Planned Parenthood®
Health Systems, Inc.

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September 12, 2012

FedEx Overnight Delivery

Mr. Erik Bodin, Director
Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

RE: Charlottesville Health Center – Planned Parenthood Health Systems, Inc.
Plan of Correction in Response to Abortion Facility Initial Licensure Survey

Dear Mr. Bodin:

Relative to the Licensure Inspection Report received on August 25, 2012, enclosed herewith is this report with our Plan of Correction. This Plan of Correction has been signed by our President/CEO & Administrator, Walter Klausmeier.

Should there be any questions regarding information contained within our Plan of Correction, please contact me at 540.562.2370 x 7030 or e-mail me at Linda.Riddle@pphsinc.org. Mr. Klausmeier appointed me to serve in his stead during the inspection. Should there be any questions, I will be out of the office from October 1 to October 17. Please contact Elaine Pleasants, VP for Operations, during that time. Her number is 919.833.7526 x 6131.

Cordially yours,

Linda D. Riddle

Linda D. Riddle
Facilities Coordinator/Acting Administrator

Enclosure: Plan of Correction

CC: Walter Klausmeier, President/CEO & Administrator
Elaine Pleasants, Vice President for Operations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-006	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE PLANNED PARENTHOOD HEA	2964 HYDRAULIC ROAD 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 on August 2 and August 3, 2012 by two (2) Medical Facility Inspectors from the Virginia Department of Health's, Office of Licensure and Certification. The facility was found out of 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 030	12 VAC 5-412-140 E Organization and management E. The bylaws shall include at a minimum the following: 1. A statement of purpose; 2. Description of the functions and duties of the governing body, or other legal authority; 3. A statement of authority and responsibility delegated to the administrator and to the clinical staff; 4. Provision for selection and appointment of clinical staff and granting of clinical privileges; and 5. Provision of guidelines for relationships among the governing body, the administrator and the clinical staff. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility failed to have provisions for selecting and appointing clinical staff and granting of clinical privileges. The findings include:	T 030	1. In Section 14.5 of the current By-Laws for PPHS, there is a section relative to selection and appointment of clinical staff and the granting or revocation of clinical privileges.	

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

Wm W Kelly — President/CEO & Administrator — 09.12.2012

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T 030	Continued From Page 1 On 8/2/12 a review was completed of the facility's bylaws with the Alternate Administrator (Alt. Adm.) and Vice President of Operations. The Alt. Adm. was asked to locate the provisions for selecting and appointing clinical staff and granting of clinical privileges. The Alt. Adm stated, "We do not have information related to selecting, appointing and granting of privileges to the clinical staff."	T 030		
T 045	12 VAC 5-412-160 A Administrator A. The governing body shall select an administrator whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility's governing body failed to name the person appointed as the administrator for the facility The findings include: On 8/2/12 a review was completed of the facility's bylaws with the Alternate Administrator (Alt. Adm.) and Vice President of Operations. The Alt. Adm. was asked to locate the Administrators appointment by the governing body. The Alt. Adm. stated, "I do not have any information where the Administrator was appointed by the governing body."	T 045	1. The By-Laws did have the section where the Administrator was appointed by the Board; however, the actual name was not in place. The By-Laws now have the name of the administrator and second alternate listed in the By-Laws so that this is name specific as appointed.	
T 065	12 VAC 5-412-170 B Personnel B. The licensee shall obtain written applications for employment from all staff. The licensee shall obtain and verify information on the application as to education, training, experience, appropriate	T 065		

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T 065	Continued From Page 2 professional licensure, if applicable, and the health and personal background of each staff member. This RULE: is not met as evidenced by: Based on a review of facility documents and interviews it was determined the facility staff failed to obtain verification of licensure for six (6) of seven (7) licensed professionals on staff. The findings were: A review of the personnel files revealed the agency failed to verify licensure for two (2) physicians, one (1) nurse practioner, two (2) certified nurse assistants, and one (1) pharmacist. An interview conducted with the administrator on 8/2/12 revealed verification had not been done and the administrator worked with human resources to obtain the verification during the survey process.	T 065	1. PPHS does do credentialing for clinicians and licensure is verified with this process; however, there was no routine check on licensure. There is now in place a policy and procedure to verify licensure of clinicians and other licensed/certified staff via the Virginia Department of Health Professions' web site. On the day of inspection, this was done for the six staff where this documentation was not readily available and the inspector did review. This will be done on a regular basis with the HCM (Health Center Manager) performing this task. The HR Manager will monitor to ensure compliance.	
T 070	12 VAC 5-412-170 C Personnel C. Each abortion facility shall obtain a criminal history record check pursuant to 32.1-126.02 of the Code of Virginia on any compensated employee not licensed by the Board of Pharmacy, whose job duties provide access to controlled substances within the abortion facility. This RULE: is not met as evidenced by: Based on interview and document review the facility failed to ensure compensated employee(s) whose job duties provides them access to controlled substances within the abortion facility had a criminal record report pursuant to 32.1-126.02 of the Code of Virginia .	T 070	1. All staff not licensed but with access to controlled substances will have a Criminal History record check pursuant to 32.1-126.02 of the Code of Virginia. This criminal record check will be done through the Department of Virginia State Police as required. Forms have been completed and submitted for staff not licensed but who have access to controlled substances. These will be done prior to September 12, 2012. This process is now part of the Policy for the HR Department and will be followed going forward.	

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T 070	Continued From Page 3 The Findings Include: On August 2, 2012, five (5) personnel files (2 physicians, 2 nurse practioners and 1 office manager) for employees whose job duties provide them access to controlled substances within the facility were reviewed. The personnel files failed to contain a criminal record report pursuant to 32.1-126.02 of the Code of Virginia. Code of Virginia 32.1-126.02 states the criminal record report must come from the Virginia State Police. The facility Administrator was interviewed on 8/2/12 and she stated, "No we did not get criminal record checks from the Virginia State Police and we are working on it".	T 070		
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 and staff interviews the facility failed to develop, implement and maintain policies and procedures to document staff participated in initial,ongoing training and education and of annual participation in fire safety and infection prevention in-service training that is directly related to their duties, and was appropriate to the level, intensity and scope of services provided. The findings include:	T 080	1. There are now Policies & Procedures in place which have been implemented to ensure that staff will participate in initial, on-going training and education and for annual participation in fire safety and infection prevention in-service directly related to duties. The HR Manager will be responsible for initial training of staff. The QM Manager will be responsible for on-going training of staff relative to duties and infection prevention. The Facilities Coordinator will be responsible for annual fire safety training and drills. The VP for Operations will monitor to ensure compliance. While training was being done and documented, there was no written policy in place delineating the process and procedure.	

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T 080	Continued From Page 4 On 8/2/12 a review was completed of the facility's policies and procedures with the Alternate Administrator (Alt. Adm.) and Vice President of Operations. The Alt. Adm. was asked to provide the policy or policies related to developing, implementation and maintaining documentation of staff's participation in initial,ongoing training and education and of annual participation in fire safety and infection prevention in-service training.	T 080		
T 095	12 VAC 5-412-170 H Personnel H. Personnel policies and procedures shall include, but not be limited to: 1. Written job descriptions that specify authority, responsibility, and qualifications for each job classification; 2. Process for verifying current professional licensing or certification and training of employees or independent contractors; 3. Process for annually evaluating employee performance and competency; 4. Process for verifying that contractors and their employees meet the personnel qualifications of the facility; and 5. Process for reporting licensed and certified health care practitioners for violations of their licensing or certification standards to the appropriate board within the Department of Health Professions. This RULE: is not met as evidenced by: Based on document review and staff interviews the facility failed to have a process for verifying current professional licensing or certification and training of employees or independent contractors and failed to have a 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	T 095	1. PPHS has credentialing done to verify all aspects of any clinician hired. However, there was no written Policy & Procedure regarding this process. This is now in place and includes periodic check of licenses on the Virginia Department of Health Professions web site. 2. There is also now in place a policy for training of employees and/or independent contractors. While training was being done and documented, the policy is now in place and this will be monitored by the HR Manager and/or the QM Manager. 3. There is now in place a Policy & Procedure for reporting licensed and certified practitioners for violations of licensing or certification standards to the Department of Health Professions. This process will be provided to staff with training on how to comply with this by the HCM. The HR Manager will maintain a log of such submissions in a secure file.	

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T 095	Continued From Page 5 Professions. The findings include: On 8/2/12 a review was completed of the facility's policies and procedures with the Alternate Administrator (Alt. Adm.) and Vice President of Operations. The Alt. Adm. was asked to provide the policy or policies related to verification of licensed professionals and 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. The Alt. Adm. stated, "We do not have a process to verify licenses or for reporting licensed staff for a violation of their licenses."	T 095		
T 155	12 VAC 5-412-210 E Patients' rights E. The facility shall provide each patient or her designee with the name, mailing address, and telephone number of the: 1. Facility contact person; and 2. The OLC Complaint Unit, including the toll-free complaint hotline number. Patients may submit complaints anonymously to the OLC. The facility shall display a copy of this information in a conspicuous place. This RULE: is not met as evidenced by: Based on observations, staff interview and document review the facility staff failed to post and provide patients with facility contact person, address and telephone numbers in order to express a complaint or concern. The findings include:	T 155	1. The Patients' Rights information has been revised to note in bold the HCM's title, local phone number with extension and the address of the site so that patients or others may initially contact the HCM regarding any complaint or concern.	

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T 155	Continued From Page 6 During a tour of the facility on 8/2/12 with the Alternate Administrator a posting of patient's rights was observed in the waiting area. The posting did not list the facility contact person, address or telephone number should a patient want to express a complaint or concern. Information given to patients at the time of their admissions related to filing a complaint did not list the facility contact person, address or telephone number should a patient want to express a complaint or concern. The Alternate Administrator stated, "We will fix that."	T 155		
T 165	12 VAC 5-412-220 A Infection prevention A. The abortion facility shall have an infection prevention plan that encompasses the entire facility and all services provided, and which is consistent with the provisions of the current edition of "Guide to Infection Prevention in Outpatient Settings: Minimum Expectations for Safe Care", published by the U.S. Centers for Disease Control and Prevention. An individual with training and expertise in infection prevention shall participate in the development of infection prevention policies and procedures and shall review them to assure they comply with applicable regulations and standards. 1. The process for development, implementation and maintenance of infection prevention policies and procedures and the regulations or guidance documents on which they are based shall be documented. 2. All infection prevention policies and procedures shall be reviewed at least annually by the administrator and appropriate members of the clinical staff. The annual review process and recommendations for changes/updates shall be documented in writing.	T 165		

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T 165	Continued From Page 7 3. A designated person in the facility shall have received training in basic infection prevention, and shall also be involved in the annual review. This RULE: is not met as evidenced by: Based on document review and interviews the facility staff failed to ensure the person designated as the infection preventionist had the training and expertise to direct an infection control program. The finding include: On 8/2/12 the personnel file of the person designated as the infection control preventionist was reviewed with the Vice President of Operations (VPO). The person designated as the infection control preventionist was not a licensed health care professional. The infection control preventionist's personal file documented the completion of two training modules related to infection control. The VPO stated, "She has completed two modules in infection control." It was pointed out to the VPO that the two modules were the same modules all staff were required to complete.	T 165	1. The QM Manager was approved for Certification Board of Infection Control training for infection control and will have a certificate for this training. This program was recommended by the inspector so that our QM Manager is trained in a manner which qualifies her to train other staff in infection control. This program also has recertification so that it is ensured the training remains current. The VP for Medical Services will monitor the training for the QM Manager.	
T 175	12 VAC 5-412-220 C Infection prevention C. Written policies and procedures for the management of the facility, equipment and supplies shall address the following: 1. Access to hand-washing equipment and adequate supplies (e.g., soap, alcohol-based hand rubs, disposable towels or hot air dryers); 2. Availability of utility sinks, cleaning supplies and other materials for cleaning, disposal, storage and transport of equipment and supplies; 3. Appropriate storage for cleaning agents (e.g., locked cabinets or rooms for chemicals used for cleaning) and product-specific instructions for use of cleaning agents (e.g., dilution, contact	T 175		

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T 175	Continued From Page 8 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 or required by the department. This RULE: is not met as evidenced by: Based on observations, interviews and document reviews the facility staff failed to ensure the exam table in the procedure room and 2 of 4	T 175	1. The recovery room chairs have been seen by a professional upholsterer who will repair the small tears on the back corners of the recliners by September 12th. The Facilities Coordinator will be performing monthly checks on all equipment and this will include monitoring the recliners and exam tables.	

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T 175	Continued From Page 9 reclining chairs for recovery were free of tears. The findings include: On 8/2/12 during the initial tour of the facility the procedure room was observed with the Alternate Administrator. The exam table was observed to have tears on the corners of the table. The Alternate Administrator stated, "We will take care of that." Also during the initial tour of the facility the recovery area was observed and 2 of the 4 reclining chairs had tears. The Alternate Administrator stated, "We will get those fixed." The tears in the exam table and recovery chair leave exposed porous surfaces which them unable to be properly cleaned to prevent the spread of infections.	T 175		
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 document review and interviews the facility staff failed to ensure a physician's order for discharge was documented for 1 of 1 patients, Patient #1. The findings include: On 8/3/12 a procedure for Patient #1 was observed and the medical record was reviewed after Patient #1 was discharged. The medical	T 255	1. There is now a policy in place for post-procedure evaluation of the patient. There has been a form revised to reflect that it is a Discharge Order which is given to patients when being released. The HCM will ensure this policy is followed and the RM will monitor.	

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T 255	Continued From Page 10 record did not have a physician's order for discharge. The Alternate Administrator reviewed the record and stated, "No we do not have a physician's order for discharge."	T 255		
T 275	12 VAC 5-412-260 C Administration, storage and dispensing of dru C. Drugs maintained in the facility for daily administration shall not be expired and shall be properly stored in enclosures of sufficient size with restricted access to authorized personnel only. Drugs shall be maintained at appropriate temperatures in accordance with definitions in 18 VAC 110-20-10 This RULE: is not met as evidenced by: Based on observations, document review and interviews the facility failed to ensure medications that were opened and accessed were dated and then discarded when expired and failed to follow Virginia Department of Health guidelines for repacking of medications. The findings include: On 8/2/12 during the initial tour of the facility with the Alternate Administrator the following was noted: two (2) 50 ml (milliliters) vials of Lidocaine 10 mg (milligrams)/ml were opened and accessed and available for used were not dated as to when they were opened and accessed. The Centers for Disease Control Injection Safety updated February 9, 2011 recommended the following: Medication vials should always be discarded whenever sterility is compromised or questionable. In addition, the United States Pharmacopeia (USP) General Chapter 797 [16 </injectionsafety/providers/references.html>] recommends the following for multi-dose vials of sterile pharmaceuticals:	T 275	1. There is now a policy & procedure in place to ensure that proper care of medications are done, as follows: a. Any medications which have been opened and are available for use will have the first use date marked clearly on the bottle and these will be used only for 28 days and then discarded; the two Lidocaine bottles in question were discarded; any medication bottle will be discarded if sterility is compromised or questionable b. Repackaged medications are properly marked on the bottle which notes medication name, strength, dosage form, quantity, name of distributor, lot number from original container and that expiration date, and clinician's name and signature/initials. The drugs will be placed in tight, light resistant, child resistant containers with the proper labeling. The repackaged items are good for six months as repackaged	

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T 275	Continued From Page 11 If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. In the emergency medication/treatment box was a repackaged bottle of misoprostol. The bottle contained 8 tablets and was labeled with the name of the medication and an expiration date of 12/12. There was no lot number on the repackaged medications. The Alternate Administrator stated, "The tablets were removed from a stock bottle and placed in the emergency kit per our agency's protocol." The stock bottle was provided and had an expiration date of 6/14. The Virginia Department of Health Pharmacy Services stated the following regarding repackaging of prescription and non-prescription drugs: If drugs are repackaged into smaller, ready-to-dispense quantities from larger bulk containers, a physician, nurse practitioner, dentist (for his/her dental patients) or pharmacist must be on the premises to supervise the repackaging and labeling. The drugs must be placed in tight, light resistant, child resistant containers with proper labeling. The label must contain the name and address of the health department, the drug name, strength and dosage form (capsule, tablet, etc), quantity, the name of the distributor/manufacturer, the lot number from the bulk container and the expiration date. The expiration date is limited to six months from the date the product is repackaged or the distributor's/manufacturer's expiration date, whichever is the shortest dating. A log must be maintained documenting the repackaging of all drugs. This log must include the date of repackaging, the drug name, strength and dosage form, quantity per bottle, the number of units repackaged, expiration date of the	T 275	or the distributor's expiration date, whichever is the shortest. c. There is a log documenting repackaging of all drugs. This log includes the date of repackaging, the drug name, strength and dosage form, quantity per bottle, the number of units repackaged, expiration date of the repackaged product and the initials of the clinician who supervised the repackaging. Any repackaged drug, prescription or non-prescription will be dispensed by a clinician with appropriate documentation and patient labeling. d. The HCM will provide oversight for this documentation to ensure it is properly done. The RM will monitor to ensure this procedure is followed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FTAF-006	A. BUILDING _____ B. WING _____	08/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTESVILLE PLANNED PARENTHOOD HEA	2964 HYDRAULIC ROAD CHARLOTTESVILLE, VA 22901

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T 275	Continued From Page 12 repackaged product, and the initials of the physician, nurse practitioner, dentist or pharmacist who supervised the repackaging. Any repackaged drug, prescription or non-prescription, must be dispensed by a physician, nurse practitioner, or dentist (for his or her dental patients) with appropriate documentation and patient labeling.	T 275		
T 360	12 VAC 5-412-340 Policies and procedures 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: 1. Facility security; 2. Safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs, supplies and services; and 3. Provisions for disseminating safety-related information to employees and users of the facility. This RULE: is not met as evidenced by: Based on observations it was determined the facility staff failed to develop, implement and maintain procedures to ensure safety within the facility to minimize hazards to patients and staff. The facility failed to store sharps containers in a safe manner. The Findings Include: A facility tour conducted on 8/2/12/ revealed sharps containers were sitting on the floor at the end of treatment tables in two procedure rooms and ultrasound. The containers were not secure to the table or floor. and had a circular open area	T 360	1. The mentioned sharps containers which were free standing in the procedure rooms have been removed. The Facilities Coordinator is researching for containers which can be attached to the wall to ensure safety within the facility for patients and staff. The Facilities Coordinator will inspect monthly to ensure sharps containers are attached as required for staff and patient safety. She will monitor this with a checklist which will include this as an item for monthly inspection.	

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T 360	Continued From Page 13 at the top in which needles were inserted. According to The Center for Disease Control, Selecting, Evaluating and Using Sharps Disposal Containers article January 1998, reads in part: Stability-containers should be stable when placed in a horizontal surface."	T 360		
T 400	12 VAC 5-412-380 Local and state codes and standards Abortion facilities shall comply with state and local codes, zoning and building ordinances, and the Uniform Statewide Building Code. In addition, abortion facilities shall comply with Part 1 and sections 3.1-1 through 3.1-8 and section 3.7 of Part 3 of the 2010 Guidelines for Design and Construction of Health Care Facilities of the Facilities Guidelines Institute, which shall take precedence over Uniform Statewide Building Code pursuant to Virginia Code 32.1-127.001. Entities operating as of the effective date of these regulations as identified by the department through submission of Reports of Induced Termination of Pregnancy pursuant to 12 VAC 5-550-120 or other means and that are now subject to licensure may be licensed in their current buildings if such entities submit a plan with the application for licensure that will bring them into full compliance with this provision within two years from the date of licensure. Refer to Abortion Regulation Facility Requirements Survey workbook for detailed facility requirements. This RULE: is not met as evidenced by: Based on interviews and a review of facility documents it was determined the facility failed to comply with state and local codes, zoning and building ordinances, and the Uniform Statewide Building Code.	T 400		

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T 400	Continued From Page 14 The findings were: An interview with the administrator on 8/3/2012 at approximately 11:00 a.m. revealed the facility staff failed to get an attestation from a licensed architecture that the facility meets the required FGI (AIA) guidelines. The administrator presented a write up from the architects that were involved in the original construction of the building. The architect did not do an onsite visit rather they reviewed the "as built" design documents for the building done in 2004. The architects review of the "as built" design documents dated 2/15/12 contained the following information: 1. It is likely that the outdoor air volume does not meet the new requirements of ASARAE 170-2008 It is likely that the design likely does not meet the new 30% efficiency rating requirements of ASARAE standard 170-2008 see recommendations; 2. The recommendations from the architect states the owner shall obtain a testing and balancing report (TAB) to verify the existing air volume and outdoor air volumes provided to the two procedure rooms. The HVAC equipment (air handler/compress units) shall be inspected to verify existing air flow, equipment capacity, model and potential for modification. This inspection and TAB report shall be provided by a certified air testing and balancing engineering consultant. Based on results of this future TAB report, the owner shall obtain the services of a licensed mechanical engineer to make system adjustments and/or design modifications. A) adjust air balancing necessary to provide increase air changes and outdoor air volumes B) increase size of fresh air intake vents C) remove existing filters and replace with new	T 400	1. The Charlottesville Health Center has two years from the date of licensure to comply with the requirements of 12 VAC 5-412-380. Its Plan of Compliance for each of the findings is to be completed within the two years from licensure. Attached is Appendix A, which is the letter from our architect, which states how compliance will be handled for the two (2) outside air exchanges per hour and for the 30% efficient filters. 2. The facility is purchasing a reclining blood draw chair. This will be done promptly to comply with this regulation so the two year timeframe is not an issue for this item. Patient safety has not been an issue as no patient has passed out from the needle draw in this lab since opening in 2004. 3. The original contractor for this building is preparing a quote for replacing the sinks in the two procedure rooms. The wrist handles on this sink are 4" long but sufficient so that water could be turned off without using the hand. There is a scrub sink in the clean lab at this site with foot peddles for the clinician to use before entering the procedure room. These items will be replaced as soon as possible at this site but well within the two years from licensure as allowed. Patient and staff health and safety have not been an issue due to the scrub sink in the clean lab.	

State of Virginia

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T 400	Continued From Page 15 30% efficiency filters and modify duct and filter sleeves if necessary. As of the date of the survey, the facility had not followed through with the recommendations from the architect. Findings during the facility tour included the following: 1. the laboratory failed to have a reclining chair 2. two sinks, located in the procedure rooms do not meet the requirement for hand washing stations. Both sinks are only 7 inches deep and have handles that must be turned on by hand.	T 400		

Appendix A

Rife + Wood
ARCHITECTS

February 15, 2012

Walter Klausmeier, Administrator
Planned Parenthood Health Systems, Inc.
100 S Boylan Avenue
Raleigh, NC 27603. tel: 919.833.7526 x 6140

Re: Facility Compliance – Planned Parenthood – **Charlottesville Clinic**

Dear Walter,
At your request, Rife+Wood Architects has have reviewed the as-built design documents for the Planned Parenthood Clinic to determine how the facility may / may not be in compliance with the newly enacted Virginia Department of Health *Regulations for Licensure of Abortion Facilities, 12 VAC 5-412.*

As project architects, Rife+Wood was involved in the build-out design and construction of the Charlottesville clinic from initial concept thru final construction (Summer 2004). The building was designed to meet or exceed the design standards of the building code in use at the time of construction Virginia Uniform Statewide Building Code (BOCA - 1996) and ASHRAE 90.1-1999.

My finding and recommendation are as follows:

PROCEDURE ROOM SIZE:
The existing facility has two procedure rooms. Both rooms exceed the requirement for a minimum 150 SF floor area for **Class A Surgical / Medical Operating Room** per Section 3.7-3.3 Ambulatory Operating Rooms. The rooms also comply with the clearance and location requirements of this Section.

Space	*Existing Size*	*Existing Floor Area*	*Required Floor Area*
Procedure Room 207	16'-2" x 18'-1"	292 sq.ft.	150 sq. ft.
Procedure Room 210	16'-0" x 18'-1"	289 sq.ft.	150 sq. ft.

Both existing Procedure Rooms 207 & 210 comply with the size and clearance standards for and Class A-Operating Rooms (150 sq.ft.). No room size modifications are required.

HEATING VENTING AND AIR CONDITIONING (HVAC):
AIR VOLUME: The existing second floor medical suite is serviced by two gas fired – heat pump units located in the attic space. Procedure Room 207 is served by Furnace 1. Procedure Room 210 is served Furnace 2. The specified furnace units are both by Payne Mnfg (Model PG8UAA042091). **Each unit serves multiple spaces and each provides a total of 1400 CFM and 460 CFM Outdoor Air.**

As designed the existing HVAC system provide the procedure rooms with Total Air Volume (cubic feet per minute / CFM) and Air Changes per hour (ach) as shown below. Total Air Changes per Hour (ach) were compliant under the Virginia Uniform Building Code (BOCA - 1996).

Per the clarifications issued by the DOH / most Frequently Asked Questions every Class A Operating / Procedure Room in an abortion facility must meet the standard shown below:

	EXISTING	*EXISTING*	*NEW REQUIREMENTS*
Room	*volume*	*Total ach*	*Minimum outdoor ach*
Procedure Room 207	320 CFM	8.21	2
Procedure Room 210	275 CFM	7.13	2

OUTDOOR (FRESH) AIR: The volume of outdoor air provided to Procedure Rooms 207 & 210 has not been verified. **Whereas this design standard has increased since 1996, it is likely that outdoor air volume does not meet the new requirements of ASARAE Standard 170-2008.** See recommendations below

AIR FILTRATION: Existing furnace filter type was specified to be compliant under Virginia Uniform Building Code (BOCA - 1996). The efficiency of the existing air filter system has not been verified. **It is likely that the design likely does not meet the new 30% efficiency rating requirements of ASARAE Standard 170-2008.**

RECOMMENDATIONS:

Owner shall obtain a testing and balancing report (TAB) to verify the existing air volume and outdoor air volumes provided to the two procedure rooms. The HVAC equipment (air handler / compressor units) shall be inspected to verify existing air flow, equipment capacity, model and potential for modification. This Inspection and TAB Report shall be provided by a certified Air Testing and Balancing Engineering consultant.

Based on results of this future TAB report, the Owner shall obtain the services of a licensed Mechanical Engineer to make system adjustments and / or design modifications.

a. Adjust air balancing necessary to provide increase air changes and outdoor air volumes.
b. Increase size of fresh air intake vents.
c. Remove existing filters and replace with new 30 % efficiency filters – modify duct and filter sleeves if necessary.

Please feel free to call on me if you have any questions regarding this summary and recommendations.

Sincerely,

Jeffrey R. Wood, AIA — 2/15/2012 date

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Facility Administrator — date
Planned Parenthood Health Systems, Inc

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