainant within thirty- (30) days of receipt of the complaint related to the proposed resolution.<br><br>The findings included:<br><br>Review of the facility's policies related to their complaint process did not include a process for notification of the complainant within 30 days after receipt of the complaint regarding the complaint's | T 145 | | |

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| T 145 | Continued From Page 11<br><br>proposed resolution.<br><br>An interview was conducted on July 24, 2012 at 4:11 p.m., with Staff #1. Staff #1 reviewed the regulation and the facility's policy/procedure and process for complaint resolution. Staff #1 reported the facility's policy/process did not include notification of the patient related to the proposed resolution or the required timeframe of 30 days after receipt of the complaint. | T 145 | Our Policy and Procedure Manual has been updated to show process for notification of the complainant within 30 days after receipt of the complaint regarding the complaint's proposed resolution.<br>2.10 Grievances under Procedure: Any serious complaint received from a patient shall be documented in writing using the Patient Complaint Documentation form and forward to the Director of Nursing and/or Administrator within one business day. The Director of Nursing and/or Administrator shall have 30 calendar days after the receipt of the complaint in which to notify the patient regarding the grievance and proposed resolution.<br>This addition to the manual is approved by and shall be reviewed annually by the Governing Board. | 08/02/12 |
| T 155 | 12 VAC 5-412-210 E Patients' rights<br><br>E. The facility shall provide each patient or her designee with the name, mailing address, and telephone number of the:<br>1. Facility contact person; and<br>2. The OLC Complaint Unit, including the toll-free complaint hotline number. Patients may submit complaints anonymously to the OLC. The facility shall display a copy of this information in a conspicuous place.<br><br>This RULE: is not met as evidenced by:<br>Based on observations, record review and interview the facility failed to provide patients with the correct name, address and toll-free complaint hotline for the state licensing agency.<br><br>The findings included:<br><br>Observation on July 24, 2012 at 8:11 a.m., during the initial tour of the facility revealed the information posted for filing a complaint with the state's licensing agency listed the wrong, name, address and phone number.<br><br>On July 24, 2012 during the review of the patient's | T 155 | On the same day of the inspection (July 24, 2012) we edited the information on all documents and policy and procedure manual to list the right contact information for the state licensing agency.<br>The Administrator will be responsible to update the information if changes occur. This addition to the manual is approved by and shall be reviewed annually by the Governing Board. | 07/24/12 |

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| T 155 | Continued From Page 12<br><br>rights information provided to patients listed the wrong, name, address and phone number for filing a complaint with the state's licensing agency.<br><br>Review for the facility's policy and procedure manuals on July 24, 2012 revealed the wrong, name, address and phone number for filing a complaint with the state's licensing agency had been documented.<br><br>An interview was conducted on July 24, 2012 at 4:11 p.m., with Staff #1. Staff #1 reported obtaining the state licensing agency's information from a website. Staff #1 reported not being aware the information was incorrect. | T 155 | | |
| T 170 | 12 VAC 5-412-220 B Infection prevention<br><br>B. Written infection prevention policies and procedures shall include, but not be limited to:<br>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;<br>2. Training of all personnel in proper infection prevention techniques;<br>3. Correct hand-washing technique, including indications for use of soap and water and use of alcohol-based hand rubs;<br>4. Use of standard precautions;<br>5. Compliance with blood-bourne pathogen requirements of the U.S. Occupational Safety & Health Administration.<br>6. Use of personal protective equipment;<br>7. Use of safe injection practices;<br>8. Plans for annual retraining of all personnel in infection prevention methods;<br>9. Procedures for monitoring staff adherence to recommended infection prevention practices; | T 170 | | |

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| T 170 | Continued From Page 13<br><br>and<br>10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices.<br><br>This RULE: is not met as evidenced by:<br>Review of the personnel files failed to:<br>have infection prevention training for three (#1,#3 and #6) of thirteen (#1-#13) staff;<br>use safe injection practices with the availabilty of expired drugs and supplies;<br>review the policies and procedures<br>have processes for annual staff training;<br>have processes for monitoring for prevention of infections and<br>have procedures for documenting annual retraining as required in Section 12 VAC 5-412-220.B.#7-#10.<br><br>The findings included:<br><br>1. Personal files were reviewed by the Surveyor on 07/24/12, at 10:10 a.m., in the facility's office. Staff members #1, #3 and #6 failed to have documentation on annual infection control training.<br><br>2. On observations during a tour of the clean utility room, on 07/24/12, at 10:05 a.m., revealed Metronidazole (Flagyl) 500 mg per 100 tablets was opened without a date, prepared for patient usage. (Flagyl is an antibiotic used to treat certain parasitic and bacterial infections.) Ampicillin (Antibiotic) 500 mg was opened for patient usage and undated. Lidocaine 2% (A common local anesthetic) was prepared for usage without a date. Labetalol Hydrochloride (Used for high blood pressure), 100 mg per 20 ml was dated 04/25/12, was expired per the facility's policies and procedures. Vasopressin 30 units per ml was expired on 06/30/12. (Vasopressin is used to raise blood pressure during a cardiac arrest.) | T 170 | Review of the personnel files failed to have infection prevention training for three of thirteen staff. Infection prevention training was held for all employees. Documentation on employee training is available for review. Director of Nursing is responsible to review staff training and competency in the future.<br><br>A copy of our Policy and Procedure was attached to the wall in the medication room to remind staff to date the medication after opening. All open medications must be discarded after 28 days.<br>All expired medications and swabs were discarded.<br>All supplies will be checked periodically every 3 months to avoid future occurrence.<br>Director of Nursing is responsible to maintain compliance and staff adherence to infection control practices. | 08/01/12<br><br>07/31/12 |

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| T 170 | Continued From Page 14<br><br>Three Swab specimen transport tubes and three fiber tip swabs expired on 02/29/12.<br><br>The facility's policy and procedure, under Injectable Medication Use, states that vials must be dated when opened and discarded after 28 days.<br><br>3. The Surveyor was unable to review policies and procedures to ensure annual retraining of all staff, procedures for maintaining staff adherence to infection control practices and a formal plan for annual training of all staff.<br><br>An interview was conducted on July 24, 2012 at 4:59 p.m., with Staff #1. Staff #1 reviewed the facility's infection control policies and procedures. Staff #1 reported the Infection Control policies were incomplete and medications were not being monitored to ensure that all medications were dated upon opening and discarded after 28 days. | T 170 | Policies and Procedures to ensure annual re-training of all staff were created. The Governing Board appointed the Director of Nursing to be responsible for staff retraining. Infection control training was conducted on August 01, 2012 for all employees. Staff will receive training on various subjects that are related to clinical practice quarterly to ensure competency.<br>Updated policy and procedure is available upon review. | 08/01/12 |
| T 175 | 12 VAC 5-412-220 C Infection prevention<br><br>C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following:<br>1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers);<br>2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies;<br>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);<br>4. Procedures for handling, storing and transporting clean linens, clean/sterile supplies | T 175 | | |

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| T 175 | Continued From Page 15<br><br>and equipment;<br>5. Procedures for handling/temporary storage/transport of soiled linens;<br>6. Procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations;<br>7. Procedures for the processing of each type of reusable medical equipment between uses on different patients. The procedure shall address:<br>(i) the level of cleaning/disinfection/sterilization to be used for each type of equipment,<br>(ii) the process (e.g., cleaning, chemical disinfection, heat sterilization); and<br>(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 control guidelines;<br>8. Procedures for appropriate disposal of non-reusable equipment;<br>9. Policies and procedures for maintenance/repair of equipment in accordance with manufacturer recommendations;<br>10. Procedures for cleaning of environmental surfaces with appropriate cleaning products;<br>11. An effective pest control program, managed in accordance with local health and environmental regulations; and<br>12. Other infection prevention procedures necessary to prevent/control transmission of an infectious agent in the facility as recommended or required by the department.<br><br>This RULE: is not met as evidenced by:<br>Based on observations, review of policies and procedures and interviews, it was determined that:<br>procedures for cleaning and disinfecting of equipment between patients was not enforced,<br>failure to insure an effective pest control program was implemented by the facility for the prevention | T 175 | | |

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| T 175 | Continued From Page 16<br><br>and control of infections as required in Section 12 VAC 5-412-220.C.7,9 and 11.<br><br>The findings included:<br><br>1. An observation conducted on July 24, 2012 at 8:38 a.m., with Staff #1 during the initial tour of the facility revealed items under the sink in the Laboratory room, making the items subject to contamination from the sink overflowing. Tears in the examination tables in Sonogram rooms #1 and #2 and Exam room #3 and the use of cloth tables in the Dirty Utility room prevents the effective disinfections between patient use. [A "Dirty" scrub/utility 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/utility room, they are taken to the "Clean" scrub/utility room where instruments are packaged and sterilized as appropriate for use again.]<br><br>Observations were conducted on July 24, 2012 from at 08:40 a.m. reveled a vinyl chair in the Laboratory with small holes in the seat of the chair. Stretchers #1-#3 contained tears in the corners of the vinyl padding. A cloth chair was located in the Recovery Room. Tape was found on one intravenous (IV) stand with a hole in the wooden surface. Exam Room #3 reveled two chairs with tears at the arm rests. These items can't be cleaned between patients, which may pass germs and viruses from one patient to another.<br><br>The policy under infection control stated that the facility would maintain a sanitary environment to reduce the source of transmission of infections by ensuring that tables and chairs are cleaned. The facility failed to ensure that potential | T 175 | On the day of the inspection (July 24, 2012) all items under sink in the Laboratory Room were removed. A sticker was placed on the drawer to remind employees not to store any items under sink.<br>Every month Director of Nursing is responsible to conduct a walk through throughout the facility to ensure cleanliness and staff adherence to infection control and prevention.<br><br>We fixed the tears in the examination tables in Sonogram room #1, #2, and Exam #3. The cloth tables in the Dirty Utility room were removed.<br><br>Vinyl chair in the Laboratory with small holes was removed.<br>Stretcher #1-#3 that contained tears in the corners of the vinyl padding was fixed.<br>Cloth chair in the recovery room was removed.<br>IV stand with a hole in the wooden surface was removed.<br>Two chairs with tears at the arm rest in Exam #3 were fixed.<br>The governing board has appointed the Director of Nursing to do a walk through throughout the facility quarterly to ensure the cleanliness, and each piece of furniture for patient use is free of tear or crack to ensure effective cleaning. | 07/24/12<br><br>08/31/12<br>07/24/12<br><br>07/24/12<br><br>08/31/12<br><br>07/24/12<br><br>07/24/12<br><br>08/31/12 |

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| T 175 | Continued From Page 17<br><br>cross-contamination among patients was being maintained.<br><br>Staff #1 confirmed during interview that effective cleaning between patients could not be maintained. July 25, 2012, at 4:58 p.m., in the facility's office.<br><br>2. No Pest Control Control Contract was reviewed by the Surveyors. Staff #1 stated that pest control was maintained by the Building Maintenance and didn't have any information on when it was done. This interview occurred in the facility's room on 07/25/12, at 4:55 p.m. | T 175 | Pest Elimination Agreement was established with local pest control company. The contracted company will perform pest control evaluations quarterly. In the future, annual pest control contracts will be maintained. The Administrator will be responsible to renew and update the contract annually. | 09/10/12 |
| T 195 | 12 VAC 5-412-240 A Medical testing, patient counseling and labor<br><br>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.<br>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.<br>2. Medical testing shall include a recognized pregnancy test and determination on Rh factor.<br>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.<br>4. A written report of each laboratory test and examination shall be a part of the patient's record. | T 195 | | |

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| T 195 | Continued From Page 18<br><br>This RULE: is not met as evidenced by:<br>Based on record review and staff interview the facility failed to ensure each patient, who received an abortion had a history and physical performed by a physician for six of twenty patients. (Patients #5, #8, #15, #18, #19, and #20)<br><br>The findings included:<br><br>Review of medical records on July 24 and 25, 2012 revealed the following patient that underwent first trimester pregnancy terminations did not have a history and physical performed by a physician:<br>Patient #5: date of procedure March 29, 2012;<br>Patient #8: date of procedure March 3, 2012;<br>Patient #15: date of procedure March 3, 2012;<br>Patient #18: date of procedure March 3, 2012;<br>Patient #19: date of procedure March 3, 2012; and<br>Patient #20: date of procedure March 3, 2012.<br><br>An interview and record review was conducted on July 25, 2012 at 3:38 p.m., with Staff #2. Staff #2 acknowledged the physician had failed to complete the history and physical portion of the form. Staff #2 acknowledged the six patient did not received a history and physical prior to the termination of their pregnancy. | T 195 | New procedure was implemented to ensure physician's compliance in documenting all services rendered including a history and physical assessment prior to procedure. Forms for physician to complete were edited and simplified to remind physician to document their finding before proceeding to the next step. The nurse is responsible to review chart completion, especially for history and physical before letting patient to proceed with the next step. | 07/31/12<br><br>08/20/12 |
| T 200 | 12 VAC 5-412-240 B Medical testing, patient counseling and labor<br><br>B. The abortion facility shall offer each patient, in a language or manner they understand, appropriate counseling and instruction in the abortion procedure and shall develop, implement and maintain policies and procedures for the provision of family planning and post-abortion counseling to its patients. | T 200 | | |

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| T 200 | Continued From Page 19<br><br>This RULE: is not met as evidenced by:<br>Based on record review and interview the facility failed to develop, implement and maintain polices/ procedures or documentation processes for providing patients with pre-op counseling and family planning. for twenty of twenty patients in the sample. (Patient #1 - #20)<br><br>The findings included:<br><br>Review of the facility's policies and procedures manuals on July 24, 2012 did not reveal policies, procedures or processes for pre-op counseling and family planning.<br><br>An interview conducted on July 24, 2012 at 12:03 p.m., with Staff #2 revealed facility staff counsel patients by phone and during their first visit regarding pre-op expectations and options. Staff #2 reported family planning counseling was performed during the patient's follow-up visit. Staff #2 reported, "a high percentage" of the facility's patients maintained their follow-up visits. Staff #2 reported he/she was not aware if the number of patient that returned for follow-up visits was tracked or trended. Staff #2 acknowledged the facility did not have policies/procedures for implementing, monitoring or maintaining provisions for pre-op and family planning counseling for all patients including patients that did not return to the facility for follow-up visits. Staff #2 was not able to offer documentation of the number of patient that returned for follow-up visits prior to exit.<br><br>Review of twenty medical records (Patients #1 - #20), who had first trimester termination of pregnancies during 2012, did not have documentation that pre-op counseling and family planning had been provided. | T 200 | Review of the facility's policies and procedures manuals on July 24, 2012 did not reveal policies, procedures, or processes for pre-op counseling and family planning. The Policy and Procedure Manual under section 2.3 Pre-Procedure Phase discusses about pre-op counseling. Pre-sedation assessment will be taken to evaluate patient status. Instruction regarding postoperative care is given to patient prior to sedation and signed documentation of follow-up care is placed on the patient's record to signify patient understands the instruction.<br>The governing board has edited current policies and procedures to add policy on family planning consultation prior to procedure and to give family planning handout on the day of the procedure. A nurse is responsible to discuss family planning methods and to remind patient about the given family planning handout as a reference. Documentation of family planning consultation is placed on the patient's record after patient signs the record that it is given. | 07/31/12<br><br>08/20/12 |

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| T 200 | Continued From Page 20<br><br>An interview and review of Patient #1 - #20's medical records was conducted on July 25, 2012 at 4:42 p.m., with Staff #1 and Staff #2. Staff #2 verified the facility staff had failed to document pre-op and family counseling for patient whether they did or did not returned to the facility for follow-up visits. | T 200 | | |
| T 220 | 12 VAC 5-412-250 A Anesthesia service<br><br>A. The anesthesia service shall be managed in accordance with the Office-Based Anesthesia provisions of the Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic (18 VAC 85-20-310 et seq.).<br><br>This RULE: is not met as evidenced by:<br>Based on record review and interview the facility's anesthesiologist incorrectly documented the level of sedation as general anesthesia for fourteen of fifteen patients that received conscious sedation. (Patients #1, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19, and #20)<br><br>The findings included:<br><br>The review of the medical records for Patients #1, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19 and #20 was performed on July 24 and 25, 2012, by three surveyors. The review revealed the "Anesthesia Record" documented the patients received "GA (general anesthesia)." The "Anesthesia Record" provided a check box for "Conscious sedation", which for fourteen of the fifteen records had not been checked.<br>[According to the Virginia Department of Health Professionals "The Board of Medicine Regulations Part III: Office-Based Anesthesia 18 VAC | T 220 | Our facility's anesthesiologist incorrectly documented the level of sedation as general anesthesia. Our facility has never provided general anesthesia service to patients. To prevent future reoccurrence we have edited all of our anesthesia forms to change the term "general anesthesia" into "intravenous sedation (IV sedation)". During an MEC meeting on July 314, 2012 it was addressed to all employees to refrain from using the term "general anesthesia" to prevent confusion. Anesthesiologist has agreed to not use the term "general anesthesia" in the future and to use correct terminology in writing and speaking. | 08/06/12 |

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| T 220 | Continued From Page 21<br><br>85-20-310 Definitions: "General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired." The definition for "Moderate sedation/conscious sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are usually required to maintain a patent airway, and spontaneous ventilation is usually adequate. Cardiovascular function is usually maintained." The regulations defined "Local anesthesia" means a transient and reversible loss of sensation in a circumscribed portion of the body produced by a local anesthetic agent."<br><br>An interview conducted on July 25, 2012 from 10:05 a.m. to 10:35 a.m., with Staff #3 revealed the facility did not employ general anesthesia. Staff #3 reported the facility employed local anesthesia and conscious sedation.<br><br>An interview was conducted on July 25, 2012 at approximately 11:42 a.m., with the Medical Director (Staff #4). Staff #4 reviewed the medical records for Patients #5 and #8. Staff #3 acknowledged the facility did not utilize general anesthesia. Staff #4 stated "We get in the habit of saying general anesthesia when we really mean conscious sedation." Staff #4 acknowledged the anesthesia records did not correctly reflect the level of sedation provided to the patients. Staff #4 | T 220 | | |

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| T 220 | Continued From Page 22<br><br>reported any medical record that documented the "level of sedation, as general anesthesia is incorrect."<br><br>An interview and review of medical records (Patients #1, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19 and #20) was conducted on July 25, 2012 at 3:32 p.m. with Staff #1 and Staff #2. Staff #2 verified the facility did not utilize general anesthesia and the physician had incorrectly checked general anesthesia rather than checking conscious sedation listed on the anesthesia record.<br><br>According to the American Society of Anesthesiologist's "Documentation of Anesthesia Care" revised 2008: "Documentation is a factor in the provision of quality care and is the responsibility of an anesthesiologist. While anesthesia care is a continuum, it is usually viewed as consisting of preanesthesia, intraoperative/procedural anesthesia and postanesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review.<br>The record should include documentation of: ... C. Doses of drugs and agents used, times and routes of administration and any adverse reactions. D. The type and amounts of intravenous fluids used, including blood and blood products, and times of administration. E. The technique(s) used and patient position(s).<br><http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx> " | T 220 | | |
| T 265 | 12 VAC 5-412-260 A Administration, storage and dispensing of dru<br><br>A. Controlled substances, as defined in 54.1-3401 of the Drug Control Act of the Code of | T 265 | | |

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| T 265 | Continued From Page 23<br><br>Virginia, shall be stored, administered and dispensed in accordance with federal and state laws. The dispensing of drugs, excluding manufacturers' samples, shall be in accordance with Chapter 33 of Title 54.1 of the Code of Virginia, Regulations Governing the Practice of Pharmacy (18 VAC 110-30).<br><br>This RULE: is not met as evidenced by:<br>Based on observations during tour, review of the policy and procedure and interview with Staff #1, it was determined that two drugs maintained in the narcotic cabinet failed to be dated after opening as required in Section 12 VAC 5-412-260. A.<br><br>The findings included:<br><br>1. On observations during a tour of the clean utility room, on 07/24/12, at 10:05 a.m., revealed Ondansetron (Zofram) 40 mg (milligrams) per 20 ml (milliners) used for nausea, opened for use with no date indicating when it had been opened. In addition, Ketamine (A fast acting anesthetic) 500 mg per 10 ml was opened and undated.<br><br>2. The facility's policy and procedure, under Injectable Medication Use, states that vials must be dated when opened and discarded after 28 days.<br><br>3. An interview was conducted on July 24, 2012 at 10:09 a.m., with Staff #1. Staff #1 verified during interview that all narcotics should be dated when opened. | T 265 | On observation during a tour of clean utility room revealed medications opened with no date to indicate when it had been opened for use. A copy of our Policy and Procedure was attached to the wall in the medication room to remind nursing staff to date the medication after opening. All open medications must be discarded after 28 days.<br>Director of Nursing is responsible to maintain compliance and staff adherence to infection control practices. | 07/31/12 |
| T 335 | 2 VAC 5-412-300 E Quality assurance<br><br>E. Results of the quality improvement program shall be reported to the licensee at least annually and shall include the deficiencies identified and | T 335 | | |

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| T 335 | Continued From Page 24<br><br>recommendations for corrections and improvements. The report shall be acted upon by the governing body and the facility. All corrective actions shall be documented. Identified deficiencies that jeopardize patient safety shall be reported immediately in writing to the licensee by the quality improvement committee.<br><br>This RULE: is not met as evidenced by:<br>Based on review of the Policy and Procedure Manual, results of the Quality Assurance Committee Meeting Minutes and interview with Staff #1, it was determined that no policy and procedure were developed to address the reporting of the results of the Quality Assurance Committee to the Governing Body and to report to the Governing Body immediately for anything that may interfere with patient safety as required in Section 12 VAC 5-412-300. E.<br><br>The findings included:<br><br>1. On July 25, 2012, the Surveyor reviewed the Policy and Procedure Manual at various times in the facility's office, at approximately 10:00 a.m. The Quality Assurance Committee Meeting, dated 05/03/12, No evidence existed to that the Meeting Minutes had been forwarded to the Governing Body for review and comment. The facility did not have a policy and procedure to address immediately reporting to the Governing Body any situation that jeopardized the safety of patients.<br><br>2. Staff #1 acknowledged during interview that no policy and procedure was developed that addressed the reporting the results of the Quality Assurance Committee Meeting and immediately report any safety issues to the Governing Body. This interview occurred in the facility's office, on | T 335 | Surveyor reviewed the Policy and Procedure Manual and did not find evidence that the Meeting Minutes had been forwarded to the Governing Body for review and comment and the facility did not have a policy and procedures to address immediately reporting to the Governing Body any situation that jeopardized the safety of patients.<br>Policy and Procedure Manual has been updated to show policy and procedure for sending results of the Quality Assurance Committee quarterly meeting minutes to the Governing Board for review and comment no later than 10 working days. The manual has been updated to include that the QA Committee must report to the Governing Board immediately for any situation that jeopardized the safety of patients and staff. This addition to the manual is approved by and shall be reviewed annually by the Governing Board.<br>Completion Date: 08/02/12 | 08/02/12 |

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| T 335 | Continued From Page 25<br><br>July 25, 2012, approximately at 10:21 a.m. | T 335 | | |
| T 340 | 12 VAC 5-412-310 Medical records<br><br>An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, but not limited to the following:<br>1. Patient identification;<br>2. Admitting information, including a patient history and physical examination;<br>3 Signed consent;<br>4. Confirmation of pregnancy; and<br>5. Procedure report to include:<br>a. Physician orders;<br>b. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays;<br>c. Anesthesia record;<br>d. Operative record;<br>e. Surgical medication and medical treatments;<br>f. Recovery room notes;<br>g. Physician and nurses' progress notes,<br>h. Condition at time of discharge,<br>i. Patient instructions, preoperative and postoperative; and<br>j. Names of referral physicians or agencies.<br><br>This RULE: is not met as evidenced by:<br>Based on record review and interviews the facility failed to maintain complete and accurate clinical records for twenty of twenty patients in the survey sample. (Patients #1 - #20)<br><br>1. The medical records failed to include physician orders for discharge (Patients #1 - #20), orders for transfer to a higher level of care (Patients #5 and | T 340 | | |

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| T 340 | Continued From Page 26<br><br>#8), and did not consistently document medications ordered (Patients #1 - #20).<br><br>2. Twenty of twenty medical records did not have physician progress notes. (Patients #1 - #20)<br><br>3. Three of fifteen medical records for patients that received surgical termination of a first trimester pregnancy had post anesthesia care documented on the intra-operative record. (Patients #5, #7, and #8)<br><br>4. Two of fifteen medical records for patients that received surgical termination of first trimester pregnancy did not have recovery room notes. (Patient #6 and #12)<br><br>5. Fourteen of fifteen medical records for patients that received surgical termination of a first trimester pregnancy had the incorrect level of sedation documented. (Patients #1, #3, #5, #6, #8, #9, #12, #13, #14, #15, #18, #19 and #20)<br><br>6. Six of twenty medical records for patients that had a first trimester termination of pregnancy did not have a physician's history and physical documented. (Patients #5, #8, #15, #18, #19, and #20)<br><br>The findings included:<br><br>1. The medical records failed to include physician orders for (a) discharge (Patients #1 - #20), (b) transfer to a higher level of care (Patients #5 and #8) and (c) did not consistently document medications ordered, notation by nursing staff or dates and times (Patients #1 - #20).<br><br>(a) A review of twenty medical records were conducted on July 24 and 25, 2012 by three | T 340 | The medical records failed to include physician orders for discharge and orders for transfer to a higher level of care.<br>Forms have been created and edited and have been used by physicians to provide signature, date and time when orders are given. The same form also contains instructions that prompt nurse to obtain physician order for medications and other specific actions such as to obtain discharge order or to obtain order to transfer the patient to a higher level of care. The nurse is responsible to review the chart for completion prior to patient discharge. | 08/20/12 |

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| T 340 | Continued From Page 27<br><br>surveyors. The review of Patients #1- #20's medical records did not reveal a documented physician's order for discharge.<br><br>An interview conducted on July 24, 2012 at 3:14 p.m., with Staff #1 and Staff #2 revealed the physician did not write discharge orders. Staff #2 acknowledged patients admitted to the facility were admitted under the care of a physician and the physician was responsible for discharging the patient.<br><br>(b) Review of Patient #5's medical record revealed a complication during surgery. The medical record documented the patient was stabilized and the physician recommended transfer to a local hospital's Emergency Department (ED) for further work-up. The patient's medical record documented emergency transport was called and the patient was transported from the facility. Patient #5's medical record did not contain a physician's order for transfer to a higher level of care.<br><br>Review of Patient #8's medical record revealed a complication during surgery. The medical record documented the patient was stabilized for transfer to a local hospital's Emergency Department (ED) for further work-up. The patient's medical record documented emergency transport was called and the patient was transported from the facility. Patient #8's medical record did not contain a physician's order for transfer to a higher level of care.<br><br>An interview was conducted on July 25, 2012 at 11:55 a.m. with Staff #4. Staff #4 reviewed the medical records for Patient #5 and Patient #8. Staff #4 verbalized awareness of Patient #5 and Patient #8's condition at transfer. Staff #4 | T 340 | | |

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| T 340 | Continued From Page 28<br><br>reported he/she had given verbal orders to the nursing staff for emergency transport. Staff #4 stated, "I did not write the order." Staff #4 reported the nursing staff did not write a verbal order to transfer the patients from the facility to the local hospital's ED. Staff #4 acknowledged the medical records did not contain a documented physician's order to transfer the patient to a higher level of care.<br><br>(c) A review of twenty medical records were conducted on July 24 and 25, 2012 by three surveyors. The review of Patients #1- #20's medical records did not reveal consistent documentation of physician ordered medications or nursing documentation of noting the medications orders with a time and date. The medical records for Patients #1 - #20 documented nursing administration of medications without a documented medication order within the medical record.<br><br>An interview and review of medical records was conducted on July 25, 2012 at approximately 3:32 p.m., with Staff #1 and Staff #2. Staff #1 and Staff #2 verified the physicians did not consistently document orders for medications. Staff #2 reported the forms utilized had changed from not listing the medications to a standing order document. Staff #2 acknowledged before the change to the standing order document the nursing staff listed the medications administered, but the medical chart did not contain physician orders for the medications. Staff #2 acknowledged the standing order document was not consistently signed by the physician for medications, which were designated to be administered pre-procedure, intra-procedure and post-procedure. Staff #2 verified the medication orders that had been signed by the physician did not include a date and time. Staff #2 | T 340 | | |

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| T 340 | Continued From Page 29<br><br>acknowledged nursing staff did not authenticate the physician's orders as to when they were received by date and time.<br><br>2. A review of the medical records for Patients #1 - #20 did not reveal physician progress notes.<br><br>An interview and review of medical records was conducted on July 25, 2012 at approximately 3:32 p.m., with Staff #1 and Staff #2. Staff #2 verified the medical records for Patient #1 - #20 did not have physician progress notes. Staff #2 reported the physicians are not documenting in the progress notes. Staff 32 reported he/she had not been aware of the requirement for physicians to document in the progress notes.<br><br>3. Three of fifteen medical records for patients that received surgical termination of a first trimester pregnancy had post anesthesia care documented on the intra-operative record. (Patients #5, #7, and #8)<br><br>Review of Patient #5's medical record revealed a complication during surgery. The documentation suggested the care and treatment received occurred intra-operatively. The time documented for the patient's stabilization and transport to the ED conflicted with the procedure ending time and discharge from the procedure room.<br><br>Review of Patient #7's medical record revealed a complication during surgery. The documentation suggested the care and medication received occurred intra-operatively. The documentation did not specify date and times nor indicate which staff administered medications to the patient.<br><br>Review of Patient #8's medical record revealed a | T 340 | Physician progress notes. A new form was created to allow physicians a separate section to document their patient assessment and findings. And a section was provided for physicians to document their progress notes.<br><br>Three of fifteen medical records for patients who received first trimester termination had post anesthesia care documented on the intra-operative record. We have edited and updated our surgical forms to separate the documentation into pre, intra, and post procedure. Each phase has its own section for physicians or nurses to document findings and/or assessment. Director of Nursing will maintain and update the forms periodically and report to the Governing Board of any changes. | 08/20/12<br><br>08/20/12 |

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| T 340 | Continued From Page 30<br><br>complication during surgery. The documentation suggested the care and treatment received occurred intra-operatively. The time documented for the patient's stabilization and transport to the ED conflicted with the procedure ending time and discharge from the procedure room.<br><br>An interview was conducted on July 25, 2012 from 10:05 a.m. to 10:35 a.m., with Staff #3. Staff #3 reviewed the medical record for Patient #7. Staff #3 stated, "I continue to write on the OR (Operation Room) record when the patient moves to the PACU (post anesthesia care unit)." Staff #3 agreed he/she did not document the date and time for his/her medical record entries. Staff #3 acknowledged Patient #7's medical record did not document, which staff had administered the medications. Staff #3 reported he/she follows patients in the "PACU" if there are complications. Staff #3 reported he/she will generally "just continue to document on the intra-operative form." Staff #3 acknowledged the care provided post operative documented on the intra-operative form creates time conflicts.<br><br>4. Two of fifteen medical records for patients that received surgical termination of first a trimester pregnancy did not have recovery room notes. (Patient #6 and #12)<br><br>Review of Patient #6 and Patient #12's medical records revealed the "Recovery" section of the nursing documentation was incomplete.<br><br>An interview was conducted on July 25, 2012 at 4:42 p.m. with Staff #1 and Staff #2. Staff #2 reviewed the medical records for Patient #6 and Patient #12. Staff #2 reported the nurse failed to complete the documentation related to recovery. | T 340 | Two of fifteen medical records for patients did not have recovery room notes. With the edited forms, recovery room note is part of the surgical form. In the past, a nurse must obtain a separate form to document recovery room notes, which left many opportunities for documentation failure. Nurses are also expected to complete the entire form prior to patient discharge. Director of Nursing will ensure nurses comply with the practice. | 08/20/12 |

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| T 340 | Continued From Page 31<br><br>5. Fourteen of fifteen medical records for patients that received surgical termination of a first trimester pregnancy had the incorrect level of sedation documented. (Patients #1, #3, #5, #6, #8, #9, #12, #13, #14, #15, #18, #19 and #20)<br><br>The review of the medical records for Patients #1, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19 and #20 was performed on July 24 and 25, 2012, by three surveyors. The review revealed the "Anesthesia Record" documented the patients received "GA (general anesthesia)." The "Anesthesia Record" provided a check box for "Conscious sedation", which for fourteen of the fifteen records had not been checked<br><br>An interview conducted on July 25, 2012 from 10:05 a.m. to 10:35 a.m., with Staff #3 revealed the facility did not employ general anesthesia. Staff #3 reported the facility employed local anesthesia and conscious sedation.<br><br>An interview was conducted on July 25, 2012 at approximately 11:42 a.m., with the Medical Director (Staff #4). Staff #4 reviewed the medical records for Patients #5 and #8. Staff #3 acknowledged the facility did not utilize general anesthesia. Staff #4 stated' "We get in the habit of saying general anesthesia when we really mean conscious sedation." Staff #4 acknowledged the anesthesia records did not correctly reflect the level of sedation provided to the patients. Staff #4 reported any medical record that documented the "level of sedation as general anesthesia is incorrect."<br><br>6. Six of twenty medical records for patients that had a first trimester termination of pregnancy did not have a physician's history and physical documented. (Patients #5, #8, #15, #18, #19, and | T 340 | Fourteen of fifteen medical records had the incorrect level of sedation documented. To prevent future reoccurrence we have edited all of our anesthesia forms to change the term "general anesthesia" into "intravenous sedation (IV sedation)". During an MEC meeting on July 31, 2012 the committee addressed all employees to refrain from using the term "general anesthesia" to prevent confusion. Anesthesiologist has agreed to not use the term "general anesthesia" in the future and to use the proper term verbally and in writing. | 07/31/12 |

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| | FTAF-0017 | A. BUILDING _____ B. WING _____ | 07/26/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NOVA WOMEN'S HEALTHCARE | 10400 EATON PLACE, SUITE 515 FAIRFAX, VA 22030 |

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| T 340 | Continued From Page 32<br><br>#20)<br><br>Review of medical records on July 24 and 25, 2012 revealed the following did not have a history and physical performed by a physician documented in their medical records: Patient #5, Patient #8, Patient #15, Patient #18, Patient #19, and Patient #20.<br><br>An interview and record review was conducted on July 25, 2012 at 3:38 p.m., with Staff #2. Staff #2 acknowledged the physician had failed to complete the history and physical portion of the form. Staff #2 acknowledged the six patients did not receive a history and physical prior to the termination of their pregnancy. | T 340 | Six of twenty medical records for patients did not have a physician's history and physical documented. New procedures were implemented to ensure physician's compliance in documenting all services rendered including a history and physical assessment prior to procedure. Forms for physician to complete were edited and simplified to remind physician to document their findings before proceeding to the next step. The nurse is responsible to review chart completion, especially for history and physical before letting patient to proceed with the next step. This addition to the manual is approved by and shall be reviewed annually by the Governing Board. | 08\20\12 |
| T 360 | 12 VAC 5-412-340 Policies and procedures<br><br>The abortion facility shall develop, implement and maintain policies and procedures to ensure safety within the facility and on its grounds and to minimize hazards to all occupants. The policies and procedures shall include, but not limited to:<br>1. Facility security;<br>2. Safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs, supplies and services; and<br>3. Provisions for disseminating safety-related information to employees and users of the facility.<br><br>This RULE: is not met as evidenced by:<br>Based on observations during tour, review of the policy and procedure and interview with Staff #1, it was determined that no policy and procedure had addressed facility security as required in Section 12 VAC-5-412-340. | T 360 | | |

State of Virginia

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| T 360 | Continued From Page 33<br><br>The findings included:<br><br>1. Review of the policies and procedure manual failed to identify how the facility would address security for staff and patients. The facility's policy and procedure manual was reviewed at various times on July 24-25, 2012.<br><br>2. An interview was conducted on July 25, 2012 at 4:39 p.m., with Staff #1. Staff #1 verified during interview that facility security was being maintained, but no formal policy and procedure had been written. | T 360 | Review of policies and procedure manual failed to identify how the facility would address security for staff and patients. Clinical Policy and Procedure manual has been updated to show policy and procedure for the facility to address security for staff and patients. This addition to the manual is approved by and shall be reviewed annually by the Governing Board. | 08/02/12 |
| T 375 | 12 VAC 5-412-360 A Maintenance<br><br>A. The facility's structure, its component parts, and all equipment such as elevators, heating, cooling, ventilation and emergency lighting, shall be all be kept in good repair and operating condition. Areas used by patients shall be maintained in good repair and kept free of hazards. All wooden surfaces shall be sealed with non-lead-based paint, lacquer, varnish, or shellac that will allow sanitization.<br><br>This RULE: is not met as evidenced by:<br>Based on observations and interview, it was determined that all equipment failed to have a preventive maintenance sticker, which ensured the equipment was safe for patient and staff use as required in Section 12 VAC-5-412-360. A.<br><br>The findings included:<br><br>1. Observations during the initial tour of the facility from 08:38 a.m. until 10:20 a.m. on 07/24/12 revealed multiple items utilized by staff and patients had no evidence that they were maintained in good repair and kept free of | T 375 | | |

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| T 375 | Continued From Page 34<br><br>hazards. These items included:<br><br>a. Sonogram Room #2 contained a heating pad with a worn and frayed electrical cord to warm speculums (for vaginal exams) without a preventive maintenance (PM) sticker indication that it had been inspected and deemed safe.<br>b. Holding Room contained a television, a water heater and water dispenser without PM stickers. A Valley Lab Force 2 Laser had a PM sticker dated 12/21/08.<br>c. Exam Room #3 contained a Shimadzu Sonogram without a PM sticker<br>d. Operating Room contained the EKG machine, a suctioning machine, an examination light, and an Automatic External Defibrillator (AED) without PM stickers.<br>e. Post Anesthesia Care Unit contained a Nellcor pulse Oximeter, a Dinapop Vital Signs Monitor and a backup generator without PM stickers.<br><br>2. Staff #1 stated during interview that current p.m. stickers had not been maintained on all ot their equipment. This interview occurred on 7/26/12, at 10:25 a.m. | T 375 | A contract with a local technician was established to quarterly evaluate items for the safety of the staff and patients. Technician has evaluated all of the items used to determine safety for the staff and patients.<br>Sonogram #2 contained a heating pad with a worn and frayed electrical cord to warm speculums. The heating pad was discarded.<br>Television, water heater, and water dispenser were evaluated and PM stickers are placed to signify the due date of next evaluation.<br>Shimadzu Sonogram was no longer used and was stored in Exam #3, it was removed from the exam #3 and stored in the store room.<br>EKG machine, suctioning machine, an examination light, and an Automatic External Defibrillator (AED) were checked and PM stickers were attached.<br>Post Anesthesia Care Unit contained a Nellcor pulse oximeter, a Dinapop Vital Signs Monitor and a backup generator were checked and PM stickers were placed to indicate the next evaluation.<br>Director of Nursing is responsible to do a quarterly check on all equipment to determine safety. | 09/04/12 |
| T 380 | 12 VAC 5-412-360 B Maintenance<br><br>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 | T 380 | | |

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| T 380 | Continued From Page 35<br><br>returned to service. Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance.<br><br>This RULE: is not met as evidenced by:<br>Based on review and interview, it was determined that a process to ensure that all equipment are safely maintained per the manufacture's specifications were not available for review, as required in Section 12 VAC-5-412-360.B.<br><br>The findings included:<br><br>1. Observations during the initial tour of the facility from 08:38 a.m. until 10:20 a.m. on 07/24/12 revealed multiple items utilized by staff and patients had no evidence that they were maintained in good repair and kept free of hazards.<br><br>2. Review of the contracts failed to demonstrate any for the annual inspection for the inspection of all equipment used by the facility to ensure safety.<br><br>3. Staff #1 stated during interview that the facility did not have a formal program available or contracts to ensure the equipment had safety inspections. This interview occurred on 7/26/12, at 10:27 a.m. | T 380 | Records shall be maintained on each piece of equipment to indicate its history of testing and maintenance. The Governing Board has appointed the Director of Nursing to be responsible for maintaining the records of equipment in the facility. The equipment record contains records of each piece of equipment, testing and maintenance. The Director of Nursing is also responsible to perform a quarterly check on all equipment to maintain proper function. | 08/31/12 |
| T 400 | 12 VAC 5-412-380 Local and state codes and standards<br><br>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 | T 400 | | |

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| T 400 | Continued From Page 36<br><br>Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building Code pursuant to Virginia Code 32.1-127.001.<br>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.<br>Refer to Abortion Regulation Facility Requirements Survey workbook for detailed facility requirements.<br><br>This RULE: is not met as evidenced by:<br>Based on observations, interviews and a facility tour it was determined that the facility failed to ensure full compliance with state/local codes, building ordinances as well as the Uniform Statewide Building Code. Additionally, the facility failed to comply with having the following: an architect attestation that the facility meets all FGI (Facility Guidelines Institute) for Health Care Facilities standards, proper ventilation, humidity, temperature controls, waste management program/services, HVAC duct system and inspection reports, proper ventilation of the treatment rooms, proper air exchange for all treatment rooms, the heating/cooling and plumbing system to meet all codes, electrical system meets the National Electrical Code ordinance and all hand washing stations meet the necessary width. length, depth & splash prevention.<br><br>The findings include:<br><br>On 7/24/12 an interview and a tour of the building | T 400 | We will be moving by 2014. And we will have completed a health survey at that time. The on-site surveyor will be able to review the building plans. The architectural team shall follow the rules set forth by the 2010 Guidelines For Design and Construction Of Health Care Facilities. The architectural team and the administrator shall oversee the project with approval from the Governing Board. This project will be completed by 2014. | |

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| T 400 | Continued From Page 37<br><br>was completed with the facility Administrator. The Administrator stated, "We do not have an attestation from an architect that the building meets the required FGI guidelines. Our building does not have the proper air exchanges per hour and we don't have ventilation of a MERV (minimum efficiency reporting value) of 7." The Administrator was asked about exhaust vents. She stated, I am unsure if the ventilation or air flow meets the FGI guidelines. None of our windows open. I could not tell you what type of insulation is in this building. It is an old building and most of it we don't know about."<br><br>The Administrator had the public corridors measured and stated, "They are not 5 feet wide."<br><br>During the tour no locking drawers or cabinets for staff's personal belongings were available. The Administrator stated, "No we do not have locking cabinets or drawers."<br><br>When asked about what type of glass the windows were constructed of the Administrator stated, "I do not know."<br><br>During the tour items were found stored under the sink in the lab and medication room.<br><br>The Administrator stated, "At this point we don't really know what we will do about the building." | T 400 | | |