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	FTAF-0018	A. BUILDING _____ B. WING _____	08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE MEDICAL CENTER FOR WOM	2321 COMMONWEALTH DR CHARLOTTESVILLE, VA 22901

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T 000	12 VAC 5- 412 Initial comments An announced Initial Licensure Abortion Facility inspection was conducted at the above referenced facility July 31- August 1, 2012 by two (2) Medical Facility Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The facility was found to not be in compliance with the State Board of Health 12 VAC 5-412, Regulations for Abortion Facility's effective December 29, 2011. Deficiencies were identified and cited, and will follow in this report.	T 000		
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 bylaws shall identify the person or organizational body responsible for formulating policies. This RULE: is not met as evidenced by: Based on an interview and a review of facility documents it was determined the governing body failed to identify the person or organizational body responsible for formulating policies. The findings were: A review of the policy and procedure manual on 7/31/12 revealed the governing body failed to identify the person responsible for formulating policies. An interview with the administrator on 7/31/12 at approximately 3:30 p.m. revealed the administrator is responsible for formulating policies and procedures.	T 025	T 025 Bylaws indicate that the administrator is responsible for development and implementation of its policies. Clarification memo attached.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9.18.12

SEP 21 2012

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T 080	Continued From Page 1	T 080		
T 080	12 VAC 5-412-170 E Personnel E. The facility shall develop, implement and maintain policies and procedures to document that its staff participates in initial and ongoing training and education that is directly related to staff duties, and appropriate to the level, intensity and scope of services provided. This shall include documentation of annual participation in fire safety and infection prevention in-service training. This RULE: is not met as evidenced by: Based on document review it was determined the facility staff failed to ensure policies and procedures were implemented and maintain regarding initial and ongoing training and education related to their duties. The findings include: The policy and procedure manuals were reviewed on 7/31/12 with the administrator present. There were no policies related to staff training and education at hire or on an ongoing basis.	T 080	T 080 The Personnel Policy states that staff duty, fire safety and infection control training shall be conducted initially and annually. The policy and procedure manual will be reviewed annually to ensure that all policies are in accordance with regulations. The administrator is responsible for development and implementation of policies. Completion date Sept 5, 2012	
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;	T 170		

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T 170	Continued From Page 2 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 10. Procedures for documenting annual retraining of all staff in recommended infection prevention practices. This RULE: is not met as evidenced by: Based on a review of facility documents it was determined the facility failed to include procedures for documenting annual retraining of all staff in recommended infection prevention practices. The findings were: A review of the policy and procedure manual revealed the facility had written infection prevention policies and procedures that contained all the required elements with the exception of procedures for documenting annual retraining of all staff in recommended infection prevention practices.	T 170	T 170 Policy on staff training in infection control has been added to the policy and procedure manual. Manual is to be reviewed annually. Administrator is responsible for ensuring that staff training is carried out and documented. Completion date Sept. 5, 2012	
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	T 175		

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T 175	Continued From Page 3 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 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	T 175		

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T 175	Continued From Page 4 or required by the department. This RULE: is not met as evidenced by: Based on a review of facility documents it was determined the facility failed to have written policies and procedures for handling, storing, processing and transporting regulated medical waste in accordance with applicable regulations. The findings were: A review of the policy and procedure manual on 7/31/12 revealed the facility failed to have a policy and procedure for handling, storing, processing and transporting regulated medical waste.	T 175	T 175 Policy on biomedical waste handling has been incorporated into the manual. Administrator is responsible for reviewing manual annually. Completion date Sept 1, 2012	
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 a review of facility documents and an interview it was determined the facility failed to develop, implement and maintain policies and procedures for patient education, follow up and reporting to include: Discharge instructions related to signs of infection, procedures for surveillance,	T 185		

State of Virginia

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T 185	Continued From Page 5 documenting and tracking infections and reporting conditions to the local health department. The findings were: A review of the policy and procedure manual on 7/31/12 revealed the discharge policy states criteria for discharge but does not refer to the above mentioned requirements. The administrator stated the patient is given a list of discharge instructions that does refer to infections however; the policy does not refer to the handout and infection. There is no evidence the agency is tracking infections.	T 185	T 185 The discharge policy has been revised. A policy on monitoring of infections has been written and implemented. The administrator is responsible for ensuring that all medical staff is aware of the need to maintain the complication log and to forward it to the Quality Assurance Committee quarterly. Completion date Sept. 12, 2012	
T 205	12 VAC 5-412-240 C Medical testing, patient counseling and labor C. Laboratory services shall be performed on site or through arrangement with a laboratory certified to provide the required procedures under the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88). 1. Facilities for collecting specimens shall be available on site. 2. If laboratory services are provided on site they shall be directed by a person who qualifies as a director under CLIA-88 and shall be performed in compliance with CLIA-88 standards. 3. All laboratory supplies shall be monitored for expiration dates, if applicable, and disposed of properly. This RULE: is not met as evidenced by: Based on observations it was determined the facility staff failed to ensure all laboratory supplies were monitored for expiration dates. The findings were:	T 205		

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T 205	Continued From Page 6 A tour of the facility on 7/31/12 revealed the laboratory contained medication and supplies that were expired to include: Rho (D) Immune Globulin Human 3 expired 6/20/12, Tuberculin purified protein derivative 1 ml opened and accessed but not dated, and lancets (20 total) that expired on 6/09.	T 205	T 205 Expired items discarded. Expiration log to be completed monthly to identify any other expired items. Staff instructed to check expiration dates in their area each day of procedures. Administrator is responsible for reviewing expiration log to ensure expired items properly discarded as well as giving the opportunity to rotate stock to reduce the risk of items becoming expired. Completion date Sept 12, 2012	
T 230	12 VAC 5-412-250 C Anesthesia service C. The facility shall develop, implement and maintain policies and procedures outlining criteria for discharge from anesthesia care. Such criteria shall include stable vital signs, responsiveness and orientation, ability to move voluntarily, controlled pain and minimal nausea and vomiting. This RULE: is not met as evidenced by: Based on interviews and document review the facility failed to have in place policies and procedures related to the criteria for discharge from anesthesia care. The findings include: A review of the policy and procedure manual on 7/31/12 revealed the facility failed to have the required policy for discharge criteria. The administrator was made aware of the findings on the exit of day 1 and failed to provide the required policy by the exit of the survey.	T 230	T 230 Discharge criteria policy modified to address these issues. Recovery room nurses trained to discharge criteria. Administrator is responsible for ensuring policies are complete. Policy manual is reviewed annually. Completion date Sept 12, 2012	
T 240	12 VAC 5-412-250 E Anesthesia service E. An abortion facility administering moderate sedation/conscious sedation shall maintain the following equipment, supplies and pharmacological agents, as required by 18 VAC 85-20-360 B:	T 240		

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T 240	Continued From Page 7 1. Appropriate equipment to manage airways; 2. Drugs and equipment to treat shock and anaphylactic reactions; 3. Precordial stethoscope; 4. Pulse oximeter with appropriate alarms or an equivalent method of measuring oxygen; saturation; 5. Continuous electrocardiograph; 6. Devices for measuring blood pressure, heart rate and respiratory rate; 7. Defibrillator; and 8. Accepted method of identifying and preventing the interchangeability of gases. This RULE: is not met as evidenced by: Based on observations and interviews it was determined the facility staff failed to have the required equipment and supplies required when administering moderate or conscious sedation. The findings were: A tour of the facility revealed the facility failed to have a precordial stethoscope as required when performing moderate or conscious sedation. An interview conducted with the administer and the physician confirmed the findings.	T 240	T 240 Precordial stethoscope has been purchased and is present in procedure room whenever sedation is administered. Administrator is responsible for ensuring proper equipment is present and in good working order. Completion date August 20, 2012	
T 255	12 VAC 5-412-250 H Anesthesia service H. Discharge from anesthesia care is the responsibility of the health care practitioner providing in anesthesia care and shall occur only when the patient has met specific physician-defined criteria. This RULE: is not met as evidenced by: Based on a review of facility documents it was determined the facility failed to have physician defined criteria for discharge from anesthesia	T 255		

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T 255	Continued From Page 8 care. The findings were: A review of the policy and procedure manual revealed the agency failed to have physician defined criteria for patients' being discharge following anesthesia.	T 255	T 255 Physician defined criteria for discharge are found in the Discharge policy. Administrator is responsible for reviewing manual annually. Completion date Sept 12, 2012	
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, 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 interviews and document reviews it was determined the facility staff failed to implement an ongoing comprehensive integrated, self assessment program of the quality and appropriateness of care or service provided. The finding were: A review of the policy and procedure manual revealed the agency has a policy related to the quality improvement program however; an interview conducted with the administrator on 7/31/12 revealed the facility has no evidence they have implemented the policy.	T 315	T 315 Audit completed. Quality Assurance committee meeting held. Minutes produced. QA results to be reported to governing authority annually. Completion date Sept 12, 2012	

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T 320	Continued From Page 9	T 320		
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; 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 interviews and document reviews it was determined the facility staff failed to implement an ongoing comprehensive integrated, self assessment program of the quality and appropriateness of care or service provided. The finding were: A review of the policy and procedure manual revealed the agency has a policy related to the quality improvement program however; an interview conducted with the administrator on 7/31/12 revealed the facility has no evidence they have implemented the policy.	T 320	T 320 Audit completed. Quality Assurance meeting held and minutes produced. QA results to be forwarded to governing authority annually. Completion date Sept 12, 2012	
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	T 335		

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T 335	Continued From Page 10 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. This RULE: is not met as evidenced by: Based on interviews and document reviews it was determined the facility staff failed to implement an ongoing comprehensive integrated, self assessment program of the quality and appropriateness of care or service provided. The finding were: A review of the policy and procedure manual revealed the agency has a policy related to the quality improvement program however; an interview conducted with the administrator on 7/31/12 revealed the facility has no evidence they have implemented the policy.	T 335	T 335 Audit completed. QA meeting held and minutes produced. QA results to be forwarded to Governing Authority annually. Administrator is responsible for ensuring QA program carried out. Completion date Sept 12, 2012	
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	T 400		

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T 400	Continued From Page 11 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, document review and interview, it was determined that the facility failed to ensure that they are in full compliance with state and local codes, building ordinances as well as the Uniform Statewide Building Code. Additionally, the facility failed to comply with various sections of chapters 3.1 and 3.7 of FGI (Facilities Guidelines Institute 2010 Guidelines for Design and Construction of Health Care Facilities) as required. Specific to those requirements the facility had no provision for a separate clean storage room and sterile supplies that meets ventilation, humidity and temperature control provisions, had no evidence of spore testing performed on the autoclave, doorways and hallway were less than the required measurements in areas where patients would have access, carpeted floors had buckled carpet, could not provide evidence of airflow filters being of at least 30 % efficiency rating, no evidence that insulation had a flame-spread of 25 or less and a smoke-developed rating of 50 or less, and no evidence of installed electrical material and equipment compliance with NFPA 70 and 99. The nurses station failed to have a work counter, the lab area failed to have a reclining chair, and failed to have lockable cabinets for staff to store personal effects. The facility also failed to have a sheltered entrance and medical records were stored in cardboard boxes on the floor in a kitchen	T 400		

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T 400	Continued From Page 12 area. The windows were not constructed of safety glass, wired or glazed with a plastic coating. The Findings Include: An initial tour of the facility was conducted with the Administrator on July 31, 2012 beginning approximately 10:15 A.M. During the tour it was noted that the facility had no separate room for the storing of clean and sterile supplies that meets ventilation, humidity and temperature control provisions, no evidence of spore testing performed on the autoclave, doorways and hallway were less than the required measurements in areas where patients would have access, carpet in the entrance and waiting areas had buckling in several places, could not provide evidence of airflow filters being of at least 30 % efficiency rating, no ventilation in non-sensitive and patient areas, on evidence that insulation had a flame-spread of 25 or less and a smoke-developed rating of 50 or less, and no evidence of installed electrical material and equipment compliance with NFPA 70 and 99. The nurses station was using a folding TV tray for a work counter where charting was done and medications were poured. The lab area had a cloth covered chair that did not recline. There were no lockable cabinets or lockers for staff to store personal effects. The entrance to the facility was not sheltered from the weather. Medical records were stored in cardboard boxes on the floor in a kitchen area that contained a refrigerator that was in use and a sink. The windows were not constructed of safety glass, wired or glazed with a plastic coating. The Administrator provided a summary from an	T 400	T 400 Clean and sterile rooms are separate. Ventilation, humidity, and temperature control being addressed by engineering company report. Spore testing has been performed weekly on autoclave since 5/24/12. Sterile tech is responsible for running sample in autoclave and administrator is responsible for getting the sample incubated and results forwarded to office. See attached timeline for architectural changes. Engineering company report addresses airflow. Recommendations to be carried out by contractor. Then nurse's station has been improved by installing a cabinet to hold medications and other supplies. Lab chair replaced with a vinyl chair. Medical records which are in boxes have been raised off the floor. Completion date August 7, 2012.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE MEDICAL CENTER FOR WOM	2321 COMMONWEALTH DR CHARLOTTESVILLE, VA 22901

(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 13 engineering company to assist them in complying with the regulations. The summary stated the facility did not meet the standard for fresh air ventilation rate, total air change rate, pressurization, supply outlet type, filtration requirements and back-up power for pressurization. stated during the tour that the facility had contacted a firm who would assist the facility in complying with the regulations.	T 400		

W.K.G. and J., Incorporated
118 North Boulevard
Richmond, Virginia 23220
(804) 359-5066 - phone (804) 353-2718 - fax

T025

Clarification of Bylaws:

The bylaws of W.K.G. and J., Incorporated state in Article X, C. Administrator, that the administrator is responsible for development and implementation of its policies. This should be understood to indicate that the governing body has identified the administrator as being responsible for formulating policies.

BYLAWS OF W. K. G. AND J., INCORPORATED

ARTICLE X

Purpose, Functions and Duties and Administrator

A. Purpose. The purpose of the corporation shall be to assure quality patient care to women seeking abortions and gynecological services and to assure that all appropriate governmental guidelines are met.

B. Functions and Duties. The duties and functions of the Board of Directors shall be to assure quality patient care to all patients of the corporation, maintain a professional standard for all staff members, ensure compliance with all state and federal regulations governing abortion facilities, encourage and provide ongoing training and education for all staff members, ensure and maintain quality assurance, and to always maintain the dignity and confidentiality of patients.

C. Administrator. The Board has designated an Administrator for the corporation. She will represent the Board and is responsible for the daily management of the facility, and development and implementation of its policies. She is authorized and empowered to carry out the rules and regulations of an abortion facility as promulgated by the Virginia Department of Health. Her duties are as follows:

i. To ensure quality of patient care.
ii. To ensure compliance with all State licensing requirements and regulations.

iii. To meet with all state regulatory representatives and act as a representative of the Board to the State Department of Health.
iv. To report all regulatory issues immediately to the Board.
v. In conjunction with the Medical Director, to staff and maintain the facility.
vi. To coordinate and report all necessary reviews and reports to the Board.
vii. To maintain appropriate administrative records.
viii. To initiate and maintain contact with outside agencies including outside physicians.
ix. To maintain appropriate patient records.
x. To ensure proper maintenance of all equipment in the facility.
xi. To ensure that all efforts are made to comply with all State and Federal policies concerning medical waste.

D. The Administrator shall designate an Assistant Administrator to act on her behalf during her absence.

Article XI

Staff and Guidelines

A Selection, Appointment and Responsibilities. All clinical staff shall be selected and granted privileges based on qualifications laid out in the appropriate job description.

B. With the exception of Medical Director and Staff Physicians, all clinical staff shall be appointed and granted clinical privileges by the Administrator.

C. The Medical Director and all Staff Physicians shall be appointed and given clinical privileges by the Board.

D. All clinical staff responsibilities shall be listed in the appropriate job description.

E. Guidelines for Relationships. The Board shall supervise the Administrator.

F. The Administrator shall operate as the direct and on-site supervisor and

T080

Richmond Medical Center for Women
Charlottesville Medical Center for Women
Peninsula Medical Center for Women
Roanoke Medical Center for Women

Clinical Policies and Procedures Manual

Department: Personnel	**Policy Description:** Personnel Policies
Page: 1 of 1	**Replaces Policy Dated:**
Effective Date: 6/21/12	**Reference Number:** 12VAC5-412-170
Approved:	

Scope:	All Staff
Purpose:	To ensure personnel are hired, trained, and reviewed appropriately so that the center may function optimally to the satisfaction of the patients, the governing authority, and other staff
Procedure:	When filling a position, the new employee form will be utilized to ensure verification of qualifications for the position. An application will be obtained from all staff. Licensure will be confirmed for those staff with a license. Confirmation will be by going on line to the appropriate board's website and conducting license look-up. Criminal history checks will be conducted for those staff with access to controlled substances. Orientation checklist will be completed. A job description will be part of each personnel file. The staff member will sign and date the job description to indicate that she is aware of her responsibilities. Job descriptions will be reviewed annually. A copy will be given to each staff member initially and when revised. Staff will participate in initial and ongoing training directly related to staff duties. Documentation of training will be kept in the personnel file as well as in the training manual. Fire safety training will be conducted initially and annually Infection prevention training will be conducted initially and annually Performance and competence will be evaluated annually; job descriptions will be reviewed at that time and revised as needed. CPR training will be kept up to date for staff working in the clinical areas. Violations of licensing or certification standards will be reported to the appropriate board within the Department of Health Professions. The administrator is responsible for reporting violations. A personnel file for each employee will be safeguarded against loss and unauthorized use. Employee health information will be maintained separately within the personnel file.
Reference:	12VAC5-412-170

Revised: Date & Initial:	9/12									
Reviewed: Date & Initial										

Richmond Medical Center for Women
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Peninsula Medical Center for Women
Roanoke Medical Center for Women
Clinical Policies and Procedures Manual

Department: Infection Control	**Policy Description:** Staff Training in Infection Control
Page: 1	**Replaces Policy Dated:**
Effective Date: 9/1/12	**Reference Number: 12VAC 5-412-220B**
Approved:	

Scope:	All personnel
Purpose:	To protect staff and patients from infection, all staff will receive training in infection control initially and annually
Policy:	All staff will receive training in infection control initially and annually
Procedure:	Upon hire, all staff will be trained in their duties as well as in infection control. Training will be conducted at least annually. Optimally, infection control training is ongoing. Training will be documented in the personnel file as well as in the training manual
Reference:	**12VAC 5-412-220B**

SEP 2

Revised: Date & Initial:										
Reviewed: Date & Initial										

Richmond Medical Center for Women
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Clinical Policies and Procedures Manual

Department: Facilities & Environment	**Policy Description:** Biomedical Waste Handling
Page: 1 of 2	**Replaces Policy Dated**:
Effective Date: 9/1/12	**Reference Number: 12 VAC 5-412-220 E**
Approved:	

Scope:	All Biomedical Waste
Purpose:	To prevent contamination with any Biomedical waste. To be in compliance with the OSHA Bloodborne Pathogens Standard
Policy:	The Center will follow procedures to ensure no accidental patient, employee, on-site contract personnel or visitor exposure to blood or other potentially infectious materials.
Procedure:	**A. BIOMEDICAL WASTE DEFINITIONS** The following materials shall be defined and processed as infectious or biomedical waste at the facility: 1) LABORATORY WASTE a) Blood and articles contaminated in the collection or processing of lab specimens. 2) PATHOLOGY SPECIMENS a) Body tissue, parts and materials used to collect or store pathology specimens. 3) INFECTED SITES a) Waste from sites known to have an infectious agent are designated and handled as biomedical 4) CONTAMINATED SHARPS, NEEDLES AND SYRINGES a) All items of this nature are discarded in designated sharps containers and treated as biomedical waste. 5) OTHER a) Any materials or items that have been contaminated or contain visible soiling by blood or other body fluids, including but not limited to sponges, suction canister contents, suction tubing, and/or draping materials. B. **MANAGEMENT OF BIOHAZARDOUS WASTE** 1) <u>GENERAL:</u> a) <u>Red</u> can liners are used to collect biomedical waste in all patient care areas in the facility. b) All other receptacles will be lined with ordinary can liners/bags to receive non-infectious waste. c) Only items which fit the definitions of "biomedical waste" are to be placed in red bags/can liners. d) Red can liners/bags containing biomedical waste are NEVER placed in or with the solid waste. e) Corrugated boxes or barrels marked "Biomedical Waste," which are provided by the medical waste company, are available to receive the individual red biomedical bags at

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SEP 2 : 2012

	the time of removal from patient care areas. (i) When full, facility personnel who have been trained in the handling of biomedical waste will be responsible for sealing these boxes at the storage site. (ii) The boxes will be stored in a designated area in the facility for regular Pick-up by the medical waste disposal company. Pick-up will be at least every two weeks. (iii) The medical waste management company will provide a manifest for a number of containers received from the facility as proof of proper handling. 2) ACCIDENTAL SPILLAGE a) Should spillage of biomedical waste materials occur, facility personnel will follow the procedure outlined in the spill kits. 3) ALTERNATIVE DISPOSITION a) In the event of an interruption of services from the contracted medical waste management due to disaster or other problem, all biomedical waste will be held at the facility and maintained in the manner outlined above until the waste management company service is resumed or an alternative waste management company is contracted. b) No hazardous waste will, at any time, be placed with or disposed of with regular waste.
Reference:	OSHA Bloodborne Pathogens Standard; 12 VAC 5-412-220 E

Revised: Date & Initial:										
Reviewed: Date & Initial										

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Clinical Policies and Procedures Manual

T 185 T255 T230

Department: Surgical Services	**Policy Description:** Discharge Criteria
Page: 1 of 2	**Replaces Policy Dated**:
Effective Date: 8/12	**Reference Number: 12VAC5-412-150, -180, -220, -250**
Approved:	

Scope:	All patients
Purpose:	To establish criteria for safe patient discharge
Policy:	All patients at the facility will be discharged when cramping and bleeding are minimal and vital signs are normal or at the discretion of the physician
Procedure:	A. Each patient should have a discharge order from the physician. B. Final Discharge Criteria: 1) Alert and oriented 2) Vital signs stable 3) Voided prior to discharge, if required by physician 4) Instructed to call physician if unable to void within 8 hours 5) Nausea, vomiting, dizziness minimal 6) Tolerates liquids well 7) Able to ambulate 8) Responsible adult to escort home if IV or MAC 9) Prescriptions given 10) Patient given follow-up instruction sheet which includes instruction to call center if signs of infection develop 11) Pain scale on discharge recorded; pain controlled 12) Menstrual pad checked a) Patient will have no unusual bleeding at time of discharge. C. Additional Information given upon discharge 1) Patients will be instructed on post-op home care as detailed on follow-up instructions. 2) RMCW discharge instructions with physician's discharge instructions will be given 3) Each patient will be given the physician's name and phone number to call in case of an emergency. D. The physician will remain on site until all patients are medically stable, sign the discharge order and be readily available and accessible until the last patient is discharged.
Reference:	**12VAC5-412-150, -180,- 250**

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Richmond Medical Center for Women
Charlottesville Medical Center for Women
Peninsula Medical Center for Women
Roanoke Medical Center for Women
Clinical Policies and Procedures Manual

Department: Facilities and Environment	**Policy Description:** Monitoring of Infections
Page: 1 of 1	**Replaces Policy Dated**:
Effective Date: 9/1/12	**Reference Number: 12 VAC 5-412-220 E**
Approved:	

Scope:	All stakeholders
Purpose:	To identify any trends or outbreaks of infection in the patients served. To identify any areas which may be strengthened to result in reduction of incidence of infections.
Policy:	All infections will be documented on the complication log form. The physician, nurse practitioner, nurse, and administrator are responsible for ensuring that the documentation is executed.
Procedure:	Whenever the physician, nurse practitioner, nurse or administrator diagnoses or becomes aware of any infection, they will document the case on the complication log form. The log will be forwarded to the Quality Assurance Committee quarterly Any outbreak of conditions or diseases will be reported to the local health department in accordance with the Regulations for Disease Reporting and Control.
Reference:	Complication log; 12 VAC 5-412-220 E; 12 VAC 5-90

Revised: Date & Initial										
Reviewed: Date & Initial										

Today's Date	Patient Name and Date of Service	Description of Complication	Management

T 205

Expiration Date Log

Location: _____

Date: _____

Item	Expiration Date	Initials

08/17/2012	[redacted]	[redacted]		[redacted]
08/17/2012	[redacted]		[redacted]	[redacted]
08/16/2012	[redacted]	[redacted]		[redacted]
08/16/2012	[redacted]	[redacted]		[redacted]
08/16/2012	CHECK CARD PURCHASE SEDATIONKIT 8006850940 MO	$37.89		[redacted]

Previous | Next

The finding of deficiency for noncompliance with 12VAC5-412-380 is inappropriate because Charlottesville Medical Center for Women (CMCW) submitted a plan for coming into compliance with this regulation along with its application, as the regulation clearly allowed. If the Department refuses to remove the finding, it should grant CMCW a variance. The plan that CMCW submitted with its application for licensure continues to be the most accurate statement of its plans to comply with this regulation within two years of licensure. In an effort to provide the Department with an update on our implementation of that plan, following is a timeline for our recent work as well as our work over the next several months:

March 16, 2012 – Brought in an architect to do an assessment of CMCW's facility for compliance with 12VAC5-412-380.

June 25, 2012 – Met with Mechanical Design and Energy Consulting Firm.

July-Oct. 2012

- Contact the local building department to schedule an inspection to determine compliance with any section of the building code or the UCSB that may be applicable based on the date of the building's construction.
- Contact fire marshal to schedule an inspection to determine compliance with the fire code.

Nov. 2012 – Assess information gathered and create a timeline for gathering any outstanding information by the end of 2012.

Nov.-Dec. 2012 – Complete information-gathering process.

Jan.-April 2013 – In consultation with an architect, evaluate whether renovations are necessary and/or feasible. Assess availability and affordability of loans that would be necessary to complete such renovations. Evaluate whether seeking any variances from discrete requirements would allow CMCW to comply with 12VAC5-412-380 and consult Department for information about the process of seeking any such variances and the documentation required. Submit any requests with appropriate documentation.

Contingent on the feasibility, cost, and variances possible, if renovations can be done, establish a timeline for developing a plan for construction, submitting for bids, evaluating bids and hiring a contractor. Consult with Department of Health concerning timeline.

If renovations cannot be done, evaluate whether to move to a new location. Establish a timeline for talking to a broker, assessing the available commercial real estate stock, availability and affordability of loans that would be necessary to accomplish a move, and for deciding whether the costs of such a move would be affordable by CMCW in the long run. Consult with Department of Health concerning timeline.

May-Nov. 2013 – If renovations are possible, begin moving forward on the items in the timeline for renovations. If renovations are not possible, begin moving forward on the items in the timeline for evaluating whether to move.

Dec. 2013-July 2014 – If renovations are possible, attempt to complete all necessary work during this period. If renovations are not possible, attempt to complete the process of moving during this period. Evaluate and seek any variances necessary, depending on the rapidity of either process, in consultation with the Department.